Approved 1-30-92
Date

MINUTES OF THE HOUSE COMMITTEE ON JUDICIARY.

The meeting was called to order by Representative John Solbach at
Chairperson

3:30 ~~xxx~~/p.m. on January 27, 1992 in room 514, of the Capitol.

All members were present except:

Representatives Allen, Douville, Gregory, Hamilton and Rock who were excused.

Committee staff present:

Jill Wolters, Revisor of Statutes
Judy Goeden, Committee Secretary

Conferees appearing before the committee:

Jack Phillips, Olathe S. R. S. Office
Ron Smith, Kansas Bar Association
Nancy Lindberg, Atty General Office
John H. Holmgren, Catholic Health Association of Kansas
Jenifer Brandeberry, Pro Choice Action League
Chip Wheelen, Kansas Medical Society
James L. Germer, Kansas Advocacy & Protective Services, Inc
Lisa Getz, St. Francis Regional Medical Center
Marilyn Bradt, Kansans for Improvement of Nursing Homes, Inc.
Kenda Bartlett, Concerned Women for America of Kansas
Katheryn Eilert, Council of Catholic Women & Right to Life
Pat Goodson, Right to Life
Chris May, Kansans for Life, by Kenda Bartlett

Chairman John Solbach called the committee meeting to order.

Jack Phillip, Olathe S.R.S. Office requested a bill be introduced concerning child support enforcement. Rep. Heinemann moved to introduce requested legislation. Rep. Macy seconded the motion. Motion carried.

Rep. Macy requested three bills be introduced concerning child support, exempting child support from garnishments, extending child support payments and to restrict a drivers license. Rep. Everhart seconded the motion. Motion carried.

Ron Smith, Kansas Bar Association, requested a proposed addition to K.S.A. 60 Rules of Civil Procedure. (Attachment #1) Rep. Heinemann moved to introduce requested legislation Rep. Macy seconded the motion. Motion carried.

Nancy Lindberg, Attorney General Office, requested introduction of bills concerning 1) fines for KBI forensic laboratory work, 2) Kansas Forfeiture Act and 3) cladestine laboratories included in felony murder. (Attachment #2) Rep. Snowbarger moved to introduce requested bills. Rep. Parkinson seconded motion. Motion carried.

Hearings were opened on HB 2671, medical treatment decisions act.

John Holmgren, Catholic Health Association of Kansas, testified in favor of HB 2671, medical treatment decisions act. (Attachment #3)

Jenifer Brandeberry, Pro Choice Action League, presented written testimony to the committee in favor of HB 2671. (Attachment #4)

Chip Wheelen, Kansas Medical Society, testified he would prefer SB 350 over HB 2671. (Attachment #5). He answered committee members questions.

James Germer, Kansas Advocacy & Protective Services, testified in favor of HB 2671. (Attachment #6) He suggested several changes in the bill and answered committee members questions.

MINUTES OF THE HOUSE COMMITTEE ON JUDICIARY,

room 514S, Statehouse, at 3:30 xxm./p.m. on January 27, 1992.

Lisa Getz, St. Francis Regional Medical Center, presented testimony for Roberta R. Johnson. (Attachment #7). She said they cannot support HB 2671 as written, however they support the concept of the bill.

Marilyn Bradt, Kansans for Improvement of Nursing Homes, Inc., testified in opposition to HB 2671. (Attachment #8) She expressed numerous concerns about the bill. She answered committee members questions.

Kenda Bartlett, Concerned Women for America of Kansas, testified in opposition to HB 2671. (Attachment #9)

Katheryn Eilert presented testimony for Bob Norcross, R.N., Hilltop Lodge, Beloit, Kansas, in opposition to HB 2671. (Attachment #10)

Pat Goodson, Right to Life, testified in opposition to HB 2671. (Attachment #11)

Chris May, Kansans for Life, submited testimony in opposition to HB 2671, which was read by Kenda Bartlett. (Attachment #12)

Chairman Solbach said that the hearing on HB 2671 will be continued to January 28, 1992.

The meeting adjourned at 4:45 p.m.

GUEST LIST

COMMITTEE: House Judiciary DATE: 1-27-92

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Mrs. Angelene L. Schmitz	514 N. Washington Beloit, KS 67420	Right to Life of Kansas
Kathryn Eilert	600 E Main Beloit, KS. 67420	Right To Life, of KS.
Mrs. Rose Eilert	RR#1 Beloit	Right To Life, KS
JUDY LUTZ	Minneapolis, KS	Council of Catholic Women
John H Holmgren	Topeka, Ks.	Catholic Health Assn
Jim Germer	513 Leavenworth Manhattan KS 66502	Kansas Adv. & Prot Svcs
Jean Krahn	513 Leavenworth Manhattan KS 66502	KS Advocacy & Prot. Services
Laura L. Dickinson	513 Leavenworth Manhattan, Ks 66502	Ks Advocacy & Protective Services
Marilyn Braeht	913 Tennessee, # 2 Lawrence, KS	KIWH
Jenifer Brandeberry	1213 S.W. Washburn Topeka, KS 66604	PCAL
Amy Bixler	5345 NW Seaton Topeka KS 66610	NOW
Paul Magathan	RR1 Cedar Point K66845	Right to Life Kansas
KEITH R LANDIS	TOPEKA	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
JEFF DEGRAFFENREID	"	KEPOR
Kerry Townsend	Topeka KS	KS Hosp. Assoc.
Sharon Huffman	Topeka	KCDC
Lisa Getz	Wichita	ST. FRANCIS REGIONAL MEDICAL CENTER
Katie Park	Topeka	AARP-CCTF Legislative Network
Tom Bell	Topeka	KHA
Marta Fishel Linenberger	Topeka	Kammca
Chip Wheelen	Topeka	KS Medical Soc.
Paul Shelby	Topeka	OJA
Nancy Lindberg	Topeka	AG
Dorothy Wrocklage	Topeka	KCCA

KOCH INDUSTRIES INC

LEGAL DEPARTMENT
LITIGATION SECTION

REX G. BEASLEY
SENIOR ATTORNEY

December 30, 1991

Ron Smith, KBA General Counsel
1200 Harrison
P.O. Box 1037
Topeka, Kansas 66601

Re: Proposed Addition to K.S.A. Chapter 60 Rules of Civil Procedure

Dear Ron:

The Wichita Bar Association proposes the following addition to K.S.A. Chapter 60. The reasons for the proposed addition is explained in the penultimate paragraph of this letter.

PROPOSED ADDITION

Parties or attorneys in possession of original deposition transcripts, original responses to interrogatories, requests for admissions, requests for production, or other original matters produced during discovery shall retain the same until the case is closed.

"Closed" means when an order terminating the action or proceeding has been filed and all appeals have been terminated or the time for appeal has expired, or when the judgment is either satisfied or barred under the provisions of K.S.A. 60-2403.

When the case has been closed the party or attorney in possession of original transcripts or other original discovery responses may destroy or dispose of the same, except as provided herein.

Original discovery documents subject to or covered by a protective order, court rule, statute, or written agreement of the parties shall be retained, returned, destroyed, or disposed of in accordance with the terms of the order, statute, rule, or written agreement.

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P.O. Box 2256 ▪ Wichita, Kansas 67201 ▪ 316/832-4030 ▪ FAX 316/832-8950
TWX 910/741-6990 ▪ TLX 417376

REASONS FOR PROPOSED ADDITION

Until recently, original discovery responses and original deposition transcripts were filed with the clerk of the court and were subject to the retention requirements of Supreme Court Rule 108. Changes in K.S.A. 60-230 (f) have altered the handling of original discovery documents without providing any guidance to counsel concerning retention of the original documents upon completion of the case. The proposed addition to the statutes provides for the retention of original discovery documents until the case is "closed". After the case is closed, the documents may be retained or destroyed, unless they are subject to a protective order, court rule, statute, or written agreement. The need for this addition occurred to me while preparing a closed file for storage. There was no need to store the voluminous discovery documents, but Supreme Court Rule 108 does not apply to parties or counsel and there is no other statutory provision or rule to relieve the apparent burden of retaining the original discovery documents in perpetuity.

Ron, if you have any questions, please do not hesitate to contact me. If an amendment is introduced, I will be willing to appear to testify at the hearing, if necessary, and if the hearing does not conflict with my scheduled commitments.

Very truly yours,

Rex G. Beasley
Associate General Counsel
Litigation

STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

2ND FLOOR, KANSAS JUDICIAL CENTER, TOPEKA 66612-1597

ROBERT T. STEPHAN
ATTORNEY GENERAL

MAIN PHONE: (913) 296-2215
CONSUMER PROTECTION: 296-3751
TELECOPIER: 296-6296

January 27, 1992

TO: Representative John Solbach, Chairperson
House Judiciary Committee Members

FROM: Attorney General Bob Stephan RTS

RE: Legislative Recommendations

1. Fines for KBI Forensic Laboratory Work - Creates a minimum, mandatory fine of $150 for all convictions, except traffic violations. Other states have adopted similar statutes as a means of funding their state forensic laboratories as well a various educational and treatment programs. The fund created would be used by the KBI to purchase equipment and train personnel and to provide services to local law enforcement agencies.

2. Kansas Forfeiture Act - Amend the Kansas Forfeiture Act which would address problems noted in recent court cases and would incorporate changes recommended in the 1991 Model Forfeiture Act.

3. Clandestine Laboratories Included in Felony Murder - Last year we amended first degree murder, K.S.A. 21-3401, so that felony murder included a death occurring during a violation of our main drug statutes. A new statute, K.S.A. 65-4159, which deals with manufacturing of clandestine laboratories, was not referenced in the felony murder statute.

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Catholic Health Association of Kansas

John H. Holmgren • Executive Director
Jayhawk Tower, 700 Jackson, Suite 801 / Topeka, KS 66603 / (913) 232-6597

TESTIMONY

Before the House Judiciary Committee
Repr. John Solback, Chair
Repr. Denise Everhart, Vice Chair

Reference: HB 2671

We appreciate this opportunity to appear before you with respect to HB 2671. We feel that this is a workable bill with only a few needed modifications. The priority listing of relatives, for the decision regarding life sustaining treatment, is a needed one, as several ethicists have argued. The provider long term care facility, hospital, hospice, or physician will find this a supportive mechanism.

One minor recommendation. There may be confusion. On page 5, line 32, citation New section 9, (d), the statement is made, quote:

> "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."

However, on line 35, P. 3, New Section 5, where it describes the event where the patient is legally incompetent, comatose, or unconscious, and who, a priori, when competent, quote "has not communicated such individuals' on the individual's medical care and treatment pursuant to section 3, it shall be presumed that it is such individual's intent that the individual shall be provided with life-sustaining treatment, including nourishment and hydration."

decisions

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These two paragraphs may be interpreted by some, as inconsistent.

We note, also, line 24, P. 4, New Section 6, which provides for "an attending physician or other health care provider who is unwilling to comply with this Act shall take all reasonable steps...to transfer...the patient to another physician or provider who is willing to do so."

In summary, we believe the proposal to be workable for Catholic institutions, at this time, and if there are no further questions raised by our members, who have only received a copy of the bill as of today.

Thank you.

John H. Holmgren
Executive Director
(913) 232-6597

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

Dedicated★Determined★Decisive

MEMBERS OF THE HOUSE JUDICIARY COMMITTEE

FROM: Jenifer Brandeberry, Pro Choice Action League

REGARDING: H.B. 2671

DATE: January 27, 1992

Pro Choice Action League believes that individuals not government can best determine their own lives, and in that spirit we applaud the committees effort in considering this type of legislation.

Pro Choice Action League supports the language which pertains to a pregnant woman's options when considering medical treatment and decisions. As I testified in previous hearings PCAL is primarily concerned that state law allow women the same options as men when planning their future. The proposed declaration on medical treatment allows for individual choices and PCAL requests that this type of language and option be left in H.B. 2671. We appreciate the committees thoughtful and fair way in drafting this piece of legislation.

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1-27-92
Att #4

KANSAS MEDICAL SOCIETY
623 W. 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

January 27, 1992

TO: House Judiciary Committee

FROM: Kansas Medical Society Chip Wheelin

SUBJECT: House Bill 2671; Medical Treatment Decisions Act

During the interim between sessions our Medical Services Committee had the opportunity to analyze the provisions of 1991 SB 350, the bill proposed last year by the Kansas Bar Association. Based on that review and considerable discussion, our Committee decided to express support for the provisions of SB 350 for the following reasons:

1. It establishes a hierarchy of family members that a physician may consult with when a terminal, incurable patient is not capable of making health care decisions and has not executed a declaration.

2. It allows an attending physician to diagnose a terminal, incurable condition without a requirement to consult another physician.

3. It provides statutory immunity to physicians and other health care providers who adhere to the guidelines.

4. It combines two, somewhat complex laws into one simpler law.

5. The advance directive could become "portable" if other states adopt the provisions of this bill.

Our Medical Services Committee does not endorse language that would broaden application to situations other than terminal, incurable conditions. It would probably not be possible to achieve consensus among our own members on the more controversial issues.

House Bill 2671 appears to meet the tests of criteria 1 and 3 but it requires that the attending physician consult with "one other qualified physician" who must certify in writing that the patient is (1) incurable, (2) in a terminal condition, and (3) incompetent to make health care decisions. This is very problematic in the many rural communities in our State where physicians are few and far between.

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Nor does HB 2671 combine the concept of a living will with that of a durable power of attorney for health care decisions. Patients who are not trained in legal matters do not appreciate the need for two different forms. Furthermore, there is no reason to believe that the provisions of HB 2671 would ever become "portable" to other states unless those states enact language similar to subsection (b) of New Section 10 (line 4, p. 6).

Yet, HB 2671 is replete with protections for physicians who follow the protocol set out, and when compared with current laws, does have considerable merit. Therefore the Kansas Medical Society must express support for HB 2671 but on balance, would prefer enactment of SB 350 with a few technical amendments.

Thank you for considering our comments.

CW/cb

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1-27-92
att # 5
2-2

Kansas Advocacy & Protective Services, Inc.

kaps

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 House Committee on Judiciary,
Representative John Solbach, Chairperson

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

RE: House Bill 2671 - Medical Treatment Decisions Act

DATE: January 27, 1992

KAPS assists disabled children and adults in gaining access to the rights and services to which they are entitled. We administer two federal programs - protection and advocacy as provided for by the Developmental Disabilities Act (P.L. 94-103 as amended), and the Protection and Advocacy for Mentally Ill Individuals Act (P.L. 99-319). We also administer the Kansas Guardianship Program, a program funded by and unique to Kansas. KAPS is a private, non-profit corporation with authority to pursue legal, administrative and other appropriate remedies on behalf of the persons it serves. There are 57 similar agencies serving our states and territories.

Our staff have reviewed H.B. 2671 and offer the following observations.

We are still somewhat troubled by the requirement that the opinion of only the attending physician be sufficient to establish a "terminal condition", and suggest that it may be preferable to have a second physician's opinion on whether there is a "terminal condition". We believe that the gravity of the decision that has to be made may very well justify having the second opinion. It will be noted that, although the Act only requires the opinion of one attending physician as to "terminal condition", the model declaration set forth on page 2 of H.B. 2671 contains provisions for two physicians, at lines 24 and 25.

Our major staff concern deals with the order of consent priority found on page 4, lines 1 - 14. It is our opinion that any time there is a guardian appointed, there also be approval by the court. The way the priorities are presently set out, it would appear that the persons in priorities A through E could override the decision of a guardian. Where the guardian is a family member, there may well not be much of a problem; but where the guardian is not a member of priorities A

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through E, this should act as a red flag. In any event, since under current law the guardian is required to seek approval of the court for the removal of a bodily organ, then it would appear that the requirement of court approval is even more important where in fact the subject is cessation of total life support.

Third, on some level, in particular when considerations are made regarding persons who, because of their level of disability, have never achieved Legal capacity, we would like to see the involvement of Institutional Ethics Committees. The Committees could be of assistance in assisting families, guardians, and medical services personnel in making difficult decisions. Where the issue involves developmental disabilities, it may be advantageous to make sure that the Institutional Ethics Committee has as at least one of its members someone with expertise in the area of developmental disabilities.

Respectfully submitted,

Joan Strickler
Executive Director

James L. Germer
Caseworker/Advocate

JLG:jag

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ST. FRANCIS REGIONAL MEDICAL CENTER

Roberta R. Johnson
Associate General Counsel

Testimony Presented to

House Judiciary Committee

Chairman Solbach and Members of the Committee, I am Roberta R. Johnson, Associate General Counsel, St. Francis Regional Medical Center, Inc. I am not able to give testimony before you today, but on behalf of St. Francis please consider my written testimony on House Bill 2671.

St. Francis Regional Medical Center, Inc. has studied and reviewed in depth House Bill No. 2671 addressing medical treatment decisions. The Hospital fully supports legislation that allows the citizens of Kansas to inform their health care providers, in advance, of the medical treatment and/or intervention they may desire when end of life decisions must be made. It is imperative, however, that legislation addressing this issue and any form utilized to communicate these decisions be clear and unambiguous to the health care provider being directed to implement the document.

In its current form, House Bill No. 2671 lacks the necessary clarity to be effectively implemented by a health care provider.

For example, the definition of "qualified patient" is ambiguous when read in conjunction with the rest of the Bill. It indicates the attending physician alone could make the determination of a "terminal condition". This is ambiguous when read in conjunction with the language of the proposed form found on page 2, lines 24 and 25 which indicate two (2) physicians (the attending and one other qualified physician certify in writing. . ." must make the determination of "terminal illness". Further, the form references a "qualified" physician, but fails to define the term.

Similarly, the ambiguity is present in the definition of "terminal condition" as well. Page 1, line 43 indicates one (1) physician, the attending, could make the decision of whether the patient has a terminal condition. The ambiguity appears again on page 3, lines 42 and 43, where language indicates the "attending physician" alone can determine a patient has a "terminal condition".

New Section 2 found on page 2, lines 2 through 4 identifies individuals who may execute a Declaration on Medical Treatment. Currently it restricts this group to those 18 or more years of age. This definition makes no

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reference to those individuals who may be considered "emancipated minors". It would be of great assistance to health care providers to have this section address the ability of "emancipated minors" to execute this Declaration. In addition, it would be of assistance to have a the term "emancipated minor" clearly defined.

Page 2, line 16 indicates the form may be witnessed by two individuals or acknowledged by a notary public. This language is ambiguous when read in conjunction with the form presented. First of all, there is no indication on the form that this option exists. I believe inserting the word OR between the witnesses line and the notary language would assist in clarifying this point. Second, however, and even more confusing, is the notary language itself which includes in its text the names of the two witnesses who signed in conjunction with the Declarant. I believe any reference to witnesses in the notary language should be omitted.

The form itself contains many ambiguities that may make it difficult for health care providers to properly implement the wishes of the Declarant. For example, page 2, line 22 references both nourishment and hydration. Any reference to the term hydration, however, is omitted from the form after line 22, page 2. Does this mean the Declarant cannot refuse hydration? Does this mean hydration is not considered "life-sustaining treatment" where nourishment is? "Life sustaining treatment" is defined on page 1, lines 26-28 as any "medical procedure or intervention that . . . will serve only to prolong the process of dying. It may be argued that hydrating an individual will prolong the dying process.

Further, page 2, line 36 restricts a Declarant's choices to refuse nourishment by allowing him choice when the "only procedure" he is receiving is "artificial nourishment". Does this mean a Declarant who is receiving pain killers cannot refuse nourishment? Does this mean a Declarant who is receiving hydration cannot refuse nourishment?

An additional concern regarding the form is the failure to determine individuals who are appropriate to "witness" the signing of this Declaration. The Natural Death Act currently in effect clearly defines appropriate witnesses to this type of document, excluding family and others who may gain from the death of the Declarant. Moreover, the Durable Power of Attorney for Health Care Decisions sets forth an identical definition for who may appropriately witness the document. It would alleviate confusion and assist health care providers, in proper implementation of this document to have the term "witness" defined.

New Section 4 allows revocation of the document "in any manner". This proposes some difficulties for Hospitals. Let me illustrate:

> As I am certain you are aware, recent federal legislation, known as the Patient Self Determination Act has placed certain duties upon Hospitals with respect to Advance Directives. One of those duties requires Hospitals to make specific inquiry of all adult in-patients as to whether they have an Advance Directive. When the question is answered in the affirmative this is documented in the medical record and a copy of the document is requested and placed in the patient's medical record. On occasion, patients have revoked the document, communicated this revocation to the Hospital and requested the copy of the document be returned to them. This creates a problem for the Hospital in that the document has become part of the Medical Record and may have been referenced in several notes in the Medical Record. Removing the document from the Medical Record can present a problem. It is the preference of St. Francis that the patient execute a written revocation or that the document remain on the Medical Record, but that it be defaced with the words void or revoked written in bold letters across the entire document.

An additional concern regarding the means of revocation as outlined in New Sec. 4 is the language stating the 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 presents two concerns. Let me illustrate one by a hypothetical.

> Assume a patient has executed a Declaration and given it to the Hospital at his last admission and the Hospital has placed it on the patient's Medical Record. The patient is dismissed from the Hospital and is to follow-up with his "attending physician" in one week. While at the "attending physician's office and in the presence of his spouse, the patient informs his "attending physician" that he wishes to revoke his Declaration. The revocation is effective and the "attending physician" makes a note in his <u>Office Chart</u>. Two days later, while his spouse is out grocery shopping, the patient suffers a heart attack. He is discovered by a neighbor and is taken by ambulance to the Hospital where he was previously admitted. He is brought to the Emergency Room and his <u>Hospital Medical Record</u> is requested and reviewed.

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The Emergency Room physician, now "the physician who has primary responsibility for the treatment and care of the patient", i.e. the "attending physician", determines the patient has a "terminal condition". He also consults a second physician who agrees the patient has a "terminal condition." An examination of the Hospital Medical Record reveals a duly authorized and executed Declaration with no evidence of revocation. No life-sustaining treatment is given and the patient dies.

The wife arrives at the hospital and is quite upset because no life-sustaining treatment was given. She indicates the Declaration was revoked and produces a copy of the Office Chart documenting the revocation.

Although the proposed legislation does provide protection from civil and criminal liability for the emergency room physician and the Hospital in the above scenario, it does not prevent the bad publicity that may result or alleviate the anger of the spouse.

A second concern regarding New Sec. 4 and the revocation provisions is that of line 32, page 3 which allows a witness to communicate a revocation. Again I will illustrate a common problem:

A woman is admitted to the Hospital. She is a widow with two children, a son and a daughter. She has been diagnosed with terminal cancer and has been certified by two physicians, one of them her attending, that she has a terminal condition. Prior to entering the Hospital she executed a Declaration on Medical Treatment and informed both of her children that she had done so. The daughter respected her mother's wishes and accepted the fact a Declaration had been signed. The son, on the other hand, was unhappy with his mother's decision and was angry that she had signed the document.

The son and daughter stayed by the mother's bedside throughout the day and finally that evening the mother persuaded the daughter to go to the cafeteria and eat dinner. She reassured the daughter that she was feeling fine and that the son would stay by her side until the daughter returned. The daughter relented and went to the cafeteria. Upon her return she found the mother had slipped into a coma from which she would not regain consciousness. The son informed the daughter that before slipping into the coma the mother had revoked her Declaration and had informed the son she wanted "everything done for her". The son informs the Hospital of the mothers revocation. The daughter

threatens a lawsuit against the Hospital if the Declaration is not honored.

Again, there is protection for the Hospital in the proposed legislation, but in the face of threatened litigation and an angry family member, such protections are of slight comfort and reassurance.

With respect to the order of "surrogate" decision makers, it is of concern that a legal guardian is the last individual to be consulted. Again, I illustrate this concern with a hypothetical scenario.

An elderly gentleman is placed under legal guardianship by his son. The son states he is employed out of the country and travels a considerable amount, and thus, requests that a neighbor of his father be appointed guardian. In reality, the son has no interest in his father who he believes has been a considerable burden to him for the past few years. He would prefer to place the responsibility for care with another person who will take the time. Several years pass and the son never makes any effort to contact or see his father. The neighbor, on the other hand, sees and assists the father daily and has several conversations with the father regarding end of life decisions. The neighbor attempts to reach the son to explain the father's wishes, but the son refuses to return phone calls.

One morning the neighbor goes to see the father and finds him unconscious. An ambulance is called and the father is taken to the Hospital. It is determined he has a "terminal condition". The doctor requires guidance on how to proceed. It seems unfair to the father to allow the son to make "end of life decisions", but pursuant to the proposed legislation, the wishes of the son would take precedence.

It is also of concern whether the term adult child includes step-children or only children related to the Declarant by blood. Clarification of this issue would be of assistance.

New Sec. 6 may pose some practical problems for the rural health care provider. For a physician in a rural Kansas area who may be the only physician in the proximate vicinity, it may be very difficult if not impossible to transfer care of the Declarant to another physician or health care provider.

Paragraph (f) of New Section 9, page 5, lines 40 and 41, is unclear and could present significant interpretation problems. It is possible this section could be interpreted to mean that a Declaration on Medical Treatment need not be

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honored. It is possible a health care provider may believe that failing to provide "life-sustaining treatment" in any and every instance is contrary to reasonable medical standards. Such an interpretation could allow a health care provider to ignore a Declaration and substitute the health care provider's judgment for the specifically declared wishes of a patient. Such an interpretation would significantly undercut the ability of an individual to make an Advanced Directive.

Although the previous testimony focuses significantly on ambiguities relating to the form that may be utilized by an individual to communicate his choices for medical care and treatment in end of life decisions, there is also a concern that must be voiced regarding New Sec. 3 (a) addressing "oral or written communications made directly to the attending physician", but only when the communication is "contemporaneous" with the provision of the proposed care or treatment and the patient is conscious and competent.

Restricting such communications only to those made "contemporaneously" with the provision of the proposed care ignores a major avenue currently being utilized by a large segment of the population to communicate these decisions to their doctors. Specifically, I refer to communications made by many patients to their family practice physicians, oftentimes during a routine annual physical examination. In fact many family practice physicians are initiating such conversations with their elderly patients and are recording their wishes in the Office Medical Record. Many patients do not wish to execute a formal written Declaration, preferring to simply tell their family doctor what they want and trusting him to carry out their wishes. Restricting the timing of such a communication to occurring "contemporaneously" with a specific treatment and further rejecting even a written communication (even though subsection (c) of the same section would allow a written declaration) appears unnecessarily restrictive.

In addition to the above, I believe the Bill could be of greater assistance to health care providers if it would designate a priority between a Declaration and a Durable Power of Attorney for Health Care Decisions. It is common for individuals to execute both documents. In such an instance it would be helpful for the legislature to state which document takes precedence.

In summary, the Bill in its current form presents several ambiguities that make it difficult for health care providers to properly implement Declarations on Medical Treatment as proposed. Clarification on the points noted above would improve the ability of Hospitals to implement the desired wishes of its patients.

Draft

KINH Kansans for Improvement of Nursing Homes, Inc.

913 Tennessee, suite 2 Lawrence, Kansas 66044 (913) 842 3088

TESTIMONY PRESENTED TO
THE HOUSE COMMITTEE ON JUDICIARY
CONCERNING HB 2671
THE MEDICAL TREATMENT DECISIONS ACT

January 27, 1992

Mr. Chairman and Members of the House Committee on Judiciary:

Kansans for Improvement of Nursing Homes is a consumer organization of approximately 800 members interested in the quality of care in nursing homes and the welfare of nursing home residents. Issues surrounding advance directives are of the greatest importance to our members. KINH represents the interests of a population most obviously and immediately concerned with how medical decisions are made at or near the end of life.

KINH followed Proposal #14 carefully, and testified on SB 350 which was then the vehicle for discussion. HB 2671 is, we believe, an improvement upon SB 350, but still contains some of the problems that troubled us in that bill as well as some wording that we find either conflicting or confusing.

Definition of "qualified patient"
New Section 1 (g) "qualified patient" means a patient 18 or more years of age who has executed a declaration and who has been determined by the attending physician to be in a terminal condition;

Comment: in Sec. 3(c) the declaration form requires certification in writing by the attending physician and one other physician with regard to withholding or withdrawing treatment, contrary to the definition of qualified patient which requires determination by only the attending physician. While this may or may not actually be contradictory, it will be confusing to the layman who will have difficulty sorting out exactly what triggers the action in the various circumstances.

The term "qualified patient" appears elsewhere in the bill only in Sec. 16, dealing with professional incompetency:
Sec. 16 (a)(10) Failure to effectuate the declaration of a qualified patient as provided in.....section 8, and amendments thereto.

Comment: This protects the patients wishes only if he or she has executed a formal declaration, but not in the instance of direct communication to the physician or through an agent designated in a durable power of attorney for health care decisions.

Sections 2 and 3 of the bill define, in effect, the individual's qualifications and how the patient would go about making known his or her wishes. We suggest that Sec.16(a)(10) be reworded to reflect all the options cited for communicating the individual's decisions.

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

Comment: 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 grimace or a gesture could be interpreted as a revocation by a witness who was in disagreement with the principle's desire not to sustain life. That interpretation, conveyed to the attending physician would be accepted as a valid revocation regardless of the principle's stated declaration.

If the declarant has, by some person's judgement, revoked the declaration while incompetent, must he or she go through the whole procedure of filling out the declaration and having it witnessed again, in order to reinstate the declaration upon regaining competence? Sec. 4 appears to give more weight to decisions made when incompetent than when competent.

The language of both the Durable Power of Attorney for Health Care Decisions and the Kansas Natural Death Act quite rightly provide for a number of ways in which the declaration or powers may be revoked but which are less open to misjudgement and misinterpretation than "in any manner".

New Sec. 5(a) If an individual who is legally incompetent, unconscious or comatose and who, while competent, has not communicated such individual's decisions on the individual's medical care and treatment pursuant to section 3, it shall be presumed that it is such individual's intent that the individual shall be provided with life-sustaining treatment, including nourishment and hydration.

New Sec. 9 (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.

Comment:
Presumption of Intent
The two sections cited seem to be contradictory. Sec. 5(a) makes a presumption that life-sustaining treatment shall be provided absent a declaration or other recognized communication to the contrary; Sec. 9(d) says explicitly that no presumption is made. KINH would prefer the latter.

Surrogate decision makers
The presumption set out in subsection 5(a) does not hold if consent is exercised by a rank-ordered list of decision makers as in 5(b) who may be empowered to act on behalf of the individual who has not made a declaration. This provision is particularly troubling to KINH. We know and understand the desire to provide a designated decision-maker in such difficult circumstances, but a legislated rank order of surrogates will not always result in the person who best understands

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the wishes of the individual making those crucial decisions. This provision seems designed more for the protection and convenience of the health care provider than for the benefit of the individual. Imperfect as the present non-system may be, we believe it has a better chance of arriving at the decision that is right for the patient than a statutory provision of this kind.

CONCLUSION

It may be that minor improvements or clarifications in the current Kansas Natural Death Act are needed. It is, however, a well-established statute that seems to be working reasonably well. We would not wish to replace it without being firmly convinced that the change would be a significant improvement.

KINH concerns about HB 2671 revolve primarily around the manner of revocation and the rank-ordered list of surrogates who will be authorized to make decisions in the event that the individual has not made a declaration of his or her wishes. They are concerns that are of major importance to us. KINH could not support HB 2671 in its present form.

Marilyn Bradt
Legislative Coordinator

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Concerned Women for America

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27 January 92

TESTIMONY BEFORE THE HOUSE JUDICIARY COMMITTEE
Representative John Solbach, Chairman
HB 2671

Mr. Chairman and Members of the Committee, I rise today in opposition to HB 2671.

We see a number of problems with this bill. The first is that Kansas already has in effect a Living Will and a Durable Power of Attorney for Health Care Decisions law in effect. We question why another law is necessary. Everything that is included in this Medical Treatment Decision Declaration can be included in a Living Will. Federal regulations now require health care providers receiving federal funds to inform patients of their rights under state law. So every patient is given the opportunity to make this decision.

There are some subtle changes in this bill. For example, changing the more restrictive "when death is imminent," to "death within a relatively short time". Neither term is precise, but it is generally agreed that "a short period of time" is a broader term than "imminent death". Another subtle change is reducing the diagnosis of a terminal condition from two physicians to one.

Under current law only the individual can execute these declarations for him or herself. HB 2671 introduces a major change in authorizing third parties to execute the declaration for the patient. This bill is promoted as the right of the individual to control his destiny. Allowing third parties the authority to make declarations for the patient is an infringement of the individual's right to control his life.

We would ask that you leave our current legislation in place as it is. The patient in Kansas already has the rights he needs.

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Eilert

Thank you for allowing me to present this written observation of House Bill No. 2671.

First in New Sec. 12. it states that this act may be cited as the (Medical Treatment Decision Act). I find this naming a bit alarming as the title (Non-Medical Treatment Act) would be more fitting, as it is attempting to combine Durable Power of Attorneys for Health Care Decisions, Living Wills, along with new Legislation to enable patient rights to elevate above the laws which have governed the Health Care Provider for years.

Page 171 defines what individuals may participate in decisions concerning such individual's medical care and treatment, in this definition is the term competent. As a Registered Nurse and a member of the KPNHAA Board of Directors it has been very evident that competency hearings are many times one sided and that in fact the individual in question is not even in attendance at these hearings, obviously this matter is more of an economic approach than one of concern for the individual. Many of the decisions in this bill relate to the wishes of the individual, but it does not elicit pre-requisites as in the Durable Power of Attorney for Health Care. In this Declaration on Page 171 it states that life-sustaining treatment may be withdrawn if I am deemed incompetent, this would affect nearly 30% of the 125 individuals who I am presently responsible for administering care to.

Let us look at the Death Penalty bill which has been voted down in this state time and time again, the major draw back was that there is no way to ensure that it (The Law) would be administered fairly, in otherwords, there was no true prerequisites to ensure that all individuals convicted of a certain crime would receive this punishment. As with this proposal, there is no way to ensure that this (Law) would be administered fairly. When the only pre-requisite is being deemed incompetent, and Health Care Decisions are transferred to another party, we then by this proposed bill give that person the right to immediately stop all treatment including Food and Fluid for whatever reason they suggest. This is not what I believe is wanted, intended, or needed in our present society.

In New Sec. 4. it states that a declarant may revoke a declaration at any time and in any MANNER? without regard to the declarant's MENTAL or physical condition. This leaves a huge gray area for the health care provider, if the above scenario where someone is deemed incompetent, this is usually the result of decreased mental ability. If then a court

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deemed incompetent individual calls out for nourishment it is to be administered although it is not the WISHES of the DPOA for Health Care Decisions, and if this nourishment is given is the Provider then guilty of a Class A Misdemeanor as is outlined in this proposed bill. New Sec. 5. subsection a. and b. only addresses if there were no advanced directives, and not the issue of reversal except those with a terminal condition. As a professional Nurse, a Christian, and a believer in Human Rights, would have to give nourishment and care regardless of the (competency) which was determined in a court some time prior to this event known as starvation, or the known withholding of the most basic needs for life!!!!!!

In New Sec. 9. sub-section f. states that this act does not require a physician or health care provider to take (Action contrary to reasonable medical standards). This is extremely questionable, does not the lack of or denial of care take an action which is contrary to medical practice. Which is the greater wrong, to walk into the ocean until submerged, or to sit on the shore till the tide changes?

I feel that the goal attempted here is death with dignity, this term is very difficult for me to define. Life has never been an exact play with scripts available and changeable at our request. When patients are questioned by me about how they view their death, it many times is drastically different from the (family views), and yet this bill infers that these individuals truly know desires and wishes.

If one was to feel that with holding medical treatment is surely the right step toward Death with Dignity, then it would surely follow that Death by Administration is our next step, for most people when questioned about fears of death relate to PAIN. How can one not lead to the other, and certainly we are not ignorant enough to forget the fact that those making decisions many times are not looking at the persons wishes, but at the economic ramifications of sustaining what is deemed as an incompetent and non-productive life!!!!!!

Also within this proposed bill it states that it does not condone homicide or suicide, how far do we have to stretch the definitions to make them palatable, if actively disallowing the basic needs of Nutrition is not seen in the definition of suicide then a narrow vision is being exhibited by the reader.

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Why is this bill needed, do we really need a bill to ensure death going to occur? Is this bill needed to ensure that estates are kept intact to the best interest of the heirs? Is this bill needed to make room for our increasingly aging population so as to not run out of space to house them? Why is this bill needed!!!!!!!!!!

Bob Norcross
R.N., Beloit
Hilltop Lodge

Lucy Eilert

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RIGHT TO LIFE OF KANSAS, INC.
TESTIMONY HOUSE JUDICIARY COMMITTEE
January 27, 1992

In 1979 we warned that the natural death act was only the first step toward a systematic elimination of the unfit, the unwanted, and the useless elderly who would be seen as a drain on the economy. House Bill 2671 is a gigantic leap in that direction and we are unalterably opposed to it in its entirety. There are some particularly dangerous sections to which we must register specific objections.

Section 3 sets up a multiple choice system that permits an individual to choose from several options. It legalizes suicide by starvation. At the other end of the spectrum it offers the option of requesting that all medically neccesary or desirable care and treatment be given. That terminology should limit it so that excessive procedures would not be used but interpretations differ and terminology changes.

There is never an obligation to use extraordinary means to prolong life and the question becomes what is an extraordinary means and what is medically necesary or desirable treatment. Its seldom a black and white situation. Some would want every possible means even extraordinary means to be used. I suspect most of us would opt for something in between.

When the law got involved with living wills a pandora's box was opened. For instance if I have not signed a declaration, does that mean that I must be placed on a respirator or resuscitated interminably? There are times when it is not appropriate to do either. At the same time I don't want antibiotics withheld because I am 95 years old, comatose and have the flu. As situations change people change their minds. As I stand here now I think that I would not want pain medication that would dull my senses, that I would want to be as fully conscious and cognitive as possible, but if the time comes that the pain is unbearable I might change my mind. I recently read about a study of AIDS patients who had said they wanted to die but as the disease progressed and the end came nearer they struggled to live as long as possible.

The withdrawal of nutrition and hydration is never morally permissable as long as the body is able to assimilate it. HB 2671 would force a doctor who holds such a conviction to violate his moral and religious beliefs either by carrying out such a directive personally or by playing Pontius Pilate.

With this bill we will have "progressed" from permitting doctors to violate the Hippocratic oath by killing unborn babies to requiring them to violate it by starving patients to death.

Section 10 initially legalized anything that was legal in any other state. It has been somewhat modified but still legalizes the laws of any other state for residents of that state who happen to be in Kansas. Again this is a potential problem for Kansas doctors and hospitals who would have to honor a request for a lethal injection by a resident of another state such as California, if that became legal.

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While the bill states in section 5 a) that if an individual has not signed a declaration there will be a presumption that life-sustaining treatment is to be continued, sec 5 b) retracts that provision by authorizing a laundry list of persons who can authorize withdrawal of treatment. The persons, including a court appointed guardian who could in effect authorize the starvation death of a patient may not necesarily have anything but a financial interest in the patient. In other words section 5 a) is totally meaningless. This appears to be a form of legalized blackmail. If one does not wish to have these decisions made by the state's preordained list of persons, one may be forced to sign a declaration to prevent this. If there is a disagreement among the members of one authorized class the bill does not permit the next class to decide. In that case the bill would solve nothing. It would be a stalemate just as if there were no law.

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There seems to be some misimpression that by distinguishing between acts of ommission and commission we can somehow separate euthanasia killing into degrees of passive and active, that a passive euthanasia that is an act of ommission is somehow less objectionable. But morally the result is the same. Justice Scalia dissenting in the Cruzan decision made the point succinctly. He says that it makes no sense to say that someone cannot kill themselves by walking into the sea, but that it is alright if you sit on the beach and let the tide come in and wash over you. The result is the same. In each case there was a concscious decision by the individual to put an end to his existence.

This legislation is fraught with danger and there is no need for it. If the chairman will permit I would like to relate a conversation we had last week in which he told me about the recent death of a close relative. He said the doctor told the family he could prolong her life for a week or two by putting her on dialysis and some other intrusive intervientions. She had not signed a will or indicated her wishes so after some discussion the family agreed to let her die. The doctor complied with their decision. HB 2671 was not necessary to permit him to do so.

Death is not a right. It is an inevitability. This bill is not about letting people die. It is about killing them.

Pat Goodson, RTLK, Inc.

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27 January 92

TESTIMONY BEFORE THE HOUSE JUDICIARY COMMITTEE
Representative John Solbach, Chairman
HB 2671

Mr. Chairman and Members of the Committee, my name is Chris May , and I am here today to present to you testimony on HB 2671 from Kansans for Life. I rise today in opposition to HB 2671.

My testimony will be short since most of the arguments that we have about this bill have already been presented. We would, though, like to express one concern that we have about this bill and others like it.

Because of the increasing expense of health care, we are concerned that human life is being treated more and more like a commodity. We are quickly moving in the direction where we will make health care decisions based upon its "rate of return". If we spend all of this money to treat this patient, will his/her productiveness after care justify the money being spent? We must guard very carefully that we do not allow this kind of thinking to influence our decisions. We believe that every life has value, and we do not want to put any tools in the hands of those who, in the name of cost-cutting and utilization of scarce resources, might deprive the aged and dependent patients of their basic constitutional right to life.

Ten years ago there was a presumption to treat all patients. This medical tradition has been eroded over the past ten years. Today there is a question regarding the treatment of patients, and the tradition of the presumption to treat may be reversed. We see HB 2671 as a part of that process.

We would urge that you report HB 2671 adversely.

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