Approved: March 24 1998
Date

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY

The meeting was called to order by Chairperson Tim Emert at 10:14 a.m. on March 23, 1998 in Room 514S of the Capitol.

All members were present.

Committee staff present: Mike Heim, Legislative Research Department
Gordon Self, Revisor
Mary Blair, Committee Secretary

Conferees appearing before the committee: Jerry Slaughter, Kansas Medical Society (KMS)
Dr. Marie Hand, Wichita, Kansans For Life
Dr. Eugene Pearce, Johnson County, Kansans for Life
Beatrice Swoopes, Kansas Catholic Conference
Harold Riehm, Kansas Association of Osteopathic Medicine
Keith Landis, Christian Science Committee on Publication for Kansas
Pat Johnson, Kansas State Board of Nursing

Others attending: see attached list

HB 2531 - Prevention of assisted suicide act

Conferee Slaughter testified in support of **HB 2531**. He offered comments on how this bill will affect the way care is delived by physicians to patients at the end of life. He emphasized that the issue of the bill is limited to assisted suicide and should not be confused with palliative care provided near or at the end of life. He stated that assisted suicide "implies *intent* to end a life, either on the part of the patient, or the patient's physician." He reviewed five principles adopted by KMS which are intended to guide a physician caring for a dying patient. He further commented on amendments which address the issues of intent and cause of action for civil damages. Following discussion by Committee regarding certain language in the bill and the "fuzziness" of it, Conferee Slaughter requested the Committee clarify the statute for KMS. There was further discussion regarding the need to educate physicians throughout the state on advanced pain management techniques. (attachment 1)

Conferee Hand, testifying in support of **HB 2531**, reviewed five reasons why she felt the bill should be passed. She briefly reviewed her credentials, work experience, and medical, cultural, and spiritutal philosophy with regard to the issue of assisted suicide. Brief discussion followed. (attachment 2)

Conferee Pearce, testified in support of **HB 2531**. He cited reasons why he felt physician assisted suicide (PAS) should be considered and prohibited by the Kansas legislature. He stated that pain medication is still underused in treating the terminally ill and cited the works of a Hospice physician who stated "there is no longer any good reason to limit the dose of pain medication, even narcotices, in the dying." He discussed emotional suffering of the terminally ill as being more common than physical suffering. He reviewed the system of PAS in the Netherlands showing how it has devolved from a patient's right to choose to a physician controlled decision. He discussed two ways in which PAS damages the healing servant. (attachment 3)

Conferee Swoopes testified in favor of **HB 2531**. She addressed the bill from the viewpoint of the Roman Catholic Church. She stated the bill "would strengthen the current legal definition of assisted suicide and provide injunctive relief for persons who suspect someone is attempting to assist in a suicide. The bill establishes criminal penalties for those violating the law and provides a cause of action for civil damages." She briefly discussed a brochure, A Living Will created by the Bishops of Kansas and she provided several constructive suggestions for those who value human life. (attachment 4)

Conferee Riehm testified in support of **HB 2531**. He reiterated previous testimony regarding the insertion of the word *intent* in Section 3 and 4 of the bill. He discussed three primary reasons for the undertreatment of pain in our society and stated that "the Kansas State Board of Healing Arts is in the process of studying the adoption of guidelines for the use of controlled substance in the treatment of pain." He also discussed two model bills which have been drafted, addressing "both state licensing board repercussions and criminal prosecution of physicians for acts related to administering to patient pain." (attachment 5)

Conferee Landis, testifying as neutral on **HB 2531**, suggested an amendment to the bill to "protect from prosecution those who provide spiritual treatment with the expectation that life, not death, will be the outcome." (attachment 6) Following brief discussion Senator Bond moved to adopt the amendment. Senator Pugh seconded. Motion carried.

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.

Conferee Johnson, testifying as neutral on **HB 2531**, inquired about whether or not certain new language added to the bill is redundant. She also cited the section on civil actions and inquired as to the bill's intent for the Board of Nursing's role in taking action on the individual's nursing license. (attachment 7)

There was discussion regarding certain sects who withhold treatment according to their religious beliefs. Kansans for Life representatives reponded that persons should be able to make their own choices. In the case of a child or an incompetent person there needs to be a surrogate who will stand in for that person. A comment was made by Conferee Riehm that "it is the disease that kills.....not the person." Further discussion centered on the clarification of New Section 6.

Written testimony in favor of **HB 2531** was submitted by the Association of Kansas Hospices (attachment 8) and Kansans for Life (attachment 9).

The meeting adjourned at 11:06 a.m. The next scheduled meeting is March 24, 1998.

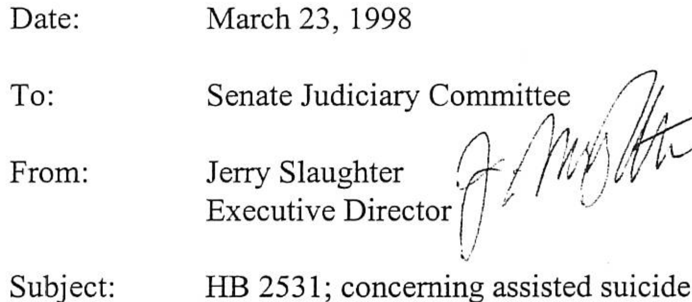
Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

SENATE JUDICIARY COMMITTEE GUEST LIST

DATE: 3/23/98

NAME	REPRESENTING
Marie Hand MD	myself.
EW Pearce	Self
BEATRICE SWOOPES	KANSAS CATHOLIC CONF.
Jeanne Gawdun	KFL
Heather Randall	Whitney Damron, PA
Clayton Porter	R.C.I.L
Cleta Renyer	Right to Life of Ks.
Pat Johnson	Bd of NSG
Dawn Reid	KSNA
Meg Draper	KMS
Jerry Slaughter	KMS
Joe Lieber	KS Co-op Council
Tom Bruno	Assoc. of KS. Hospice
KEITH R LANDIS	CHRISTIAN SCIENCE COMM ON PUBLICATION FOR KS
Doug Wareham	Ks. Grain & Feed Assn. Ks. Fertilizer & Chemical Assn.
Tom Tunnell	" " "
Jolene M. Grabill	KTLA

KANSAS MEDICAL SOCIETY



Date: March 23, 1998

To: Senate Judiciary Committee

From: Jerry Slaughter
Executive Director

Subject: HB 2531; concerning assisted suicide

The Kansas Medical Society appreciates the opportunity to appear today as you consider HB 2531, which amends the assisted suicide law. This bill makes it abundantly clear that Kansas does not condone, nor will it tolerate, assisted suicide in any manner, by any person. We would like to offer our comments within the context of how this measure will affect the way care is delivered by physicians to patients at the end of life.

There is probably not a more emotionally wrenching, clinically frustrating medical situation than care at the end of life. Frequently, the clinical choices involve balancing treatment options that are less than ideal, and do not hold the promise of full, if any, recovery. Often it is difficult to achieve consensus among family members on how to proceed. It is not uncommon for the patient to be incapacitated and incapable of making medical decisions for themselves. Physicians struggle to find direction and clarity in situations where legal, moral, cultural, familial, and ethical considerations collide. In short, the issues surrounding end of life care are complex. They are not reducible to simple answers or sweeping generalizations.

The issue before you today is limited to assisted suicide, which must not be confused with curative or comfort care that is provided near or at the end of life. Assisted suicide implies *intent* to end a life, either on the part of the patient, or the patient's physician. It is a far cry from trying to cure or provide comfort care as a person goes through the dying process. KMS has adopted some principles which are intended to guide physicians in who care for patients in the dying process. Those principles are:

- physician assisted suicide is fundamentally inconsistent with the physician's professional role as a healer;
- the principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment by patients who possess decision-making capacity;
- there is no ethical distinction between withdrawing and withholding life-sustaining treatment at the patient's request;
- physicians who care for patients with terminal illnesses should seek to educate themselves about advanced pain management techniques;

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- physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care, including providing palliative treatment even though it may potentially hasten death.

As to the bill before you, we have a couple of comments. Under the current statute there must be intent to assist a suicide for it to be illegal. We believe that is an appropriate standard which should be a part of this bill. Particularly because of situations in which physicians prescribe pain medications to dying patients. These medications can have the dual effect of controlling pain, yet slowing respiration and potentially hastening death. As long as the physician's intent is to cure the patient, or control pain and provide comfort care, he or she should not inadvertently violate the assisted suicide act. The house committee adopted our suggested amendment to New Section 4 (page 2, line 4) which re-inserted the concept of intent into the bill, and we believe very strongly that it should remain.

Additionally, new sections 5 - 7 outline a new cause of action for civil damages in these cases, and list individuals who would have standing to bring such an action. While we are unsure of the full impact of these sections, we do have some questions. We are concerned that the unintended result could be more intrusion into the already complicated clinical situation involving the dying patient. Does this new language start to drive a legal wedge between family members who may not agree on the best course of action for a loved one? Will it make it difficult for physicians to aggressively treat pain in dying patients because a family member believes a physician is "about to violate" this act, and seeks an injunction to prevent the administration of powerful pain medications that could have the dual effect of hastening death? Obviously, this is not the intent of these sections, but we have questions about how it will be interpreted by the courts in the future. Any statutory guidance the legislature could give now will help minimize contentious litigation in the future in these emotionally charged situations.

Our plea to you is to be cautious in legislative intervention in this area because of the unintended effect it may have on care provided those going through the dying process. Please do not tie the hands of physicians, or patients, in accessing optimal curative or comfort care in end of life situations. Decisions on care at the end of life should be made by the patient and family in consultation with their physicians and other family advisors or counselors. We should strive to minimize intrusions which further complicate an already difficult situation.

Thank you for considering our comments.

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In Support of H.B. 2531,
The Prevention of Assisted Suicide Act

by Marie M. Hand M.D.
Kansas Senate Judiciary Committee, March 23, 1998

Mr. Chairman, members of the Committee, good morning, and thank you for the opportunity to speak to you today.

H.B. 2531 should be passed for five reasons:

1) There are a growing number of citizens who believe that the worth of a human being can be measured in terms of their quality of life, and that when a person's quality of life declines below a certain arbitrary threshold, it is morally acceptable to destroy.

2) This attitude is being legitimised on both coasts of this country by the courts, anb by the passage of laws which allow innocent persons to be killed at their own request.

3) Here in Kansas, we know better. However, we need strong deterents against this practice in our state, and I believe that H.B.2531 would provide this deterent.

4) The bill is stated in precisely the correct manner, particularly in regards to addressing the intent of a physician caring for a patient. The physician's intention in treating patients should always be to provide either curing or comfort. His primary intent should never be to directly kill the patient.

5) It would not impede the traditional work of physicians in their role as comforters and healers.

I am an internal medicine physician currently in private practice in Augusta. I graduated from the University of Kansas in 1986, and the University of Kansas School of Medicine in 1990. I served for 4 years as an internal medicine resident and Chief Resident also at K.U. Subsequently I joined the internal medicine staff at the Eisenhower V.A.M.C. in Leavenworth. Additionally, during the three years which I spent at the V.A., I was a member of the K.U. clinical faculty, responsible for teaching residents. Caring for hospitalized veterans, I frequently discussed end-of-life medical and ethical issues with residents, doctors, other staff, family members, lawyers, insurance companies, and patients.

The hard truth is that, in the majority of cases, the patient is the last person capable or willing to make any serious medical or ethical decision concerning his or her own life. The competent chronically or terminally ill person waits for advice and listens to the counsel of physicians, health care workers, and family members. In the current

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environment, their advice cannot necessarily be depended upon to be ethically sound and totally unselfish.

It is unfortunate indeed, that as a society, we have become so morally bankrupt as to see the need to have this discussion. It is a sad day in the history of Western Civilization and Western Medicine, when we must strengthen the laws which protect the most vulnerable among us from being coerced into suicide.

Hippocrates- the Greek Father of Western Medicine- stated in his Oath, "I will not administers a poison if asked to do so." The God of the Jews and of Christianity said, "Honor your father and your mother," and "Thou shalt not kill." The Declaration of Independence called for the protection of life, liberty and the pursuit of happiness-- in that order. As philosophical descendents of these great and wise traditions, we should uphold them in every possible way. House Bill 2531 should become a law.

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PHYSICIAN ASSISTED SUICIDE

Physician assisted suicide should be considered by the Kansas Legislature as there is much interest in the subject in the media, legislatures, the courts and amongst the public.

Physician assisted suicide should be prohibited by the Kansas Legislature because it is not in the best interests of the terminally or chronically ill, the public, or the healing professions.

A plea for death is always a plea to end suffering. Physical symptoms, pain, nausea, depression, etc. can always be relieved according to Dr. Ira Byock, an experienced hospice physician who serves as president of the Americal Academy of Hospice and Palliative Medicine. There is no longer any good reason to limit the dose of pain medication, even narcotics, in the dying. "The right dose is the one that works," (Byock)

Emotional suffering is more common than physical suffering. Fear of abandonment or inability to cope can be relieved by attentive, compassionate comfort care. To commit suicide in fear is to die with "unrelieved terror", a cruel not merciful death. (Hendin) The relief of distress of broken or imcomplete interpersonal relationships can be catalysed by the comfort care team. But it is the emotional work of those involved to forgive, thank, love, and accept. To commit suicide with broken relationships is to die without the wholeness, peace, and serenity of loving and being loved.

The suffering of loss of control, dying badly, humiliation, or loss of personhood is a plea to maintain the ego. Suicide at this stage is a denial of the existential suffering of acceptance of the real person within. It short circuits the work and the fruits of "dying well". The suicide at this stage dies with ego magnified and spirit shriveled. (Peck)

For the public, the "right to die" quickly becomes the "duty to die". In the Netherlands, the country with the greatest experience in physician assisted suicide, the original goals of individual liberty and relief of suffering have devolved. The physician, not the patient, now determines when suffering is unbearable and when the patient should die. The Dutch call it "termination of the patient without specific request". (Hendin) Although the Dutch have many safeguards and reporting requirements, they are usually ignored. As a consequence of the lax oversight by the Dutch authorities, there is a Dutch Patient Association which publishes a list of "safe hospitals". The Oregon law permitting physician assisted suicide has been little used to date, because physicians and people want the secrecy that leads to the slippery slope the Dutch have traveled.

Physician assisted suicide damages the healing servants in two ways: 1. It elevates the physician to the ultimate moral status that knows no regulation or control. 2. It shifts the emphasis of the healers from curing and caring to solving problems of human existence by ending human existence. It subverts the real effort to provide comfort care for the terminally and chronically ill and to innovate and master new techniques for comfort care.

The passage of House Bill No. 2531 will encourage us all to work towards ending the suffering of the terminally and chronically ill, not their lives.

Testimony to Kansas Legislature March 23, 1998

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Works Cited

Byock, I Dying Well. Riverside NY. 1997

Hendin, H. Seduced by Death. Norton, NY. 1997

Peck, M.S. Denial of the Soul. Harmony, NY. 1997

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TESTIMONY

H.B. 2531

SENATE JUDICIARY COMMITTEE
Monday, March 23, 1998 – 10:00 a.m. – Room 514-S

KANSAS CATHOLIC CONFERENCE
Beatrice E. Swoopes, Programs Director

Chairman Emert, members of the Judiciary Committee – my name is Beatrice Swoopes, Programs Director of the Kansas Catholic Conference, which represents the Roman Catholic Bishops of Kansas. Thank you for the opportunity to speak to the provisions of **H.B. 2531** – the prevention of assisted suicide act.

This bill would strengthen the current legal definition of assisted suicide, and provide injunctive relief for persons who suspect someone is attempting to assist in a suicide. The bill establishes criminal penalties for those violating the law, and provides a cause of action for civil damages.

The Kansas Catholic Conference strongly endorses **H.B. 2531**.

The Catholic Church teaches a reverence and respect for human life from the moment of conception to natural death. We value life as a gift from God, the decision to end life is not ours.

There is a difference between allowing death and assisting it. That is why the Bishops of Kansas several years ago created the "Declaration of a Catholic on Life and Death" – A Living Will, that allows death without using extraordinary

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means to sustain life. The Prologue* of that document further explains the significance that death and suffering have in our journey of life.

The subjects of assisted suicide and euthanasia are extremely complex. Legalizing either would only compound the problems, and add to the prevailing lack of respect for human life that permeates our society today. Our energy would be better spent in providing means to adequate pain relief, hospice care for the terminally ill and dying, and education that would enable a better understanding of suffering and the part it plays in this great mystery of life and death.

We applaud you, our Kansas legislators, for keeping our state among the many that still ban assisted suicide. Suicide is morally wrong, and assisted suicide is an aberration of the concept of compassion. Passage of **H.B. 2531** will further strengthen that conviction.

*"Declaration of a Catholic on Life & Death" attached

K sas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

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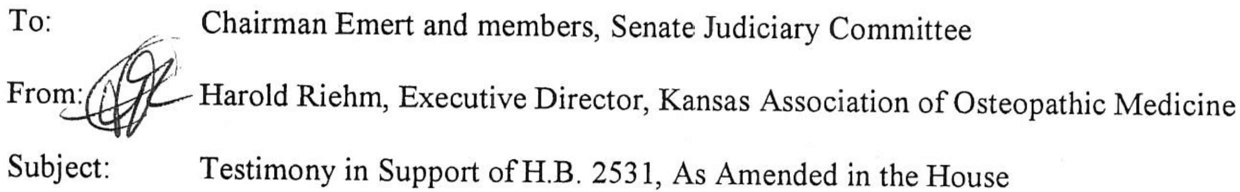
March 23, 1998



To: Chairman Emert and members, Senate Judiciary Committee

From: Harold Riehm, Executive Director, Kansas Association of Osteopathic Medicine

Subject: Testimony in Support of H.B. 2531, As Amended in the House

Thank you for this opportunity to express our support of H.B. 2531, as amended in the House. KAOM submitted written testimony in the House Hearing on the bill, urging, as did the Medical Society, insertion of the word "intent" in Sec. 3 and 4 of the Bill. We think this further clarifies and enhances safeguards for physicians administering pain relief to patients suffering from pain, when the consequences of administering such relief may be a hastening of death.

KAOM also supports language added in House Committee of the Whole, which requires the KU Med Center to conduct a series of seminars and symposiums on pain management throughout the State. As a physician group regulated by the Board of Healing Arts, we will urge the Board's cooperation to make these meaningful events.

Though this bill is an effort to clarify and redefine Assisted Suicide in Kansas, the general milieu in which it occurs is one of considerable concern to physicians. Few physicians support physician assisted suicide. Yet many are concerned about treating patients suffering intractable pain, and the possible repercussions by the Sate resulting from administration of such care.

Research into pain management overwhelmingly concludes that pain continues to be undertreated in this society. Many studies, in attempting to determine the cause, conclude that there are three primary reasons: (1) inadequate education of physicians and other providers; (2) physician fear of discipline by State licensing boards; and, (3) physician fear of criminal prosecution. The latter is currently of particular concern to Kansas physicians, given the recent criminal conviction of Dr. Stan Naramore.

These are not topics addressed in H.B. 2531. I note them now, though, because they deal with the same issue although from different perspectives. Hopefully, in the next Session these issues can be addressed.

Currently, the Kansas State Board of Healing Arts is in the process of studying the adoption of "Guidelines for the Use of Controlled Substances in the Treatment of Pain" as well as the whole area of pain management. A model draft of "Guidelines" will be soon available from the Federation of State Licensing Boards.

On another front, at least two "Model Bills" have been drafted addressing both state licensing board repercussions and criminal prosecution of physicians for acts related to administering to patient pain. Again, these also merit future review in Kansas.

Several States have already adopted either Guidelines, new State laws, or both. While this may be viewed as matters of physician protection, which to some extent it is, it is equally a matter of patient protection with the goal being pain treatment commensurate with patient need.

I will be pleased to respond to questions.

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Unprecedented Changes in State Pain Policy

David E. Joranson, MSSW, Senior Scientist, Director; Aaron M. Gilson, MS, MSSW, Researcher for Policy Studies; Carolyn Williams, MBA, Research Program Administrator
Maria Monterroso, *Abogado*, MA, Policy Analyst; Karen M. Ryan, MA, Policy Analyst
From the Pain & Policy Studies Group (PPSG), University of Wisconsin Comprehensive Cancer Center, Madison

I. CURRENT SITUATION

Purpose. To describe the recent trend in development of state pain policies, identify the reasons, benefits and risks, and recommend next steps.

A new trend in state pain policy. In the last ten years, there has been a new and rapidly growing trend for states to adopt policies which address the prescribing of opioid analgesics for chronic pain. Figure 1 presents the trend for three basic types of new policies: state laws (statutes), administrative regulations and medical board guidelines. Other state responses to the pain problem include State Pain Commissions,[1] "summit" meetings,[2] and state task forces.[3-6]

Relevance for pain professionals. State policies express the attitude of the state government about pain management and the medical use of controlled substances, including the opioid analgesics. It is essential that pain professionals know these policies. Furthermore, it is essential that pain professionals be involved in the adoption and revision of these policies to ensure that they reflect the current state of medical practice, do not reflect misinformation about drugs and pain, and do not interfere with patient care.

Reasons for this trend. There is increasing recognition on the part of health professionals, the public and policy makers that

- the management of pain, including chronic non cancer pain, is inadequate; and
- the past avoidance of opioid analgesics for chronic pain is changing[7]

Impetus for change. The impetus for change in state policy is coming from the following:

- **State medical boards** are adopting guidelines to recognize that opioids have a role in the management of chronic pain, and to specify the acceptable parameters;
- **Chronic pain advocates** (both patients and physicians) are asking their legislators to adopt Intractable Pain Treatment Acts or other legislation with the intent of providing immunity from discipline for physicians who prescribe opioids for chronic pain, and to "make it easier to get pain relief."
- Following the **Supreme Court decision on assisted suicide**, state agencies, legislators, and interest groups increasingly are looking for legislative alternatives; "what laws can we pass to address barriers to pain management?"

II. BENEFITS AND RISKS

To make change in the pain policy, each type of state policy has its own potential benefits and risks. Opinions differ on the subject; these are ours.

Statutes and regulations
(See Tables 1 and 2)

Potential benefits
- Using the force of law can be a profound way to create or change policy;
- In some states, it is necessary to change laws to recognize that controlled substances have medical value; [8-9]
- Changing laws and regulations is necessary to remove or modify existing barriers; [10-11]
- A law can provide immunity from discipline (although not from investigation) for physicians who prescribe opioids for pain (also see 'risks' below); [12-13]
- Legislatures can create commissions to study the pain problem and make recommendations; [1]
- The legislative process can be used to redress problems with state agency policies or practices;
- inadequate treatment of pain;

California	1990*
Colorado	1991*
Colorado	1997
Florida	1994*
Minnesota	1997*
Missouri	1995*
Nevada	1995
North Dakota	1995
Ohio	1997*
Oregon	1995*
Rhode Island	1997*
Texas	1989*
Texas	1997
Virginia	1988
Washington	1993
Wisconsin	1995

* Grants immunity from discipline for physicians who prescribe opioids for intractable pain.

Potential risks
- With laws, you have to be careful what you ask for, and very careful how the language is drafted;
- Changing laws and regulations may not be an efficient way to:
  - -change public and professional knowledge and attitudes;
  - -make it easier for physicians to treat pain;
  - -improve patient access to pain management.
- Opening state medical practice laws to legislative reconsideration can produce unanticipated results, such as further greater restrictions on prescribing;
- Some **Intractable Pain Treatment Acts (IPTA)** are forging new policy on fundamental matters of medical decision-making and patient access to pain medicine by (cite current status):
  - defining medical use of opioid analgesics as a "therapy of last resort"
  - suggesting that use of opioid analgesics outside the Act may not be accepted medical practice;
  - requiring an evaluation of the patient by a specialist in the organ system believed to be the cause of pain;
  - -requiring a written informed consent to qualify the physician and patient;
  - -applying to all intractable pain patients, including those with cancer, sickle cell and HIV disease;
  - -implying that opioids may be used for pain only in cases where the cause of pain cannot be removed;
  - -excluding pain patients who use drugs "for non-therapeutic purposes";

Medical Board Guidelines
(See Table 3)

Potential benefits
- Guidelines are a relatively simple way to express the attitude or policy of a medical board
- A guideline issued by a state medical board is a more direct and flexible method than statutes for communicating policy from the licensing agency to the licensees;
- Medical boards, as compared to legislatures, may be able to more easily take into consideration the current and changing state of clinical medicine and science;
- Guidelines from a number of state medical boards have already encouraged better pain management, and have positively clarified the role of opioids for the management of chronic pain;
- State medical boards are accustomed to considering the balance between improving quality of medical care and protecting public health;

Potential risks
- Guidelines do not carry the force of law and therefore do not provide any guarantees;
- Membership of state medical boards may change, thus guidelines may change;
- Guidelines may be unclear, communicate a less-than-positive message, and may lack consistency from state to state;
- Guidelines may not be effective if they are not implemented in board investigatory policy, or communicated to state physicians and other regulatory bodies.

Alabama	1995
Arkansas	1997
Iowa	1997
Louisiana	1997
Nevada	1996
New Jersey	1993
Oregon	1996
Texas	1995

III. CONCLUSIONS

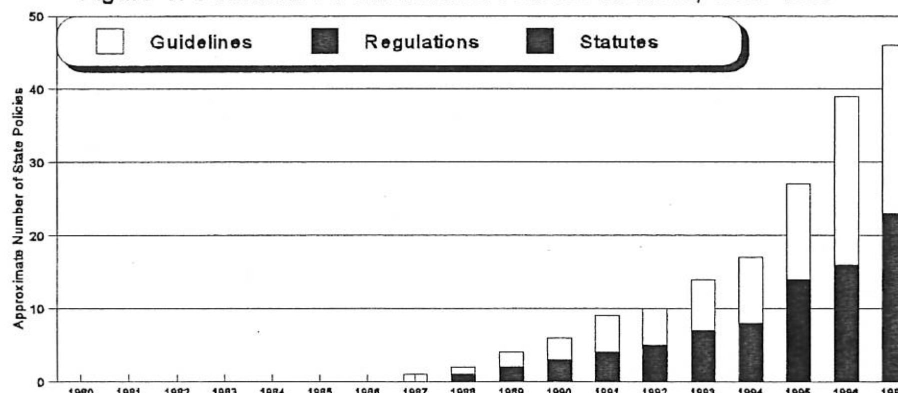
Laws and regulations. The use of laws as the method to address pain management is likely to increase as legislatures and state agencies grapple with assisted suicide and pain issues. However, the use of laws and regulations should be used with caution so that the future of pain management is only enhanced and not unduly restricted. Objectives should be defined, and the method chosen according to its potential to achieve the desired outcomes. The potential benefits and risks of various methods should be weighed carefully.

Medical board guidelines. This method of clarifying public policy has also increased in recent years, and is likely to continue. The Pain & Policy Studies Group and the Federation of State Medical Boards of the U.S. are cooperating a) to evaluate existing guidelines, b) to develop principles for improved guidelines, and c) to present six more workshops on pain management for medical board members (see APS Poster #844).

Table 3 - State Guidelines/Statements

State	Year Enacted
Alaska	1993
Arizona	1997
California	1994
Colorado	1996
Florida	1996
Georgia	1991
Idaho	1995
Massachusetts	1989
Maryland	1996
Minnesota	1995
Montana	1996
New Mexico	1996
North Carolina	1996
Ohio	1996
Oklahoma	1994
Oregon	1991
Rhode Island	1995
Tennessee	1995
Texas	1993
Utah	1993
Vermont	1996
Washington	1996
West Virginia	1997
Wyoming	1996

Figure 1. Cumulative Pain-Related Policies in Effect, 1980-1997



IV. RECOMMENDATIONS

1. **Monitor this major policy development.** The rapid increase in state pain-related policy should be regarded as a development of major significance for the pain field; pain professionals and their organizations should actively monitor and influence the development of state policies;

2. **Get to know your board.** Pain professionals should get to know their state licensing board members, their policies and issues, and offer assistance;

3. **Make use of existing information.** Policy makers, medical regulators and pain professionals are encouraged to review the resources available through the PPSG Website, at

http://www.biostat.wisc.edu/painpolicy

4. **Work to achieve a balanced policy.** State pain-related policies should strive to a) express a positive attitude toward pain management, b) encourage use of opioid analgesics consistent with the state of clinical experience, scientific knowledge and professional consensus, c) continue efforts to address misuse, abuse and diversion of controlled substances without interfering in their appropriate medical uses.

Support provided by the Robert Wood Johnson Foundation.

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3. Cancer Care, Inc. (1997). Improving access to pain medications in New York: A proposal for discussion and action. Cancer Care, Inc.

4. Task Force on Life and the Law. (1996). When death is sought. A report from the New York State Task Force on Life and the Law.

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Christian Science Committee on Publication For Kansas

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5 Jud 3-23-98 att. 6

To: Senate Committee on Judiciary

Re: HB 2531

The following amendment to HB 2531 is proposed for your consideration:

On page 2, after line 6, add a new subsection "(c)" to read:

> (c) Providing spiritual treatment through prayer alone, in lieu of medical treatment, does not violate K.S.A. 21-3406 and amendments thereto.

This amendment was not offered when the bill was being worked in the House as it seemed unnecessary to explain that providing spiritual treatment was not the same as withholding necessary treatment or attempting to cause death. Many have found this method of treatment effective in the removal of life threatening conditions and rely on it for that purpose.

We believe the proposed amendment is needed to protect from prosecution those who provide spiritual treatment with the expectation that life, not death, will be the outcome

Your favorable consideration of this proposal will be appreciated

Keith R. Landis
Committee on Publication
for Kansas

Senate Judiciary
3-23-98
att 6

Kansas State Board of Nursing

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Patsy L. Johnson, R.N., M.N.
Executive Administrator
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To: The Honorable Senator Tim Emert, Chairperson
and Members of the Judiciary Committee

From: Patsy L. Johnson, M.N., R.N., A.R.N.P.
Executive Administrator
Kansas State Board of Nursing

Date: March 23, 1998

Re: HB 2531

Thank you for allowing me to appear before the Judiciary Committee.

The Board of Nursing takes no position with regard to assisted suicide. However, there are some questions as to the new language added to K.S.A. 65-1120 in subsection 8, page 8, lines 22-29. Under new subsection (a) (9) the board may deny, revoke, limit or suspend a license if a licensee is found after hearing to have assisted suicide in violation of K.S.A. 21-3406.

> Is the language in (a) (9) (A) redundant since (a) (2) specifically addresses felonies and in that subsection absolutely bars licensing someone with a felony conviction listed in article 34 of chapter 21, (Page 7, lines 27-37)?
>
> Also, if (a) (9) (B) and (C) are civil actions, is it the intent that the Board of Nursing take action on the individual's nursing license?

I would appreciate clarification on these issues.

Thank you.

Senate Judiciary
3-23-98
att 7

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ASSOCIATION OF KANSAS HOSPICES

March 23, 1998

Testimony by the Association of Kansas Hospices (AKH)

HB2531: A bill related to physician assisted suicide

Hospice has set the standard for excellence in care of the dying. Many authorities, notably the Institute of Medicine of the National Academy of Sciences, have supported the hospice approach and advocated extending it more widely throughout the medical system. However, **barriers exist to improving care of the dying** in general and the growth of the hospice approach in particular.

The public debate over physician-assisted suicide has helped focus attention on the plight of the dying in the US and on shortcomings in end of life care. AKH believes that the vast majority of persons who might seek assistance in dying results from lack of awareness and open access to excellent hospice and palliative care. Widespread anecdotal evidence in hospice and palliative care indicate that **good end of life care resolves many of the pressures that lead to requests for aid in dying.** AKH believes **that it is critical to address these barriers to adequate pain management and appropriate end of life care.**

It is important to note that **the bill retains patient access to adequate pain management and symptom control as well as to advance directives regarding end of life care. AKH will continue to work within the state to educate the public about hospice and palliative care, to identify and work to remove barriers to quality care at the end of life, and to speak as advocate for all Kansans at the end of life.** To these ends, AKH pledges its continuing time, energy and resources. **The Association of Kansas Hospices is currently working with the Kansas Medical Society and others to stengthen physician education in pain management and end of life care.**

Kansans Should Have Access to Quality Care at the End of Life

The experience of dying, for far too many Americans, does not go well. A major four year study, funded by the Robert Wood Johnson Foundation, began in 1989. ***The Study to Understand Prognosis and Preferences for Outcomes and Risks of***

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Treatment became known as the SUPPORT study. The study discovered, in short, that **many patients died in considerable pain, without their health care wishes being known to their physicians and with family finances depleted.** The Institute of Medicine has cited a variety of studies indicating that 40 to 80 percent of terminally ill patients receive inadequate medication for their pain.

The truth of the findings of the SUPPORT study have become more clear to Americans. The study demonstrated the experience of many Americans and provided "whispers" of the need to improve care at the end of life. More recently, our society has sounded "screams" for help for quality care at the end of life. The debate on physician assisted suicide highlights our country's need to more adequately meet the needs of those at the end of life.

Developments: From the growing awareness of need for more quality care at the end of life, a plethora of initiatives and studies are appearing across the country.

* The state of New York recently named a "Commission on Quality Care at the End of Life."
* The state of Maryland has begun a four year project to address end of life care.
* Twenty-one state legislatures, during the past year alone, have considered bills dealing with pain treatment for terminally ill patients.
* Texas and Minnesota enacted laws that address pain medications for those at the end of life.
* South Dakota required medical schools to teach students about hospice care and pain management.
* The American Medical Association adopted a dying patients bill of rights, created an Institute of Ethics to address issues in end of life care, and has called for increased physician education on pain management and end of life care.
* Six Catholic Healthcare Organizations have joined in a "Coalition for Compassionate Care" at the end of life.
* Rosalyn Carter has become spokeswoman for "Last Acts" to create consumer awareness and savvy regarding end of life care.
* The Project on Death in America is focused on addressing end of life care.
* The Robert Wood Johnson Foundation has earmarked 12 million dollars for "Promoting Excellence in End of Life Care."
* The North Carolina Medical Society has named an End of Life Issues Task Force that involves the State Hospice Organization as well.
* Maryland has begun a "Physician's Pain in Palliative Care Hotline" to offer physicians consultation on pain management in palliative care.

Opportunity:

Americans are coming more fully to terms with the reality that we each, at some point, come to the end of life. Rather than continuing futile treatment OR turning to despair and hopeless, America stands at the threshold of embracing a third, more healthy choice. That choice is the **development of quality care at the end of life.** More than ever before, there are numerous indicators, like the few mentioned above, that our country is ready to move forward in dealing more adequately, fully and healthily in addressing end of life care. To this discussion, hospice brings expertise and experience in pain management, symptom control, comprehensive care for both patient and loved ones, bereavement support and care for social and emotional needs of patients and families.

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SSJC 3-23-98 Writ #9

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IN SUPPORT OF H.B. 2531,
THE PREVENTION OF ASSISTED SUICIDE ACT

by Robyn Johnson, Legislative Director, Kansans For Life, Inc.
Kansas Senate Judiciary Committee, March 23, 1998

Chairman Emert, members of the Judiciary Committee. Thank you for the opportunity to present testimony in support of H.B. 2531. My name is Robyn Johnson. I am the Legislative Director for Kansans For Life, the state's largest single-issue pro-life organization with 75 local chapters and over 100,000 members.

While most members of this committee are familiar with our efforts to pass laws which protect women and the unborn, it is also the mission of Kansans For Life to support public policy which protects the right to life of the chronically ill, the disabled, the elderly and the terminally ill.

Kansans For Life exists to promote the sanctity of human life in all its stages from conception through natural death and to protect the right to life of all innocent human beings from the threats of abortion, infanticide and euthanasia.

For the past eight years, in the state of Michigan, Dr. Jack Kevorkian has helped seventy-six people to die. Fifty-five of them female.

Twenty-five persons were suffering from cancer, twenty from Multiple Sclerosis, eleven from A L S, one from AIDS, one from Emphysema and one from Alzheimer's Disease. The other cases involved various complaints.

Most recently, in 1996, Dr. Kevorkian helped eighteen people die, and just last year, in 1997 he helped twenty-eight people to die. Since the beginning of 1998, Jack Kevorkian has helped two people die.

Jack Kevorkian helps people die in Michigan. Assisted suicide is illegal in Michigan. Jack Kevorkian has been arrested numerous times for this offense. He has been through a series of trials in a court of law but juries fail to convict him.

Kansas affiliate to the National Right to Life Committee

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Legal experts believe the reason Dr. Kevorkian continues to break the law and go unpunished is do to the lack of civil remedies in Michigan's assisted suicide statute. Criminal penalties alone have failed to deter and punish Jack Kevorkian for his involvement in the killing of innocent people.

Assisted suicide is illegal in Kansas. There are criminal penalties for infringement of K.S.A. 21-3406 but currently no civil remedies exist.

Kansans For Life is thankful for the wisdom of Kansas lawmakers who are responsible for the state's current law prohibiting assisted suicide and for physicians who abide by the statute and their oath to uphold the sanctity of human life.

H.B. 2531 will improve the current Kansas law prohibiting assisted suicide by establishing a more detailed legal definition of assisted suicide, providing for injunctive relief to persons who suspect an assisted suicide may be attempted, and establishing criminal penalties and civil remedies for violation of the law.

H.B. 2531 will better protect the lives of thousands of vulnerable people in Kansas who suffer from painful illness, disability, depression, and the natural effects of old age. It will prevent someone like Jack Kevorkian from helping people to die in Kansas.

Kansans For Life urges the members of the Senate Judiciary Committee to pass H.B. 2531 the Prevention of Assisted Suicide Act and continue to uphold and improve the Kansas tradition of preventing assisted suicide in our state.