Approved: April 10, 2002
Date

MINUTES OF THE HOUSE FEDERAL & STATE AFFAIRS COMMITTEE

The meeting was called to order by Chairperson Doug Mays at 1:40 p.m. on February 21, 2002 in Room 313-S of the Capitol.

All members were present except: Representative Judy Morrison, Excused
Representative Broderick Henderson, Excused

Committee staff present: Mary Torrence, Revisor of Statutes
Russell Mills, Legislative Research Department
Shelia Pearman, Committee Secretary

Conferees appearing before the committee:
Representative Daniel Thimesch
Nancy Armstrong, Veteran
Jim Bunker, Advisory Board Chairman
Steve Goodman, Kansas Soldiers Home Superintendent
Hue Grossman, Springhill
Wendy Hanault, Veteran's Spouse
Paula Koch, Pharmacist
Ronald Pope, Kansas Trial Lawyers Association
Tonya Ricklefs VanSickle, Kansas Persian Gulf War Health Initiative
Ken Rogers, Gulf War Veteran

Others attending: See attached list

Without objection, bill was introduced as requested by Representative McKinney regarding tribal law enforcement officer added to listed officers regarding battery of law enforcement officers listed. [HB 3004]

Without objection, bill was introduced as requested by Representative Wilson urging Citizens Advisory Group and U.S. Congress to create a coal miners commemorative stamp. [HR 5051]

Chairman Mays re-opened the hearing on **HB 2711** - Health care providers' rights of conscience act. Mr. Pope addressed the concerns of members of the Kansas Trial Lawyers Association remains opposed to the proposed legislation originally drafted as **HB 2491** although some concerns were addressed. This legislation opens an additional avenue to insurance companies to deny payment of claims with a major effect on Kansas citizens predominantly on rural citizens. He urged the committee to not design a bill to determine an individual's health care based on monetary profit by an insurance corporation despite physician's directives. Upon questioning by committee, Mr. Pope referred to the conscientious objectors of the Vietnam War era which was not applicable to corporations not supplying materials for the war. He also discussed the accessibility of insurance contracts versus the benefits summary for each individuals. He recommended the decision regarding specific medical services and products should to remain between the physician and the patient rather than include the insurance company. (Attachment #1)

Chairman Mays acknowledged written testimony submitted by Kansas Nurses Association (Attachment #2) opposing **HB 2711**, as well as Kansas Hospital Association (Attachment #3) and Kansas Medical Society (Attachment #4) in support of **HB 2711**.

Ms. Koch was fired from a pharmacist position after working for 18 months with an alternative dispensing agreement permitting her not to dispense the "morning after" pill because of her faith. (Attachment #5) She emphasized pharmacists have worked very hard to be considered partners in the health care team and believe they should be granted the same protection of the law that physicians currently experience. She cited the American Pharmaceutical Association policy which unequivocally recognizes the pharmacist's right to exercise conscientious refusal.
The hearing on HB 2711 was closed.

Chairman Mays opened the hearing on **HB 2770 - Persian Gulf War veterans health initiative act,**

funding. Due to time limitations, Representative Thimesch introduced the bill and cited written testimony available (Attachment #6).

Ms. VanSickle cited Dr. Lea Steele's study of over 2,000 Kansas Persian Gulf War veterans publish+ed in the American Journal of Epidemiology which was nationally recognized due to presentation of patterns of Gulf War Illness victims. She stated the toll-free hotline is a welcomed tool for Kansas Veterans to obtain and share information regarding illnesses they have encountered since returning from the war including birth defects of their dependents. She urged the committee to support **HB 2770** to honor the veterans in their time of need who served our country. (Attachment #7)

Mr. Bunker stated the troops were exposed to many different toxic elements during the war. He urged the committee to support **HB 2770** to further show that Kansas cares about the increasing medical needs of its veterans. (Attachment #8)

Ms. Armstrong provided the committee information regarding medical claims which have been dismissed despite easily diagnosable and treatable illnesses relating to her service in the Gulf War. She stated it is incumbent upon the State of Kansas to continue with their research into these Gulf War illnesses, to encourage the United States Government to commit more money to the research and accept the finding of any and all research without dismissing it. (Attachment #9)

Mr. Grossman stated more than 180,000 Gulf War Veterans are ill as a result of their service. He filed claims for disability in 1997 but is still awaiting his claim following a medical retirement. He urged the committee to support **HB 2770**. (Attachment #10)

Mr. Rogers expressed appreciation to the committee for the legislative funding provided during the 2001 session for Dr. Steele's research and expressed concern about the continuance of the program provided by **HB 2770** due to budgetary constraints. (Attachment #11)

Ms. Hanault addressed the committee regarding her son's birth defect. In 1995, the doctors were not familiar with a condition which was later listed in a national magazine about the increased defects in Gulf War Veterans' dependents. She urged support of **HB 2770** for the well-being of the veterans and their dependents.

Mr. Goodman urged the committee to support **HB 2770** in order to obtain funding for addressing the illnesses experienced by the Gulf War Veterans.

Representative Thimesch clarified the funding for this project would come from the sales of the various military license tags inasmuch as the project was not included in FY 2003 budget.

Representative Wilson made a motion to recommend HB 2770 favorable for passage. Representative Cox seconded the motion. The motion carried.

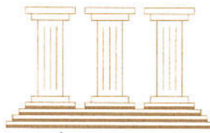
The meeting adjourned at 3:10 p.m. The next scheduled meeting is February 25, 2002.

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.

HOUSE FEDERAL & STATE AFFAIRS COMMITTEE GUEST LIST

DATE 2/21/2002

NAME	REPRESENTING
Hugh J. Grossman	Gulf War Veterans
Tonya Van Sickle	KSPGWHI KS Comm on Vet Affairs
James Bunker	
Carla Mahany	PPKM
KENNETH L. ROGERS, SR.	Gulf War Veterans
Nancy H. Armstrong	Gulf War Veterans/Spouse
Diane Albert	KDOR - DMV



KANSAS TRIAL LAWYERS ASSOCIATION

Lawyers Representing Consumers

TO: Members of the House Committee on Federal and State Affairs

FROM: Ron Pope
Kansas Trial Lawyers Association

RE: 2002 HB 2711

DATE: Feb. 21, 2002

Chairman Mays, and members of the House Committee on Federal and State Affairs. Thank you for the opportunity to appear before you today on behalf of the Kansas Trial Lawyers Association. I am Ron Pope, a practicing attorney from Topeka and a member of the KTLA Executive Committee.

KTLA has serious concerns about the far-reaching implications of House Bill 2711, an act which addresses health care professionals' right of conscience. KTLA understands that in part, the intent of the bill is to allow a health care professional to refuse to provide certain health care treatments or services based upon their right of conscience, KTLA must oppose HB 2711 as written. Like its 2001 predecessor, HB 2711 is overly-broad, vague, ambiguous and probably unconstitutional as written. HB 2711 goes far beyond what is necessary to achieve the purpose of allowing an individual health care provider as a matter of personal conscience to decline to provide a health care service if providing such service violates the health care providers' religious or moral principle. We do not believe that such a right of conscience should extend to health care payers or health care institutions.

In Sec. 3(f), the act defines a health care payer as *"any employer, public or private organization, corporation, partnership, limited liability company, sole proprietorship, association, agency, network, joint venture or other entity including its employees, agents, owners, directors, operators or managers, that pays for any health care service or product including, health maintenance organizations, health plans, insurance companies, management service organizations, and employers that pay for or provide health benefits or health insurance coverage as a benefit to their employees and any person attempting to establish a health care payer."*

Section 6(a) provides, *"a health care payer has the right to decline to pay for any health care service subject to this act."*

A fundamental problem with this bill is that health care insurers will be able to deny coverage, after the fact, for health care services that they allege violate sincerely held

House Fed. & State Affairs
Date 2/21/02
Attachment No. 1
Page 1 of 2

Terry Humphrey, Executive Director

Jayhawk Tower • 700 SW Jackson, Suite 706 • Topeka, Kansas 66603-3758 • 785.232.7756 • Fax 785.232.7730

E-Mail: triallaw@ink.org

religious or moral principles. This standard is simply too vague and ambiguous to be meaningfully enforced. It will allow insurance companies to deny coverage for medically necessary procedures prescribed by qualified health care providers that the insured has already paid premiums for. It will allow insurance companies and other health care payers to avoid payment for any procedure by simply claiming that they have religious or moral convictions against the performance of that procedure. For example, a dying child could be denied a blood transfusion or organ transplant. Patients may experience difficulty in getting providers to implement their advance directives. A person's living will could be violated by a hospital, forcing the family to continue paying thousands of dollars a day to keep the patient in a permanent vegetative state against the patient's literal will.

KTLA believes that HB 2711, as written, is clearly unworkable. Its vagueness as to when it would be applicable to deny coverage for health care services raises serious constitutional implications. It also would appear to interfere with contractual rights of insureds who, after paying premiums, would be denied insurance coverage for medically required.

KTLA also opposes the special immunities created by this bill for physicians and hospitals against malpractice liability. Just a few examples of the problems posed by this bill include the following hypothetical situations:

- A person with AIDS could be refused medication, treatment, or counseling.
- Men and women alike could be denied reproductive related treatments or procedures.
- Rape and incest victims could be denied treatment or counseling.
- The bill contains no exceptions for treating patients in an emergency situation.

The bill does not require notice to the public that a provider, institution, or health care payer does not provide or pay for a specific procedure. This disproportionally impacts individuals who reside in rural areas and those of lower income levels who do not have the resources to find another health care facility or physician willing to perform the needed medical service.

HB 2711 violates the fundamental liberty and constitutional rights of individuals to make decisions about their own medical treatment. It also conflicts with federal law. The federal Medicaid statute, for example, requires that Medicaid recipients be given access to family planning services, which could be denied by this bill. 42 U.S.C. 1396d(a)(4)(c).

What happens to patients' rights to treatment when a CEO or hospital board is replaced? Will treatment no longer be provided or paid for because of the new CEO's religious or moral beliefs?

For the reasons stated above, KTLA opposes HB 2711. We appreciate the opportunity to present our concerns to you today about this bill and stand ready to answer any questions that you may have.

1208 SW TYLER
TOPEKA, KANSAS 66612-1735
785.233.8638 * FAX 785.233.5222
www.nursingworld.org/snas/ks
THE VOICE AND VISION OF NURSING IN KANSAS

TERRI JOHNSON M.S.N., A.R.N.P.
PRESIDENT

TERRI ROBERTS J.D., R.N.
EXECUTIVE DIRECTOR

For More Information Contact
Terri Roberts J.D., R.N.
troberts@sound.net
February 19, 2002

H.B. 2711 Right of Consciousness Protection for Health Care Providers

Written Testimony

Representative Doug Mays and members of the House State and Federal Affairs Committee, the KANSAS STATE NURSES ASSOCIATION at this time cannot support H.B. 2711 as written. We have been in dialogue with other healthcare disciplines, our position at this time is that the statutory provisions are not necessary.

Since 1992 KANSAS STATE NURSES ASSOCIATION has had a position statement entitled "Guidelines for the Registered Nurse in Accepting or Rejecting a Work Assignment" which has served RN's in situations when he/she is in a potential situation that makes the individual uncomfortable or unable to perform their assignment due to ethical, religious or other personal beliefs. We know that RN's and institutions use the Guidelines and find them helpful.

Thank you.

House Fed. &
State Affairs
Date 2/21/02
Attachment No. 2
Page 1 of 5

Guidelines for the Registered Nurse in Accepting or Rejecting a Work Assignment

FROM THE KANSAS STATE NURSES ASSOCIATION

Preface

Nurses are concerned about current social and economic conditions that have the potential to lead, and in some cases, have led to chronic, unsafe staffing assignment patterns. These conditions create serious ethical dilemmas and could lead to situations that endanger patient safety as well as render the nurse, at all levels of the agency, legally liable.

Nurses know that the fulfillment of their responsibility to patients is contingent upon the availability of an adequate number of nurses who are able and qualified to carry out clinical activities at a level consistent with patient needs. All nurses share a responsibility, within the context of their positions, to ensure that safe nursing care is delivered at an acceptable level of quality. As stated in the ANA Code for Nurses, the nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others. The nurse's decision regarding accepting or making work assignments is based on his/her moral, ethical and professional obligation to assume individual responsibility for his/her nursing judgment and action.

Issues central to these ethical dilemmas are:

- the right of the patient to receive safe, professional nursing care at an acceptable level of quality;
- responsibility for the appropriate use, as well as distribution, of nursing care services when nursing becomes a scarce resource; and
- responsibility for providing a practice environment that assures adequate nursing resources for the agency while meeting the current socio-political reality of the shrinking health care dollar.

Assumptions

The staff nurse, the nurse manager, the nurse administrator, and the agency administrator may differ in their interpretation and application of the underlying principles of professional ethics and the Kansas Nurse Practice Act. Such differences often create a potential for conflict in which both nurse and patient suffer. The following guidelines are intended to support both staff nurses and administrators as they practice within an environment of conflicting requirements.

1. The patient has the right to receive competent nursing care.
2. A nurse's ability to provide care in different settings is dependent on basic education, clinical experience and specialized education.
3. Appropriate orientation and training to a new or changing clinical setting and/or patient population is essential for the nurse to function safely.
4. Nursing management coordinates nursing resources to ensure that patients receive quality nursing care.
5. Nursing staffing decisions are made by nurses with appropriate education and experience.
6. The nurse may be held legally responsible for judgments exercised and action taken in the course of nursing practice. (ANA Code, 1985, 8,9) (K.S.A. 65-1120(a)(6) & K.A.R. 60-3-109a)
7. The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities and delegating nursing practice. (ANA Code, 1985, 10,11) (K.S.A. 65-1124 (m), 65-1165 & K.A.R. 60-3-110)
8. If the nurse does not feel personally competent or adequately prepared to carry out a specific function, the nurse has the right and responsibility to refuse. (ANA Code, 1985, 11)
9. Nursing management has the right and the responsibility to take appropriate action in accordance with agency policies.
10. Written policies assist all staff in making consistent and appropriate decisions.
11. Mental and/or physical fatigue or stress interfere with a nurses's physical and mental health and may impair performance of clinical activities and judgments.

KANSAS STATE NURSES ASSOCIATION
Council on Practice (2000)

Duane Jaeger, R.N., M.S.N., C.S., A.R.N.P., Chairperson
Pearl Teel, R.N., M.N.
Elizabeth Smith, R.N.
Kelly Elliott, R.N., Ph.D., A.R.N.P., C.N.M.
Barbara Parker, R.N., M.S., A.R.N.P.
Astrid Zagorski, R.N., C, B.S.N.
Eldonna Sylvia, R.N., A.R.N.P., C.F.N.P.
Michael Nelson, R.N., B.S.N.

KANSAS STATE NURSES ASSOCIATION
Council on Practice (1992)

Duane Jaeger, R.N., B.S.N., Chairperson
Mary Stancer, R.N., B.S.N., Vice-Chairperson
Beatrice Carney, R.N., M.N., C.S.
Mary Lee Hough, R.N., B.S.N.
Martha Hutcheson, R.N., M.P.H.
Linda McAnarney, R.N.
Gloria Solis, R.N., B.S.N., C.C.R.N.
Lois Wilkins, R.N., M.S.N., A.R.N.P.

House Fed. & State Affairs
Date 2/21/02
Attachment No. 2
Page 2 of 5

This document was developed by the KANSAS STATE NURSES ASSOCIATION (KSNA) Council on Practice in 1992 and revised in March 2001.

The Council used two other state nurses' association publications from which many words and ideas for this publication were found.

North Carolina Guidelines for the R.N. in Giving, Accepting, or Rejecting a Work Assignment, 1986 and

Nebraska Nurses' Association Guide for Nurses Accepting or Rejecting a Work Assignment, 1989

12. Administrative planning and budgets affect staffing patterns. Staffing patterns are based on patients' needs and priorities for care. These staffing requirements are then adjusted to the knowledge and skill mix of the available nursing staff.
13. Nursing judgments are used in decisions on admission, placement, transfer and discharge of patients.
14. Licensed nurses have individual accountability for the care of each patient.
15. Nursing competencies are discussed at the time of employment, and clinical areas in which the nurse is competent and prepared to serve are clearly defined and updated annually or as competencies change.
16. Since the nurse in charge of a patient care area is responsible for providing consultation and direction to other nursing staff, a nurse floated to a charge position requires a substantial amount of clinical experience and a high level of clinical judgment and skill in that area.
17. There is a clearly defined written mechanism for immediate internal review of proposed assignments that includes the participation of the staff involved.
18. Incidents in which the appropriateness of staffing is in question are fully documented, reviewed, and used for decision-making.
19. The complexity of the delivery of nursing care is such that only professional nurses with appropriate education and experience can define nursing care.
20. Effective use of resources is an essential component of quality patient care.
21. Individual patient safety takes precedence over agency needs and priorities.

Application of Assumptions and Principles

The following scenarios are presented to provide specific examples of how a nurse may apply the principles and legal concepts outlined above in the actual work setting. Staffing dilemmas will always be present and mandate that active communication between staff nurses and all levels of nursing management be maintained to assure patient safety. The likelihood of a satisfactory solution will increase if there is prior consideration of the choices available.

Consideration of available alternatives should include recognition that: professional nurses should be involved in negotiations, not conflict; professional nurses are accountable for nursing judgments and actions regardless of the personal consequences; and, providing safe nursing care to the patient is the ultimate objective of negotiations.

Scenario I

A Question of Competence

It is important for the nurse to recognize his/her level of competence before deciding whether to accept or reject an assignment. In order to do this, begin with clarifying what is being asked of the nurse.

- How many patients will the nurse be expected to care for?
- Does the care of these patients require the nurse to have specialty knowledge and skills in order to deliver safe nursing care?
- Will there be other qualified and experienced RNs on the unit?
- What procedures and/or medications will the nurse be expected to administer?
- How complex are these procedures/medications? (For example, administration of chemotherapy or ongoing assessment of a patient on a cardiac monitor.)
- What kind of orientation would be necessary for the nurse to function safely in this unfamiliar setting?

After these questions have been answered, the proposed assignment should be discussed by the nurse with the manager initiating the request. During this dialogue, continue to clarify the understanding of the expectations of the request. Now is a decision point:

1. If the nurse perceives that safe patient care can be provided, the nurse should accept the assignment. The nurse would now be ethically and legally responsible for the nursing care of these patients.
2. If the nurse perceives there is a discrepancy between his/her abilities and the expectation of the assignment, further negotiation is needed before a decision is reached.

At this point, it may be appropriate to consult the next level of management, such as the House Supervisor or the Nurse Executive.

In further negotiation, the nurse needs to continue to assess whether he/she is qualified to accept either a portion or the whole of the requested assignment. In negotiating, point out options which might be mutually beneficial. If the nurse feels unqualified for the assignment in its entirety, the dilemma becomes more complex.

At this point it is important for the nurse to be aware of the legal rights of the agency. Even though the nurse may have a legitimate concern for patient safety and legal accountability in providing safe care, the agency has legal precedent to initiate disciplinary action, including termination, if the nurse refuses to accept an assignment. Therefore, it is im-

CODE OF ETHICS FOR NURSES

1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
2. The nurse's primary commitment is to the patient, whether an individual, family, group or community.
3. The nurse promotes, advocates for and strives to protect the health, safety and rights of the patient.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.
5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence and to continue personal and professional growth.
6. The nurse participates in establishing, maintaining and improving healthcare environments and conditions of employment conducive to the provision of quality healthcare and consistent with the values of the profession through individual and collective action.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice and for shaping social policy.

REFERENCE: American Nurses Association. (2001). Code of Ethics for Nurses, Washington, D.C.

2/21/02 Attach #2 pg 3

portant to continue to explore options in a positive manner, recognizing that both the nurse and the agency have a responsibility for safe patient care.

Other options may include:

- Identify a qualified nurse from another unit who could take the requested assignment while the nurse in the situation takes that nurses assignment.
- Call in a qualified off-duty nurse;
- Share the requested assignment among several nurses of varying qualifications.

If none of these options are viable or acceptable the nurse is at a final decision point:

1. The nurse may accept the assignment, documenting carefully concerns for patient safety and the process used to inform the agency (manager) of these concerns. Keep a personal copy of this documentation and send a copy to the Nurse Executive. Courtesy suggests that a copy be sent to the manager(s) involved as well. Once this decision has been reached, it is unwise to discuss the situation or feelings about the situation with other staff and/or patients. Now the nurse is legally accountable for these patients. From this point withdrawal from the agreed upon assignment may constitute abandonment.
2. The nurse may refuse the assignment, being prepared for disciplinary action. Any concerns should be carefully documented for patient safety. The process used to inform the agency (manager) of these concerns should also be documented. The nurse should keep a personal copy of this documentation and send a copy to the manager(s) involved.

Scenario II
A Question of an Additional Shift

When a nurse is asked to work an additional shift, the nurse should clarify what exactly is being asked. For example:

- would the additional shift be with the same patients the nurse is currently caring for, or would it involve a new patient assignment?
- Is the nurse being asked to work because there is no relief nurse coming for present patient assignments or is it because the work unit will be short of professional staff on the next shift?
- Is the nurse's reluctance to work another shift because of a new patient assignment he/she does not feel competent to accept? (If yes, then refer to Scenario 1, "A Question of Competence.")
- How long is the nurse being asked to work — the entire shift or a portion of the shift?

Remember, the institution is legally responsible for the care of all current patients as if relief is not available. Based on the nurse's self assessment, the proposed assignment needs to be discussed by the nurse with the manager initiating the request. During this dialogue, continue to clarify the understanding of the expectations of the request. Now is the time for a decision.

1. If the nurse perceives that safe patient care can be provided, and is willing to work the additional shift, the nurse may accept the assignment.
2. If the nurse chooses not to work the additional shift, the nurse refuses the assignment.

At this point, it is important for the nurse to be aware of the legal rights of the agency. Even though the nurse may have legitimate concern for the patient safety, and his/her own legal accountability in providing safe care, or legitimate concern for other commitments, the agency has legal precedent to initiate disciplinary action, including termination, if the nurse refuses to accept an assignment. Therefore, it is important to continue to explore options in a positive manner, recognizing both the nurse and the agency have a responsibility for safe patient care.

Other options may include:

- Identify another qualified nurse who is willing to work an additional shift;
- Call in a qualified off-duty nurse;
- Consider sharing the requested shift by splitting the uncovered time with the personnel assigned to the next shift.

If none of these options are viable or acceptable the nurse is at a final decision point:

1. The nurse may accept the assignment, documenting carefully concerns for patient safety and the process used to inform the agency (manager) of these concerns. Keep a personal copy of this documentation and send a copy to the Nurse Executive. Courtesy suggests that a copy be sent to the manager(s) involved as well. Once this decision has been reached, it is unwise to discuss the situation or feelings about the situation with other staff and/or patients. Now the nurse is legally accountable for these patients. From this point withdrawal from the agreed upon assignment may constitute abandonment.
2. The nurse may refuse the assignment, being prepared for disciplinary action. Any concerns should be carefully documented for patient safety. The process used to inform the agency (manager) of these concerns should also be documented. The nurse should keep a personal copy of this documentation and send a copy to the manager(s) involved.

Scenario III
A Question of Diagnosis/ Treatment

Some nurses have identified certain patient populations having specific diagnoses or receiving certain treatments for whom they are reluctant to provide care. This reluctance is related to personal moral tenets of fear for personal or family's health.

If the nurse concludes that the reluctance will lead to refusal to care for any specific patient population, the nurse must inform his/her employer. This communication should occur prior to employment or as soon as new information leads the individual to a conclusion to refuse an assignment. This communication should not be delayed until the time of a patients assignment.

In communication with the employer at the time of interview, the nurse should remember the following:

- Be prepared to provide the employer a strong rationale and documentation to support the necessity for refusal to care for a specific patient population. Recognition by the organization of an individual nurse's right to refuse to care for a specific patient population sets a major personnel precedent and will not be made lightly.

ANA PRINCIPLES FOR NURSE STAFFING

The nine principles of nurse staffing adopted by ANA are as follows:

I Patient Care Unit Related

a. Appropriate staffing levels for a patient care unit reflect analysis of individual and aggregate patient needs.

b. There is a critical need to either retire or seriously question the usefulness of the concept of nursing hours per patient day (HPPD).

c. Unit functions necessary to support delivery of quality patient care must also be considered in determining staffing levels.

II Staff Related

a. The specific needs of various patient populations should determine the appropriate clinical competencies required of the nurse practicing in that area.

b. Registered nurses must have nursing management support and representation at both the operational level and the executive level.

c. Clinical support from experienced RN's should be readily available to those RNs with less proficiency.

III Institution/Organization Related

a. Organizational policy should reflect an organizational climate that values registered nurses and other employees as strategic assets and exhibit a true commitment to filling budgeted positions in a timely manner.

b. All institutions should have documented competencies for nursing staff, including agency or supplemental and traveling RNs, for those activities that they have been authorized to perform.

c. Organizational policies should recognize the myriad needs of both patients and nursing staff.

REFERENCE: Principles of Nurse Staffing, ANA, 1999

- A health care agency has a responsibility to provide [illegible] for all patients accepted into the organization. Due to this [illegible]sibility, a nurse cannot be guaranteed that he/she will never be asked to provide care for the patients in question.
- If the employer chooses to honor the nurse's reluctance to care for a specific patient population, the nurse must expect to be assigned to an area in which these patients are least likely to be found.
- The nurse should remember too, that even if the nurse's request is honored, the occasion may arise in which the situation requires the nurse to care for patients in this population.
- If the nurse's request is not honored by the employer, the nurse's responsibility is to agree to meet the employer's expectations or to decline the position or resign.

Consider the occasion where the nurse's request has been communicated, but the nurse is now faced with a proposed assignment to a patient in this population.

The nurse is at the final decision point and must choose one of the following options:

1. The nurse may accept the assignment, documenting carefully concerns for patient safety and the process used to inform the agency (manager) of these concerns. Keep a personal copy of this documentation and send a copy to the Nurse Executive. Courtesy suggests that a copy be sent to the manager(s) involved as well. Once this decision has been reached, it is unwise to discuss the situation or feelings about the situation with other staff and/or patients. Now the nurse is legally accountable for these patients. From this point withdrawal from the agreed upon assignment may constitute abandonment.
2. The nurse may refuse the assignment, being prepared for disciplinary action. Any concerns should be carefully documented for patient safety. The process used to inform the agency (manager) of these concerns should also be documented. The nurse should keep a personal copy of this documentation and send a copy to the manager(s) involved.

Resources For Nurses

Access to Personnel File

Employees generally by institutional policy are entitled to review and request copies of all materials maintained in their personnel records. This includes the completed job/position application, performance appraisals and written reprimands or disciplinary reports (if any). A request to review or receive copies should be written, dated and signed by the employee and given to the human resources or personnel department for processing.

Chronology of Events

Preparation of a chronology of the events surrounding any unsatisfactory assignment discussion should be maintained in sufficient detail to refresh the employees memory about what was said by whom and what employees were present during discussions or negotiations. These notes should be kept separate and distinct from any patient records and should describe with sufficient clarity, yet protect the identity of particular patients when describing for example acuity or other personnel's assignments. Store this personal documentation in a safe place with other personal records.

Where to Report Unsafe Care

KDHE — The Kansas Department of Health and Environment is responsible for licensing Kansas health care facilities. Patterns of unsafe staffing may be reported to the KDHE licensing division by calling 785.296.1500.
JCAHO — JCAHO accredited hospitals can also be reported to the Joint Commission on the Accreditation of Healthcare Facilities by calling 800.994.6610, by fax at 630.792.5636, by e-mail at complaint@jcaho.org, or for more information, visit their web site at www.jcaho.org/compl.htm.
HCFA — The Health Care Financing Administration (HCFA) also receives reports and investigates potential violations of Medicare Conditions of Participation and may be reached by calling 816.426.2011 or by fax at 816.426.6769.

KSNA — the Voice and Vision of Nursing in Kansas

KSNA
KANSAS STATE NURSES ASSOCIATION

KANSAS STATE NURSES ASSOCIATION
1208 SW Tyler Topeka, Kansas 66612-1735
PHONE: (785) 233-8638 FAX: (785) 233-5222
WEB SITE: www.nursingworld.org/snas/ks

House Fed. & State Affairs
Date 2/21/02
Attachment No. 2
Page 5 of 5

Memorandum

Donald A. Wilson
President

February 20, 2002

To: House Federal and State Affairs Committee
From: Thomas L. Bell
Senior Vice President/Legal Counsel
Re: House Bill 2711

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of House Bill 2711. This bill creates the Health Care Providers Rights of Conscience Act. Such a law would codify the notion that a health care provider has the right to refuse to perform certain specified health care services. It would also establish a procedure for the exercise of this right.

KHA is in general support of this right of conscience. It is an idea that the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has recognized and required to be included in hospital policies. Having said this, we want to be quick to point out the JCAHO also recognizes the patient's right to treatment or service within the hospital's capacity, its stated mission and philosophy, and relevant laws and regulations. The JCAHO structure is instructive and provides a good template for how numerous hospitals currently deal with this issue:

The hospital attempts to accommodate employees who provide advance notification to their supervisor that they do not wish to participate in an aspect of care or services because of cultural values, ethics, or religious beliefs. The policy addresses:

- *The fact that the employee is informed during orientation that he or she may request to not participate in an aspect of care because of cultural values, ethics, or religious beliefs.*
- *That if the employee identifies an aspect of care or service in which he or she does not wish to participate, he or she should make a request in writing to be excused from participation. The request should include the cultural, ethical, or religious reasons and the aspect of care or service from which he or she wishes to be excused.*
- *The fact that the supervisor will review the request to justify appropriateness and to see if accommodation is possible.*

House Fed. &
State Affairs
Date 2/21/02
Attachment No. 3
Page 1 of 2

- *That if accommodation is possible, the supervisor will notify the employee and others who need to be involved in the accommodation. There will be an understanding that if events prevent the accommodation at a specific point because of an emergency situation, the employee will be expected to perform assigned duties so he or she does not negatively affect the delivery of care or services.*
- *That if an accommodation is not possible, the employee will be allowed to explore other job opportunities within the hospital where an accommodation might be possible.*
- *That if an employee does not agree to render appropriate care or services in an emergency situation because of personal beliefs, the employee will be placed on a leave of absence from his or her current position and the incident will be reviewed.*

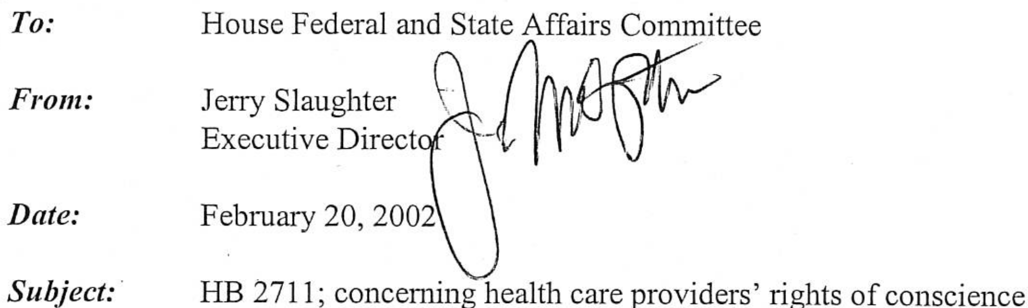
This JCAHO policy generally mirrors the structure set out in HB 2711. The biggest difference, however, is that HB 2711 as introduced does not adequately recognize emergency situations. It is especially in these kinds of circumstances that the patient's right to care and treatment weighs the heaviest. In our opinion, there needs to be greater recognition of emergencies both in the delineated health care services subject to the act and elsewhere. For example, blood transfusions are a type of service often provided in an emergency and should be excepted from the bill. Also, Section 5 (d) attempts to clarify that a hospital must still perform its duties in emergency cases. We agree with this, but other provider's duties in such cases should also be recognized.

In summary, the policy set out in HB 2711 is one that is generally recognized in the health care setting and one that we support. There are, however, several amendments that should be made to the bill.

Thank you for your consideration of our comments.

623 SW 10th Avenue
Topeka KS 66612-1627
785.235.2383
800.332.0156
fax 785.235.5114

kmsonline.org



To: House Federal and State Affairs Committee

From: Jerry Slaughter
Executive Director

Date: February 20, 2002

Subject: HB 2711; concerning health care providers' rights of conscience

The Kansas Medical Society appreciates the opportunity to appear today on HB 2711, which codifies the right of health care providers to refuse to participate in patient care procedures or services which they may have objections to on moral grounds.

Let me say from the outset that we have tried to approach this legislation objectively, looking carefully at its actual content, and keeping separate the fairly obvious religious, political and emotional dynamics associated with it. Most particularly, our interest in this legislation should not be construed as a statement on abortion, for it decidedly is not. We take no position on that issue.

When this bill was introduced last year we identified several concerns which we discussed with the sponsors. During the intervening months the bill was substantially altered to address many of the concerns we raised. Our objections to the bill were related to the specific language and approach, not the underlying philosophy. It is a universally accepted ethical principle in medicine that a physician should be free to choose whom to serve, except in the case of an emergency, or if the refusal would constitute discrimination. Said another way, the right of a physician to not participate in certain procedures and services is imbedded in medical ethics. However, the obligation of a physician is to put the best interests of the patient above all else, and in cases where a physician chooses to not participate in a service, that obligation can be met by identifying a qualified substitute physician for the patient. Obviously, that means there may be times when the physician's desire to not participate is subordinate to the welfare of the patient. In such cases, such as emergencies, the physician must participate in providing the service to the extent of their capability. The overarching ethical principle involved in this legislation is fundamental to the physician-patient relationship, and we support it. That ethical principle, by the way, also applies in the affirmative. A physician is ethically free to choose to participate in certain services, so long as they are legal and within his or her current competence.

House Fed. &
State Affairs
Date 2/21/02
Attachment No. 4
Page 1 of 2

A couple of key areas of the bill that we identified concerns with should be mentioned. Because physicians have an ethical obligation (and probably a legal one as well) to provide life-saving services in the case of emergencies, we asked the sponsors to remove the reference to blood transfusions, which has been done. Obviously, it is unacceptable and contrary to the well-being of a patient to have a health care provider refuse to participate in a blood transfusion in an emergency or when it is medically necessary. Another concern had to do with emergency situations as a whole, wherein it would be detrimental to the best interests of the patient to have a physician or health care provider refuse to provide medically necessary care. This also was addressed in the amendments to the bill, and is intended to make it clear that a provider's duty to provide emergency care takes precedence over the provider's desire to not participate. Another concern of ours was the reference to sterilization. There are times when a hysterectomy (surgical removal of the uterus) is clearly medically necessary for reasons unrelated to contraception. Qualifying language was also added to address those situations.

We sincerely appreciate the willingness of the sponsors to address our concerns. Particularly as it relates to emergency situations, this bill recognizes the greater weight that must be given to the well-being of the patient, even if it means subordinating the desires of the provider. Our view is that these changes are in the best interest of patients, and go a long way to assuring that this bill will not result in medically necessary care being interrupted or withheld. Our goal was to make sure that the bill strikes the correct balance between recognizing the rights of providers while protecting the rights of patients to receive medically necessary care.

We continue to have some concerns about the language as it relates to health care payers. Our concern is that we would not want to create a situation where an insurance company could refuse to pay for a medically necessary service on the grounds that it had a moral objection to the service, unless it had an explicit mission or corporate philosophy that clearly was in conflict with the particular service. Frankly, at this point we do not have a good suggestion on how to amend section 6 of the bill to address those concerns without substantially altering the intent of the sponsors to protect the rights of insurers that are owned or operated by religious institutions. We would like to work with the sponsors of the bill to further refine this area.

We have not found instances of physicians being forced to participate in certain services against their will in our state. However, we realize this bill affects all health care providers, many of whom are employees, which puts them in a little different situation than most physicians. With the addition of the amendments discussed above, this bill is consistent with well established ethical principles, and we can support it. Thank you for the opportunity to offer these comments.

February 20, 2002

Mr. Chairman, and members of the Federal and State Affairs Committee, I would like to thank you for the opportunity to speak today. My name is Paula Koch and I'm a licensed pharmacist in Kansas. I'm sharing this testimony with you to explain why I believe HB2711 is important, relevant, and why it should be passed.

In October of 2000 my employer threatened to fire me because I did not want to dispense the morning after pill, a medication that violates my Christian faith. Approximately 18 months before this incident I had discovered that our clinic dispensed the morning after pill. I made arrangements with the pharmacy supervisor for him to dispense the prescription. I met with the Chief Physician to discuss why I didn't want to dispense the morning after pill and asked if she would come to the pharmacy and dispense the prescription when my supervisor was absent. She agreed.

In the next 18 months, on 3 different occasions the physician dispensed the morning after pill instead of me. In October of 2000 however she refused to dispense the prescription. She stated she was too busy and also refused to let the nurse practitioner come to the pharmacy to dispense it. I was told by the Clinic Administrator that I did not have the option to refuse to dispense any medication. I filed an appeal with the medical staff committee per clinic policy and my pharmacy supervisor attempted to make accommodations with the physician.. After the October incident the pharmacy pre-packaged and pre-labeled morning after pills. All the prescriber had to do was walk to the pharmacy or send a nurse to the pharmacy, pick up the pre-packaged prescription and take it to the patient in the exam room. This entire process would take less than one minute.

Despite these changes, the Chief Physician refused to accommodate me. After the medical staff committee meeting where the modifications and my appeal were allegedly discussed, she met with my supervisor and myself. She told me that "Your religion does not matter and as long as I write a legal prescription you have to fill it. I am your commanding officer. If you do not follow my direct order you will be written up for insubordination and consequently fired." She did not mention the proposed accommodations or the fact that they would be necessary two or three times a year. Instead, I was reprimanded about understanding the consequences of my actions and how I had damaged the reputation of the clinic.

After this meeting with the Chief Physician I filed a complaint at the local clinic, requesting a blanket accommodation. This request was denied. I then filed a complaint with the Regional EEO office. Eventually I had to hire an attorney and file a lawsuit. Finally, in July of 2001, nine months after the original incident, my employer agreed to accommodate me.

During this process I battled many things. First was anxiety over job security. Every time my supervisor was scheduled to be gone I had difficulty sleeping. I worried if that workday would be the day I was commanded to dispense a prescription I believed was harmful. Secondly, I had to deal with the belittling of my job performance. The physician's position was that it had been my responsibility to inform the clinic I would not dispense the morning after pill BEFORE I was hired. Then she stated they would not have hired me and would have hired a pharmacy

technician instead. Since I did not want to dispense the morning after pill, I was being equated with a pharmacy technician. My license, six years of pharmacy school, and 3 and ½ years of experience did not seem to matter. Since I did not want to dispense a medication that is considered legal, but that I believe is potentially harmful; I was not worthy of being called a pharmacist. I was also told that a "pharmacist" conscience clause was bizarre because a pharmacist is simply a conduit of the physician's wishes. Pharmacists have worked very hard to be considered partners in the health care team. We are jointly responsible for every prescription that is prescribed and subsequently dispensed by the pharmacy. Physicians have full protection of the law. If they do not wish to provide a health care service based on moral, ethical, or religious convictions they may do so without fear of termination. I firmly believe pharmacists and other health professionals should be granted this same right. HB 2711 gives a health care provider an option to follow his or her conscience.

I have been a pharmacist for less than five years and would like to continue for several more years. I have dedicated my professional life to serving the public and teaching pharmacy students. I've used my vacations to serve as a pharmacist in a Guatemalan mountain village medical clinic. I love being a pharmacist. However, I am unsure how long I will be able to practice pharmacy. As a pharmacist I took an oath to protect life and not harm it. I in good conscience cannot dispense a prescription I believe has the potential to destroy a life. To do so would violate both my religious beliefs and my professional ethics. When an employer commands me to dispense a prescription that violates my conscience, he or she is forcing me to go against the very essence of who I am.

During my lawsuit I was told I needed to separate my spiritual life from my professional life. This simply is not possible. My faith is the foundation of all areas of my life, including my career. We do not ask health care providers to leave their race or ethnicity at the door when they clock into their job. Why should we ask them to leave their ethical, moral, or religious beliefs? These beliefs can define a person as much as race or ethnicity.

In August of this year I had the opportunity to change jobs. During my interview with my prospective supervisor I discussed my conscience objection to the morning after pill. He replied, "I don't have to agree with you to respect you." We then discussed options and alternatives if I was presented with a prescription I conscientiously objected to. I feel very fortunate that my current employer is willing to accommodate me. As I have testified, that is not always the case.

The Kansas Pharmacists Association representatives are officially opposing this bill. I attended the annual meeting in September of 2001. We discussed the balance of recognizing and respecting a pharmacist's conscience with establishing systems in the workplace to ensure a patient can obtain a prescribed medication. I believe this bill accomplishes both these goals. Requiring health care providers to provide prior, written notice to their employer allows for the establishment of alternative systems in each unique health care setting. I believe that the testimony you heard yesterday from KPhA representatives does not accurately reflect the majority of Kansas pharmacists. The Journal of Kansas Pharmacy December 2001 issue reported that 86 % of Kansas pharmacists supported a pharmacist's right of conscientious objection.

Unlike the KPhA, the American Pharmaceutical Association is unequivocal in its recognition of conscience rights. The national association "…recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patient access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal."

In closing, I would like to ask each of you to think about your own lives. What if your employer demanded you to do something you believed was wrong? How would you respond? It's a big decision with difficult consequences resulting from either choice. Would you do it simply because it was your job and that was expected of you? If you did, would you be able to look at yourself in the mirror every morning and evening, knowing you did something that violated your personal code of ethics? Are you willing to risk losing your job and perhaps your professional reputation? "To thine own self be true", is it worth all the possible consequences? This is the very dilemma that health care professionals are facing. These are not isolated incidents and these issues will not go away. Now is the time to address them. HB2711 gives health care professionals the freedom to make difficult choices without fear of demotion or termination.

Thank you for your time. I would be happy to respond to any questions.

STATE OF KANSAS

DAN THIMESCH
REPRESENTATIVE, 93RD DISTRICT
30121 WEST 63RD STREET SOUTH
CHENEY, KANSAS 67025
(316) 531-2995

STATE CAPITOL
ROOM 278-W
TOPEKA, KANSAS 66612-1504
(785) 296-7680
1-800-432-3924
(DURING SESSION)

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
AGRICULTURE RANKING MINORITY
ENVIRONMENT
LEGISLATIVE POST AUDIT
TAX, JUDICIAL & TRANSPORTATION BUDGET
SUBCOMMITTEE
CAPITOL RESTORATION
SOUTH CENTRAL/SEDGWICK COUNTY DELEGATION
GULF WAR ADVISORY BOARD

TESTIMONY HB 2770

HOUSE FEDERAL AND STATE COMMITTEE

I am here today to ask for favorable support of HB 2770. To continue our efforts helping our sick Kansas Gulf War Veterans.

The Kansas Legislature showed wisdom and a real vision in 1997 when we overwhelmingly passed the Persian Gulf War Veterans health initiative act. This act provided direction for a survey and research study, to identify the real problem of Gulf War illness.

This year our Kansas study was sided in a GAO report. Kansas was asked to testify in two sub committee hearings in Washington, DC. Other private researchers were also asked to testify. Our study and others have identified specific syndromes, correlations between different exposures and health problems, location and time spent in theater and severity of health problems.

The Federal Government has spent at least 3/4 of a billion dollars and has not answered any questions about Gulf War illness. Private research is asking for Federal research money to be redirected to them (Kansas is asking for 2 million) last year Texas received 5 million. We now believe that more than 130,000 veterans are ill, and more family members are showing symptoms. The Gulf War was the most toxic war ever fought. Gulf War illness is a progressive illness and many of our veterans health is becoming worse.

HB 2770 will continue our very important work in Kansas.

- Continue - Persian Gulf War Veterans information phone line.
- Up-dating our data base communicating with our 7,500 Kansas veterans that deployed to the Gulf.
-
- To promote programs and activities designed to assist persons and families affected by Gulf War illness, to improve the general health of our veterans.

For so little, we have done so much but much more needs to be done.

Please support HB 2770

> "We are not afraid to entrust the American people with unpleasant facts,
> Foreign ideas, alien philosophies...for a nation that is afraid to let it's people
> judge the truth and falsehood in an open market is a nation that is afraid
> of it's people."
>
> John F. Kennedy

THE KANSAS PERSIAN GULF WAR VETERANS HEALTH INITIATIVE

A Project of the Kansas Commission on Veterans Affairs

700 S.W. Jackson, Suite 701
Topeka, KS 66603-3758
email: kspgwvets@cjnetworks.com

Telephone (785) 296-3976
Fax (785) 296-1462
Information Network: 1-888-474-9838

Good afternoon Chairman and members of the committee. I would like to thank you for your time this afternoon. My name is Tonya Ricklefs Van Sickle, I am the Program Assistant for the Kansas Persian Gulf War Health Initiative, a program of the Kansas Commission on Veterans Affairs. I have been there for nearly two years, most of that time working directly with Dr. Lea Steele. I would like to share with you today what this program has accomplished for Persian Gulf War veterans.

It has been over a decade since the United States sent men and women to the Persian Gulf. The job of defeating Saddam Hussein was quick and causalities were few. Our military forces did a job that the world could be proud of. Soon after people began returning home, stories spread about unusual illnesses. The reaction from the federal government was slow and veterans quickly became frustrated and continued to be confused.

In 1997, the State of Kansas developed a program to address the issues Gulf War veterans are facing. This program made Kansas one of the few states assisting veterans with their disturbing health problems. I can also tell you that because of Kansas legislative support, we have been one of the few remaining successful programs across the country.

In November of 2000, Dr. Lea Steele's study of over 2,000 Kansas Persian Gulf War veterans was published in the American Journal of Epidemiology. This study has been nationally recognized because it has shown never before seen patterns in who is more likely to have Gulf War Illness. As a result of this national recognition, the former director of the Kansas Persian Gulf War Health Initiative, Dr. Lea Steele has been appointed to the VA advisory board on Gulf War Illness by the Secretary of the VA, Anthony Principi. Dr. Steele's hard work has given this program a wonderful reputation and a sturdy foundation of knowledge that can be shared with veterans nationwide.

In April and May of 2001, we shared our knowledge of Gulf War Illness with veterans across Kansas. Newsletters were mailed to 6,500 veterans and their families informing them about what programs were available to them as Gulf War veterans, about our Kansas study results, and where we were conducting town hall meetings that they could attend. These meetings were held in towns as large as Kansas City and as small as Colby.

Sharing information is one of the most important jobs that the Kansas Veterans Commission does. Everyday I talk to veterans who are just happy to find out that they are not alone. The nature of Gulf War Illness is that it is confusing both to the doctors and the patients. Many veterans are not satisfied with the health care that they receive from the VA, but more importantly, they feel that nobody takes the time to really understand and listen to what they are experiencing.

Our program has a toll-free hotline that is available for veterans to contact us with questions. The idea is for me to share with them information that makes them better educated patients. But, more often, the veterans are sharing information with me. They are just happy that someone is listening and believes them. Gulf War Illness is something that veterans are suffering from in silence. They get up and go to work like you and I, have families and try to live their life the best way that they can. I have spoken to hundreds of Gulf War veterans and that opportunity to fully experience life has been taken from them. It can be simple things like constantly having to treat a skin condition, to having such impaired memory function that you forget how to find your way home. Some Gulf War veterans experience such exhaustion that they can no longer play for any length of time with their children or headaches that leave them physically drained for days. These are a few of the wide ranges of impairments that can effect Gulf War veterans.

There are still many questions that need to be answered for Gulf War veterans. Currently, I am contacting veterans in Junction City to participate in a study that we are working on with Midwest Research Institute in Kansas City and Dr. Lea Steele at the Kansas Health Institute. Recently, the Veterans Administration has decided to provide service-connected benefits to Gulf War veterans who have ALS (more commonly known as Lou Gerhigs disease). Also, a recent study conducted by the VA has shown that Gulf War veterans children do show a increase in birth defects.

There is more information that is going to be revealed about what happened to our men and women while they were in the Gulf. Kansas was there early on to provide an example of a program that educated and supported our veterans when they needed it. I personally feel proud everyday to work in such a unique and wonderful program. I also feel proud and honored to serve and work for and with such amazing veterans who were willing to go and protect me many years ago.

Kansas Persian Gulf War Veterans Health I(iative

James A. Bunker Chairman

1703 SW 66th Street Pauline, Kansas 66619
Voice (785) 862-9201 VOICE MAIL (785)221-0162 EMAIL Kansasvet@yahoo.com
Home Page: http://www.geocities.com/kansasvet

TESTIMONY HB 2770

HOUSE FEDERAL AND STATE COMMITTEE

I am here today to ask for favorable support of HB 2770 and to continue helping our Kansas Veterans.

For over 200 years, this country has sent its son and daughters into harms way. They are given the best of everything to insure their safe return to their mother, father and loved ones. No matter how well our government tries to keep them safe, some will come home in need of care. This may be in long-term treatments in our hospital or in finding the answers to why they are getting sick from some unknown cause.

In the forties and fifties, the DoD looked at the power of the atom, not fully understanding how radiation will harm any one. To them, the atomic bomb was something that was going to save lives in war. It took over 40 years, and the willingness of those in power to spend money on research, for many of those veterans to get the help they need for the sickness that had befallen them.

In Vietnam, herbicides was used to clear away some of the hiding places of the enemies. At the time, it was something that would help the troops, in fact it saved who knows how many lives; but just like before, unforeseen health problem would arise for its' use. With the help of states and privet research, even the children of the veterans are now getting help. Because of ongoing studies, to this day the VA is still adding to the list of thing that is attributed to Agent Orange.

In the gulf war, our troops had been exposed to many different toxic elements, some of it to protect from CBW. Some of it was CBW along with the toxic smoke of the oil well fires. To date, the Gulf War has been the most toxic war ever fought and I pray that we ever do fight. Gulf War illness is a progressive illness and many of our veterans health is becoming worse. We have found in our studies that many of them do not want the VA comp; they just want their health back. Just 2 months ago, the VA said that GWV are 2 times more likely to get ALS than non-GWV veterans and who knows what else is yet to come.

I do not know what has made the GWV sick, and I think the DoD is not sure on it either, nor are they really looking for ways to make use healthy again. I feel their focus is on how not to let this happen in war that is yet to be fought. After all, history has shown their job is to fight wars and to try to keep men safe. Moreover, is has shown that it takes politicians funding research to help the veterans after they leave the service.

I do feel we need to build on what we have done in our state, and that we need to keep on looking for ways that will help the veterans to lead a more productive life.

The Kansas Study was the first study to show that time and place mattered in the relationship of GWI. The study was sited in a GAO report. We sent some one to testify in two sub committee hearings in Washington, DC; and she is now a member of the VA Gulf War health board.

Some of what I feel that the state needs to do is:

- Do blood sample of both sick and healthy veterans to look and see what all the sick veterans have in common and look to see what is different with the non-sick veterans.
- To do a phone survey of the veterans to see how their health has changed. For those that report changes in health, look for why their health improved, (life style change, medication, other treatments)
- Look to see if there are some well defined illness common with the veterans, and see how that may contribuilt to their problems.

The Kansas study has shown the rest of the country that we care about out veterans, and that we intend to take care of them. Kansas is now known for its' leading role in finding help for ill Gulf War veterans. With your help, we can do even more.

Please support HB 2770

Nancy H. Armstrong
12956 NW Parallel St.
Benton, KS 67017
(316) 778-1619

To our esteemed Senators, Representatives, fellow veterans, family, friends and distinguished guests,

Let me introduce myself. My name is Nancy Armstrong. I am a former ET1(SW), USN. I served from 1979 until 1992. I am a Gulf War Era Veteran. Additionally I am a veterans advocate that works to help other veterans on a grassroots basis.

I am testifying before you today on a very recognizable problem to me and most veterans. That is the current atmosphere in the United States, our federal government, the Department of Defense and the Department of Veterans Affairs is an obstacle to the Gulf War veteran and those still serving in the military seeking treatment for their illnesses.

I can speak to this from personal experience. I have easily diagnosable and treatable illnesses but over the last 4 years I have had claims summarily dismissed or delayed for many months. The most recent has been for almost 2 years. The Gulf War veteran has been waiting for 11 years. The only illness that has been identified and published is Lou Gehrig's Disease. It was published that only 40 cases have been identified. That isn't even a drop in the bucket compared to the thousands that served and the various unidentified illnesses.

Since the Gulf War veteran has had a hard time getting treatment even being denied treatment, he or she is afraid to come forward. Those who remain on active duty won't come forward at all because it will negativly affect their careers.

To begin with we have the Atomic veterans they fought for disability and fifty+ years later they are finally being treated. Did you know that Agent Orange was used in the Korean War as well? Most veterans fighting in this war suffer permanent frostbite damage to their extremities, yet it is not a recognizable problem under the current laws. Let us revisit for a moment the Agent Orange debacle. As veterans were complaining about their illnesses the authorities denied the use of this herbicide and even denied there were illnesses.

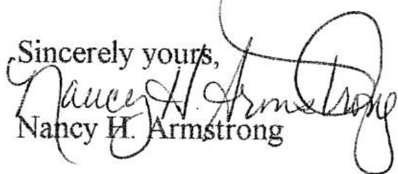
Because these other veterans had to fight so hard for treatment, the Gulf War veterans have learned from experience. They hide in the shadows, they work everyday if they can. They can be your neighbor next door. In my case, my Gulf War veteran is my husband. He served aboard ship but he has too experienced strange and inexplicable illnesses, some just surfacing in the last year. He can still work and hides from the Department of Veterans Affairs, even refusing to register as a Gulf War veteran with them.

There is a law, Title 38, that says veterans do not have the burden of proof . I am here today to tell you that the Gulf War veteran does appear to bear that burden.

It is incumbent upon the State of Kansas to continue with their research into these Gulf War illnesses, to encourage the United States Government to commit more money to the research and accept the findings of any and all research without dismissing it . Let the State of Kansas lead by example. And maybe someday we will finally get all the Gulf War veterans with illnesses to come forward, get their well deserved treatment and get it before they die, as some have.

Thank you for your time. Thank you for all those Gulf War veterans still waiting for treatment and recognition of their illnesses. Please help them so they can help themselves.

Sincerely yours,



Nancy H. Armstrong

House Fed. &
State Affairs
Date 2/21/02
Attachment No. 9
Page 2 of 2

My name is Hugh Grossman and I live in Spring Hill, KS. I was one of many Gulf War Veterans who traveled to this State House to urge some of you to support a Gulf War Initiative. The results of our efforts, thanks to you, was to approve the funding for **HR 6008** known as the Persian Gulf War Veterans Health Initiative Act.

I was one of the few to see Gov. Graves sign the bill into law and receive an original copy of the bill. The bill in question funded a two-fold effort. The first effort was to investigate health problems reported by Gulf War Veterans. The second was to have an office with a toll-free number, to serve as a information resource for Gulf War Veterans about health issues, and Government programs and benefits.

The study that investigated the Gulf War illness with Dr. Lea Steele at the helm, asked questions that no one else in this country was asking. The findings were surprising. The illness rates were connected with where we were stationed and when and how long we were there in the theater of operations.

I served 2 tours in Vietnam and a tour in Thailand. I joined the Army Reserves in 1985 and proudly served in the Gulf War. My service in the Gulf War ultimately cost me 2 careers I loved as a Police Sargent in the Springhill Police Department and the Army Reserves. I had to take a medical retirement in January 1997.

My life now, like over 180,000 Gulf War Veterans who are sick is best described as a life of quiet desperation. We wonder what caused our illness. I like thousands of other Gulf War Veterans battle with the Department of Veterans Affairs and with the Social Security Administration. I filed claims with both agencies in 1997. In November 2001 I was awarded SS Disability, although they tell me it will take 8 months to process my claim. My claim with the VA was remanded fact to the Wichita office in Jan. 2001, with the finding that my chronic fatigue syndrome was service connected to the Gulf War. My claim still sets in Wichita waiting a decision. Talk about frustrating...

I have personally called the office of the Kansas Commission on Veterans Affairs a dozen times this year to ask questions. Tony Van Sickle has been very helpful to me and other vets who have called for help from the office.

I am telling you from my heart, that it would be a travesty to drop the program now, when the way to keep it going will only take your approval to change a state statute for funding.

I personally believe our fight with Iraq is not over. You can be proud of what our Kansas study accomplished it received national attention. Doctors and people from the highest levels of our government have looked closely at our Kansas study, and are trying to figure out ways to help our troops – if they go back to the region.

I commend this body of State Legislators for approving the study to begin with and I ask your help to keep the Kansas Commission on Veterans Affairs office open to help my fellow Gulf War Veterans get help and answers when they need them.

Thank you for your time. May God Bless Kansas and my God Bless America.

Good Afternoon,

My name is Ken Rogers, I am a disabled veteran and a survivor of the Gulf War.

I was here a year ago in support of a Bill that would extend the operation of The Kansas State Veterans Affairs Office for The Persian Gulf War Veterans Health Initiative and the research into the illnesses that has effected so many Kansas veterans, which was so graciously passed by the State of Kansas.

That brings me to why I am here today. It was brought to my attention that the office of The Kansas Persian Gulf War Veterans Health Initiative of the Kansas Commission on Veterans Affairs has not been refunded, and will be closed soon and I am here to ask you why!

The House Bill 2770 that has been introduced by Representative Thimesch is to keep The Kansas State Veterans Affairs Office for The Persian Gulf War Veterans Health Initiative open and the research and the support for Kansas Gulf War veterans to continue, and to let us veterans know that the State of Kansas is not going to turn their backs on us in a time when most of us need your support more than ever.

This state has become a beacon to all of the other states who are very supportive of their own states veterans, and are even now trying to do what this state has already accomplished in the fact finding research that has put Washington, D.C. on notice to get to the bottom of this before one of the state governments does it for them.

The research that has been accomplished so far here in Kansas has really put the federal government on notice that if the government won't help the Gulf War veterans then the State of Kansas will. I am here to ask you to help me and my fellow brothers and sister who are suffering from a lot of unknown illnesses to back this House Bill 2770 and to keep moving forward in finding answers to what has afflicted so many Kansas veterans by keeping this program alive and active until there is not one more veteran asking for help.

I suffer from a lot of ailments, and I deal with them to the best of my ability. It would be great to wake up one morning and feel no more pain, and to be able to tell all of the veterans who contact me that my state has helped me deal with my illnesses and has found out how to treat it and maybe one day cure my illnesses.

If you don't help support us now, then this state will be shelling out a lot more on our health care in the years to come. So why not keep this project alive and even build on it and seek funding to do more research into the causes of our illnesses on a more broader scale than the Federal Government wants anyone to do.

Thank You for your time, and please help us!