SB 354

Department of Legislative Services

Maryland General Assembly
2017 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 354 (Senator Guzzone, *et al.*)
Judicial Proceedings

Richard E. Israel and Roger "Pip" Moyer End-of-Life Option Act

This bill creates a process by which an individual may request and receive aid in dying from the individual's attending physician. The bill exempts, from civil or criminal liability, State-licensed physicians who, in compliance with specified safeguards, dispense or prescribe a lethal dose of medication following a request made by a qualified individual. The bill includes criminal penalties for violating specified provisions of the bill.

Fiscal Summary

State Effect: General fund expenditures increase by $176,300 in FY 2018 to establish an electronic data collection system and hire a research statistician to develop and administer the data collection program. Future year expenditures reflect the elimination of one-time-only costs, ongoing contractual services, and annualization. The Medicaid program may realize savings to the extent a qualified individual dies sooner than would otherwise occur; any such impact cannot be reliably estimated, is likely minimal, and is not reflected below. The bill's penalty provisions are not expected to materially affect State finances or operations.

(in dollars)	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Revenues	$0	$0	$0	$0	$0
GF Expenditure	176,300	84,400	87,700	91,200	95,000
Net Effect	($176,300)	($84,400)	($87,700)	($91,200)	($95,000)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: The bill's penalty provisions are not expected to materially affect local government operations or finances.

Small Business Effect: None.

Analysis

Bill Summary:

Request for Aid in Dying

The bill allows an attending physician licensed to practice medicine in the State who follows specified procedural safeguards to prescribe self-administered medication to a qualified individual to bring about the individual's death. The bill defines the medical practice of prescribing such medication as "aid in dying." A "qualified individual" is defined by the bill as an adult who (1) has the capacity to make medical decisions; (2) is a resident of the State; (3) has a terminal illness with a prognosis of death within six months; and (4) has the ability to self-administer medications.

An individual may request aid in dying by making an initial oral request for such aid to the individual's attending physician. After the initial oral request, the individual is required to make a written request on a form substantially similar to the one specified in the bill. The request must be signed and dated by the individual and two witnesses. The bill includes restrictions on who may be a witness. The attending physician may not be a witness, and only one witness may be a relative or a person entitled to any benefit on the individual's death. The individual must wait at least 15 days after the initial oral request and at least 48 hours after the written request before making a second oral request to the attending physician for aid in dying.

The physician's participation in the process is voluntary. If the physician does not want to participate, the physician must, on request, transfer a copy of the individual's records to another attending physician.

Determination of Qualifications, Including Required Consultation/Assessment

Upon receiving an individual's written request for aid in dying, the attending physician must determine whether the individual (1) is a qualified individual; (2) has made an informed decision; and (3) has voluntarily requested aid in dying. For the purpose of establishing residency in the State, a physician must accept as proof (1) a valid Maryland driver's license or identification card; (2) registration to vote in the State; (3) evidence of owning or leasing property in the State; (4) a copy of a Maryland resident tax return for the most recent tax year; or (5) based on the individual's treatment history and medical records, the attending physician's personal knowledge of the individual's residency in the State. An attending physician must ensure that an individual makes an informed decision by

informing the individual of the individual's medical diagnosis, the individual's prognosis, the potential risks associated with self-administering the medication to be prescribed for aid in dying, the probable result of self-administering the medication, and any feasible alternatives and health care treatment options, including palliative care and hospice.

The attending physician must refer an individual who has requested aid in dying to a consulting physician who is qualified by specialty or experience to confirm a diagnosis and prognosis regarding an individual's terminal illness. The consulting physician must then (1) examine the individual and relevant medical records; (2) confirm the diagnosis that the individual has a terminal illness; (3) refer the individual for a mental health professional assessment, if required; (4) verify that the individual is a qualified individual, has made an informed decision, and has voluntarily requested aid in dying; and (5) document in writing that the consulting physician's duties have been fulfilled.

If the attending or consulting physician's medical opinion is that the individual may be suffering from a condition causing impaired judgment or that the individual otherwise does not have the capacity to make medical decisions, the physician must refer the individual to a licensed mental health professional for a mental health professional assessment. The mental health professional must perform a mental health professional assessment, and the individual may not receive aid in dying until the mental health professional determines and reports, in writing, that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

Required Notifications/Dispensing Medication

Following the second oral request for aid in dying, the attending physician must inform the individual regarding specified matters relating to the individual's decision, including the individual's ability to rescind the decision at any time. The physician must counsel the individual regarding the self-administration of medication prescribed for aid in dying and must confirm that the individual's request is not based on the coercion or undue influence of another person. The physician must also discuss, alone with the individual (except for an interpreter as necessary), whether the individual is feeling coerced or unduly influenced.

The physician must fulfill all specified documentation requirements and verify that the individual is making an informed decision before the physician may write the prescription for the medication. The physician may dispense the medication for aid in dying, as well as any ancillary medications needed to minimize the individual's discomfort, to the qualified individual if the physician holds a dispensing permit. If the physician does not hold a dispensing permit or does not wish to dispense the medication, the qualified individual may request and provide written consent for the prescription to be dispensed by a pharmacist. The physician must then contact a pharmacist who may fill the prescription. The bill specifies that a pharmacist who has been contacted and to whom an attending

physician has submitted a prescription for medication for aid in dying may dispense the medication and any ancillary medication only to the qualified individual, the attending physician, or an expressly identified agent of the qualified individual.

Required Documentation/Prohibition Against Discovery

The attending physician must ensure that the medical record of a qualified individual contains (1) the basis for determining that the qualified individual is an adult and a resident of the State; (2) all oral and written requests by the qualified individual for medication for aid in dying; (3) the attending physician's diagnosis of terminal illness and prognosis as well as a determination that the qualified individual has the capacity to make medical decisions; (4) documentation that the consulting physician has fulfilled the consulting physician's duties; (5) a report of the outcome of and determinations made during the mental health professional assessment, if applicable; (6) documentation of the attending physician's offer to rescind the qualified individual's request for medication at the time the attending physician wrote the prescription; and (7) a statement by the attending physician that all requirements for aid in dying have been met and specifying the steps taken to carry out the qualified individual's request for aid in dying, including the medication prescribed. The attending physician must submit to the Department of Health and Mental Hygiene (DHMH) any information required by regulation.

Upon death, the attending physician may sign the death certificate. A person that, after the qualified individual's death, remains in possession of medication prescribed for aid in dying must dispose of the medication in a lawful manner.

All records or information collected or maintained as part of the aid in dying process are not subject to subpoena or discovery and may not be introduced into evidence in any judicial or administrative proceeding, with limited specified exceptions. Notwithstanding such limitations, DHMH must adopt regulations to facilitate the collection of information from physicians regarding a qualified individual's request for aid in dying. DHMH must produce an annual statistical report of information collected from physicians and make that report available to the public.

Legal Effect of Aid in Dying

The bill shields persons who act in accordance with the provisions of the bill, and in good faith, from civil and criminal liability and professional disciplinary actions. A professional organization or association, a health care provider, or a health occupations board may not subject a person to discipline, suspension, loss of license, loss of privileges, loss of membership, or any other penalty for participating or refusing to participate in good-faith compliance with the provisions of the bill. The bill does not, however, limit liability for

civil damages resulting from any negligent conduct or intentional misconduct by any person.

An individual's request for aid in dying or an attending physician's prescription of medication made in good faith does not constitute neglect or provide the sole basis for the appointment of a guardian or conservator.

For all legal, recordkeeping, and other purposes, a qualified individual's cause of death under the bill is natural and specifically as a result of the underlying terminal illness. For contractual purposes, any provision that deems the cause of death as anything other than the terminal illness is void. A provision in an insurance policy, annuity, contract, or any other agreement issued or made on or after October 1, 2017, is not valid to the extent that it would attach consequences to or otherwise restrict an individual's decision regarding aid in dying. Likewise, an obligation under an *existing* contract (including an insurance policy, contract, or annuity contract) may not be conditioned on or affected by the making or rescinding of a request for aid in dying. A qualified individual's act of self-administering medication for aid in dying may not have an effect under a life insurance policy, a health insurance policy, or an annuity contract that differs from the effect under the policy or contract of the qualified individual's death from natural causes.

Policies Regarding Aid in Dying

A health care provider (including a health care facility) may adopt written policies prohibiting participation in aid in dying. If the provider distributes the policy and finds that a physician participates in violation of the policy, the provider may take specified employment actions. Even so, any written prohibition does not prohibit a health care provider from participating in aid in dying while acting outside the course and scope of employment, or prohibit an individual from privately contracting with the individual's attending physician or consulting physician for aid in dying purposes.

Conversely, a health care facility may not require a physician on staff to participate in aid in dying.

Penalty Provisions

Actions in accordance with the bill do not constitute suicide, assisted suicide, mercy killing, or homicide, and the bill specifically does not authorize a licensed physician or other person to end an individual's life by lethal injection, mercy killing, or active euthanasia.

An individual who willfully alters or forges a request for aid in dying, conceals or destroys another's rescission of a request without authorization, or coerces or exerts undue influence on an individual to make a written request for the purpose of ending the individual's life

can be charged with a felony and is subject to a maximum penalty of 10 years in prison, a $10,000 fine, or both. The penalties provided in the bill do not preclude the application of other criminal penalties.

Current Law/Background: In 1999, Maryland became the thirty-eighth state to outlaw physician-assisted suicide with the signing of Chapter 700. The law establishes that any individual who knowingly assists another person's suicide or suicide attempt is guilty of a felony and subject to a fine of up to $10,000, imprisonment for up to one year, or both. The law was passed as part of a national response to Dr. Jack Kevorkian, who assisted in the suicide of a Michigan man suffering from amyotrophic lateral sclerosis.

Refusal of Medical Treatment

A competent adult's right to legally refuse medical treatment stems from the common law principle of bodily integrity. In *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990), the U.S. Supreme Court outlined the corollary notion that an individual generally possesses the right not to consent to and to refuse medical treatment. For purposes of the Court's analysis, it assumed that a competent individual's right to refuse treatment also stemmed from the Fourteenth Amendment's Due Process Clause, and the court held it constitutional for a state to require a standard to determine competence. State standards vary, based in the common law, the Fourteenth Amendment right to privacy, or both.

Maryland courts have approached the issue through the common law. In *Stouffer v. Reid*, 413 Md. 491 (2010), the Court of Appeals acknowledged the common law right of a competent adult to refuse medical care under the doctrine of informed consent. The court noted, however, that the right is not absolute and must be balanced against four countervailing State interests: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession.

While the right of a competent adult to refuse medical treatment is well established, issues regarding medical care arise when an individual is deemed incompetent. Maryland codified procedures for medical decision-making for an incompetent individual in the Health Care Decision Act passed in 1993 (Health-General Article, Title 5, Subtitle 6). The Act allows an adult who has decision-making capacity to deal with future health care issues through written instructions, a written appointment of an agent, or an oral statement to a physician or nurse practitioner. The advance directive outlines the individual's instructions regarding the provision of health care or withholding or withdrawing health care. The individual may name an agent to make health care decisions under circumstances stated in the directive, and the Act outlines the authority of surrogate decision makers based on their relationships with the individual. The directive becomes effective when two physicians have certified in writing that the patient is incapable of making an informed decision.

The Act specifically establishes that withdrawing or withholding health care that results in the individual's death is not assisted suicide and that there is no criminal or civil liability for those who act in good faith under the Act. However, if a party destroys or falsifies another's advance directive revocation or falsifies an advance directive or affidavit with the intent to cause actions contrary to the patient's wishes, that party is guilty of a misdemeanor and faces a maximum penalty of one year in jail and/or a $10,000 fine. The party is also susceptible to other criminal charges.

Assisted Suicide

The U.S. Supreme Court has drawn a legal distinction between withdrawing life support and assisted suicide based on causation and intent. In *Gonzales v. Oregon*, 546 U.S. 243 (2006), the court found that a state law prohibiting assisted suicide did not violate the Due Process Clause or the Equal Protection Clause of the U.S. Constitution, emphasizing the court's deference to the states in formulating policy regarding assisted suicide.

A majority of states have specific laws prohibiting assisted suicide. Most laws are codified, some are based in the common law, and others have no specific law, or the law is otherwise unclear. In Maryland, as outlined above, assisted suicide is a felony and carries a maximum penalty of one year incarceration and/or a $10,000 fine. California, Colorado, Oregon, Washington, and Vermont have carved out exceptions to the assisted suicide prohibition. All five states have established laws outlining particular circumstances and procedures for terminally ill, competent adults to receive life-ending, self-administered medication from a physician. However, these states have made explicitly clear that aid in dying laws do not permit mercy killing or euthanasia.

Aid in Dying in Other States

Currently, five states, California, Colorado, Oregon, Vermont, and Washington, have laws that allow a doctor to write lethal prescriptions for dying patients to self-administer. Such laws are referred to as "end-of-life option" laws, "death with dignity" laws, "aid in dying" laws, and "patient choice and control at end-of-life" laws. Montana permits the practice based on a decision by the state Supreme Court. Four states, Nevada, North Carolina, Utah, and Wyoming, have no specific bans or case law prohibiting the practice, but its legality remains unclear. The remaining 40 states prohibit the practice through statute or case law.

In December 2016, the District of Columbia passed a bill authorizing the practice, but the bill has yet to take effect and may be overridden by the U.S. Congress under the District of Columbia Home Rule Act, which authorizes the U.S. Congress to review all legislation passed by the DC Council before it may become law.

Oregon was the first state to legalize physician aid in dying when its "Death with Dignity Act" was adopted through ballot measure in 1994. The Act exempts from civil or criminal liability state-licensed physicians who, in compliance with specific safeguards, dispense or prescribe a lethal dose of drugs upon a terminally ill patient's request. In response to the Oregon action, in 2001, the U.S. Attorney General issued an interpretive rule addressing the implementation and enforcement of the Controlled Substance Act with respect to the Act. The rule determined that using controlled substances to assist suicide is not a legitimate medical practice and, as a result, dispensing or prescribing them for that purpose was illegal under federal law. The U.S. Supreme Court rejected the Attorney General's rule, again showing deference to the states.

The Oregon Health Authority tracks that state's Death with Dignity Act and publishes an annual report. In its February 2016 report, the most recent report available, the Oregon Health Authority advises that, since the law's passage, 1,545 prescriptions have been written, and 991 patients have died. In calendar 2015, 218 prescriptions were written, and 132 deaths occurred as a result. The median age at death was 73, and 78% of those who died were age 65 or older. No patient that ingested the medication has ever regained consciousness.

In 2008, Washington voters adopted an initiative mirroring the Oregon Death with Dignity Act by a vote of 58% to 42%. The standards and procedures are very similar to those in Oregon. The state also tracks statistics in an annual report. In calendar 2015, medicine was dispensed to 213 individuals; 202 are known to have died with an age range of 20 to 97. Of those individuals, 166 died after ingestion of medication, and 24 died without the medicine. For the remaining 12 individuals, whether they ingested the medication is unknown.

Vermont became the first state to pass aid in dying legislation, passing a law modeled after the Oregon and Washington laws on May 20, 2013. Certain safeguards, including a waiting period between a patient's requests for medication and requiring physicians to report prescriptions to the state's department of health, were scheduled to terminate July 1, 2016; however, legislation that passed in May 2015 retained these requirements. The 2015 legislation also requires the state's department of health to generate a public report about utilization and compliance with the law every two years, starting in 2018. According to media reports, as of December 18, 2016, physicians in Vermont had written 38 prescriptions for terminally ill patients.

In 2009, the Montana Supreme Court was asked to determine whether the consent defense to homicide could be applied to a doctor who prescribed medication to a mentally competent, terminally ill patient for the patient to self-administer to end the patient's life. In weighing the factors that would prevent a consent defense, the court determined that there was "no indication in Montana law that physician aid in dying provided to terminally

ill, mentally competent adult patients is against public policy." While Montana has not codified an aid in dying exception, based on the court's ruling, a physician has an affirmative defense to a homicide charge.

In 2015, California passed the End of Life Option Act, also similar to the Oregon Act. The bill was first introduced during the regular session, but it failed to gain support and was withdrawn. The bill was reintroduced during a special legislative session on health care later in the summer, and it passed after a sunset provision requiring lawmakers to vote on renewing the bill in 10 years was added. The first report on the use of the authorization is due to be published by the California Department of Public Health by July 1, 2017.

On November 8, 2016, Colorado voters adopted Proposition 106, the End of Life Options Act, by a vote of 65% to 35%. The standards and procedures are similar to those in other states. The law went into effect on December 16, 2016, and requires the Colorado Department of Public Health and Environment to track the number of people who seek to use the law, and to issue an annual report.

Approximately 19 states are expected to consider aid in dying legislation during their 2017 legislative sessions, including Delaware, New Jersey, New York, and Ohio.

Internationally, assisted suicide and euthanasia are legal under certain conditions in five countries. Switzerland has allowed assisted suicide since 1942; the Netherlands enacted a law legalizing euthanasia and assisted suicide by a physician in 2001; Belgium legalized euthanasia in 2002; Luxembourg adopted a law regulating euthanasia and assisted suicide in 2009; and Canada adopted legislation legalizing physician-assisted death in 2016.

2015 and 2016 Maryland Legislation

In 2015, Maryland considered end-of-life option legislation, largely based on the Oregon statute. Senate Bill 676 and House Bill 1021 of 2015 both received a hearing, but no further action was taken. A legislative workgroup was convened after the legislative session to study issues related to the 2015 legislation. Three meetings were scheduled between September and December to allow senators and delegates to (1) receive additional comments regarding Maryland's legislation from interested parties in the State; (2) learn about the implementation and use of similar end-of-life option laws in other states; and (3) discuss the components of end-of-life option legislation and areas of agreement and disagreement. Senate Bill 418 and House Bill 404 of 2016 included several changes that, in part, sought to address concerns raised during the 2015 legislative session and the subsequent workgroup meetings.

Additional Background

Richard E. ("Dick") Israel, one of the individuals for whom the bill is named, was born and raised in Hutchinson, Kansas, and graduated from the University of the South (BA), Washington and Lee University (LLB), and Oxford University (MA). Mr. Israel came to Annapolis in 1975 and joined the staff of the then Maryland Department of Legislative Reference and later served for 25 years as an assistant Attorney General. A resident of Annapolis for 30 years, Mr. Israel was elected to the Annapolis City Council in 2005 where he sat on the Rules and City Government Committee and the Economic Matters Committee and chaired the Finance Committee. Mr. Israel suffered from Parkinson's disease for which there is no cure. Mr. Israel died in July 2015.

Roger "Pip" Moyer, the second individual for whom the bill is named, was born on August 16, 1934, in Annapolis. He was elected to the Annapolis City Council in 1961 and mayor in 1965 and 1969. Mr. Moyer was known as a leader in civil rights and historic preservation. He successfully campaigned for the city's historic district, protected the waterfront from high-rise development, and ushered in boat shows. After serving as mayor, Mr. Moyer worked as a leader in the Annapolis Housing Authority. Mr. Moyer died in January 2015, 20 years after being diagnosed with Parkinson's disease.

State Expenditures: DHMH indicates that the Vital Statistics Administration (VSA) will be responsible for implementing the bill's requirements. VSA estimates that it needs one full-time research statistician to develop required regulations, oversee the development and implementation of an electronic data collection system, prepare instructional materials, provide training and technical assistance to physicians, review records, analyze data, and prepare the annual report. The DHMH Office of Information Technology estimates the initial cost of developing and implementing the data collection system at $117,000, with ongoing annual maintenance costs of $10,000.

As a result, DHMH general fund expenditures increase by $176,289 in fiscal 2018, which accounts for the bill's October 1, 2017 effective date. This estimate reflects the cost of contractual services to develop and implement the data collection system and hiring one full-time, grade 15 research statistician. It includes a salary, fringe benefits, contractual services, one-time start-up costs, and ongoing operating expenses. The estimate assumes that the data required to be collected under regulations will include detailed demographic, personal, and medical information.

Position	1
One-time Contractual Services	$117,000
Salary and Fringe Benefits	52,305
One-time Start-up Expenses	4,640
Ongoing Operating Expenses	2,344
Total FY 2018 State Expenditures	**$176,289**

Future year expenditures reflect a full salary with annual increases and employee turnover, ongoing operating expenses, and contractual services to maintain the data collection system.

Additional Information

Prior Introductions: SB 418 of 2016, a similar bill, was heard by the Senate Judicial Proceedings Committee, but later withdrawn. Its cross file, HB 404 of 2016, was jointly assigned to the House Health and Government Operations and the House Judiciary committees. The bill received a hearing, but no further action was taken. SB 676 of 2015, another similar bill, received a hearing in the Senate Judicial Proceedings Committee, but no further action was taken. Its cross file, HB 1021, was jointly assigned to the House Health and Government Operations and the House Judiciary committees. The bill received a hearing, but no further action was taken.

Cross File: HB 370 (Delegate Pendergrass, *et al.*) - Health and Government Operations and Judiciary.

Information Source(s): Judiciary (Administrative Office of the Courts); Department of Health and Mental Hygiene; Maryland Insurance Administration; Oregon Health Authority; Washington State Department of Health; *The Denver Post*; www.sevendaysvt.com; WAMU; Compassion and Choices; Department of Legislative Services

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md/jc

Analysis by: Nathan W. McCurdy

Direct Inquiries to:
(410) 946-5510
(301) 970-5510