

Department of Legislative Services
Maryland General Assembly
2015 Session

FISCAL AND POLICY NOTE

House Bill 1021 (Delegate Pendergrass, *et al.*)
Health and Government Operations and
Judiciary

Richard E. Israel and Roger "Pip" Moyer Death with Dignity Act

This bill creates a process by which a “qualified patient” may request and receive “aid in dying” from the patient’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 qualified patient’s request. The bill also includes criminal penalties for violating the provisions of the bill.

Fiscal Summary

State Effect: Maryland Insurance Administration special fund revenues increase minimally in FY 2016 due to \$125 rate and form filings fees. Any increase in workload can be handled with existing resources. The Medicaid program may realize savings to the extent a qualified patient dies sooner than would otherwise occur; any such impact cannot be reliably estimated. The bill’s penalty provisions are not expected to materially affect State finances.

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 a physician who follows specified procedural safeguards to prescribe self-administered medication to a “qualified patient” to bring about the patient’s death. The bill defines the medical practice of prescribing such medication as “aid in dying.” A “qualified patient” is defined by the bill as an adult, who is competent, who is a resident of the State, and who has a terminal illness with a prognosis of death within six months. A patient may request aid in dying by making an initial oral request for such aid to the patient’s attending physician. After the initial oral request, the patient 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 patient 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; a person entitled to any benefit on the patient’s death; or an owner, operator, or employee of a health care facility where the patient is receiving treatment or resides. The patient 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 transfer a copy of the patient’s records to another attending physician.

Determination of Qualifications

Upon receiving a patient’s request for aid in dying, the attending physician must determine whether the patient (1) is a qualified patient; (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 patient’s treatment history and medical records, the attending physician’s personal knowledge of the patient’s residency in the State. An attending physician must ensure that a patient makes an informed decision by informing the patient of the patient’s medical diagnosis, the patient’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.

Required Consultation/Evaluation

The attending physician must refer a patient who has requested aid in dying to a consulting physician who is qualified by specialty or experience to confirm a diagnosis and prognosis regarding a patient's terminal illness. The consulting physician must (1) examine the patient and relevant medical records; (2) confirm the diagnosis that the patient has a terminal illness; (3) refer the patient for a competency exam if required; (4) verify that the patient is a qualified patient, 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 patient may be suffering from a condition causing impaired judgment or that the patient is otherwise not competent, that physician must refer the patient to a licensed mental health professional for a competency evaluation. The mental health professional must perform a competency evaluation, and the patient may not receive aid in dying until the mental health professional determines and reports, in writing, that the patient is competent and is not suffering from a condition causing impaired judgment.

Required Notifications/Dispensing Medication

Following the second request for aid in dying, the attending physician must inform the patient regarding specified matters relating to the patient's decision, including the patient's ability to rescind the decision at any time. The physician must also counsel the patient regarding the self-administration of medication prescribed for aid in dying. The physician must fulfill all specified documentation requirements and verify that the patient 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 patient's discomfort, to the patient 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 patient may request and provide written consent for the prescription to be dispensed by a pharmacist. The physician may 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 must dispense the medication and any ancillary medication to the qualified patient, the attending physician, or an expressly identified agent of the qualified patient.

Required Documentation/Prohibition Against Discovery

The attending physician must ensure that the medical record of a qualified patient contains (1) the basis for determining that the qualified patient is an adult and a resident of the State; (2) all oral and written requests by the qualified patient 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 patient is competent; (4) documentation that the consulting physician has fulfilled the physician's duties; (5) a report of the outcome of and determinations made during the competency evaluation, if applicable; (6) documentation of the attending physician's offer to rescind the qualified patient'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 patient's request for aid in dying, including the medication prescribed. Upon death, the attending physician may sign the death certificate. The underlying terminal illness must be listed as the cause of death. An individual who, after the patient'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.

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, or other specified penalties 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 other negligent conduct or intentional misconduct by any person.

A patient'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 purposes, an 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 other agreement is not valid to the extent that it would attach consequences to or otherwise restrict an individual's decision regarding aid in dying. A qualified patient's act of self-administering medication for aid in dying may not have an effect under a life, a health, or an accident insurance or annuity policy that differs from the effect under the policy of the patient's death from natural causes.

Written Policies Regarding Aid in Dying

A health care provider 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.

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 a patient from privately contracting with the patient's attending physician or consulting physician for aid in dying purposes.

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 physician to end a patient'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, or coerces or exerts undue influence on a patient to make a written request for the purpose of ending the patient'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 ALS.

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 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 (the 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 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. Oregon, Washington, and Vermont

have carved out exceptions to the assisted suicide prohibition. All three 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, the states have made explicitly clear that aid in dying laws do not permit mercy killing or euthanasia.

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 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. Since the law’s passage, 1,327 prescriptions have been written and 859 patients have died. In calendar 2014, 155 prescriptions were written and 105 deaths occurred as a result. The median age at death was 72 and 67.5% of those who died were 65 years 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 2013, medicine was dispensed to 173 individuals; 159 are known to have died with an age range of 29 to 95. Of those individuals, 119 died after ingestion of medication and 26 died without the medicine. 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. Vermont’s law, however, drops certain safeguards after July 1, 2016, including no longer requiring a waiting period between a patient’s requests for medication and no longer requiring physicians to report prescriptions to the state’s department of health.

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.

During the 2015 legislative session, at least 16 states, including Maryland, have introduced legislation regarding aid in dying; 8 additional states have expressed interest in legislation.

Internationally, euthanasia and assisted suicide are legal under certain conditions in four Western European 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; and Luxembourg adopted a law regulating euthanasia and assisted suicide in 2009.

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 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 and sat on the Rules and City Government Committee, the Economic Matters Committee, and chaired the Finance Committee. Mr. Israel suffers from Parkinson’s disease for which there is no cure. Mr. Israel moved out of Annapolis in 2013 for treatment and resigned as alderman.

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.

Additional Information

Prior Introductions: None.

Cross File: SB 676 (Senator Young, *et al.*) - Judicial Proceedings.

Information Source(s): Department of Health and Mental Hygiene, Maryland Insurance Administration, Judiciary (Administrative Office of the Courts), Death with Dignity National Center, Department of Legislative Services

Fiscal Note History: First Reader - March 5, 2015
md/ljm

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