HB 1328

Department of Legislative Services

Maryland General Assembly
2025 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1328 (Delegate Hill, *et al.*)
Health and Government Operations and Judiciary

End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass 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. Criminal penalties are established for violating specified provisions of the bill. The bill's provisions are severable.

Fiscal Summary

State Effect: General fund expenditures increase, by as much as $750,000, in FY 2026 for contractual services to create a reporting system to receive and organize information required to be submitted by attending physicians under the bill, as discussed below. Future years reflect ongoing maintenance costs for the reporting system. The bill's penalty provisions are not expected to materially affect State finances or operations.

(in dollars)	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030
Revenues	$0	$0	$0	$0	$0
GF Expenditure	750,000	50,000	50,000	50,000	50,000
Net Effect	($750,000)	($50,000)	($50,000)	($50,000)	($50,000)

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) has a terminal illness; and (3) has the ability to self-administer medication.

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. At least one of the oral requests must be made while the individual is alone with the attending physician.

The physician's participation in the process is voluntary. If the physician cannot or does not want to participate, the physician must, on request, transfer the individual's care and 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. 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 a condition that is causing impaired judgment.

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 request 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. If a pharmacist does not wish to or is unable to dispense the mediation for aid in dying or any ancillary medication, the pharmacist must notify the qualified individual, the attending physician, and any expressly identified agent of the qualified individual that the pharmacist does not wish to or is unable to do so.

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; (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 Maryland Department of Health (MDH) 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, MDH must adopt regulations to facilitate the collection of information from physicians regarding a qualified individual's request for aid in dying. MDH 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 health care provider or a health occupations board may not subject a person to censure, 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 a State or federal insurance policy, annuity, contract, or any other agreement issued or made on or after October 1, 2025, 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 facility may adopt written policies prohibiting participation in aid in dying. If the facility distributes the policy and finds that a physician participates in violation of the policy, the facility 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 taken 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.

A health care provider acting within the scope of their license or certification and in compliance with the bill must be deemed to be acting within the standard of care of the provider's license or certification. The bill does not exempt a health care provider from meeting the medical standards of care for an individual's medical treatment.

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

or to destroy a rescission of a written request can be charged with a felony and is subject to a maximum penalty of 10 years in prison, a $10,000 fine, or both. A sentence imposed may be separate from and consecutive to or concurrent with a sentence for any crime based on the act establishing the violation.

Current Law: 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. Murad Jacob "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 (now the Appellate Court of Maryland) 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, but some are based in the common law. Other states have no specific law, or their law is otherwise unclear. To qualify under death with dignity statutes, one must meet specified requirements, including that the individual is mentally competent.

State Expenditures: Under the bill, the attending physician must submit to MDH any information required by regulation; MDH must adopt regulations to facilitate the collection of information from physicians and produce and make available to the public an annual statistical report on the information collected. MDH advises that it must create a reporting system to receive and organize the information submitted by physicians. While the bill does not specifically require an electronic reporting system to be developed, MDH advises that it would do so. **Given the highly sensitive nature of the information being collected and the security protocols that would need to be developed, MDH estimates costs of $750,000 for contractual services to develop the electronic data system to collect and securely maintain the information from physicians.** Additionally, MDH estimates ongoing system maintenance costs of approximately $50,000 annually beginning in fiscal 2027. This estimate assumes that MDH can produce the annual statistical report using existing budgeted resources.

Additional Comments: Currently, 10 states (California, Colorado, Hawaii, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, and Washington) and the District of Columbia have laws that allow a doctor to write lethal prescriptions for dying patients to self-administer. Such laws are generally 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. As of February 26, 2025, 14 states are considering aid in dying legislation during their current legislative sessions, including Delaware and Maryland.

Maryland has previously considered such legislation. In 2015, the end-of-life option under consideration was 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. Legislation has continued to be introduced, intermittently, since then.

Additional Information

Recent Prior Introductions: Similar legislation has been introduced within the last three years. See SB 443 and HB 403 of 2024 and SB 845 and HB 933 of 2023.

Designated Cross File: SB 926 (Senator Smith) - Judicial Proceedings.

Information Source(s): Office of the Attorney General; Judiciary (Administrative Office of the Courts); Maryland Department of Health; Maryland Insurance Administration; Department of Legislative Services

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