House Legislative Analysis Section

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REFERENDUM ON PHYSICIAN-AIDED SUICIDE

House Bill 5474 (Substitute H-2)
Sponsor: Rep. Ted Wallace
Committee: Judiciary

Senate Bill 200 with House committee amendment
Sponsor: Sen. William Van Regenmorter
Senate Committee: Judiciary
House Committee: Judiciary

First Analysis (2-3-98)

THE APPARENT PROBLEM:

To date, there have been only two Michigan laws enacted with regard to assisted suicide since the June 4, 1990, report of the first of what are estimated to be between 80 and 100 suicides attended by retired Royal Oak pathologist Dr. Jack Kevorkian: Public Act 270 of 1992, which enacted a temporary (21-month) ban on assisted suicide until a commission could study the issue and make legislative recommendations, and Public Act 3 of 1993, which amended the assisted suicide act before it was even enacted. Both the legislation and Dr. Kevorkian's activities have resulted in four circuit court cases that were appealed and that the state supreme court finally ruled on in a memorandum opinion on December 13, 1994, that affirmed the constitutionality of the ban. Meanwhile, at the federal level, challenges to the assisted suicide bans in both Washington and New York states also progressed through the federal court system, and resulted in two decisions issued by the U.S. Supreme Court on June 26, 1997, affirming the constitutionality of state laws banning assisted suicide. (See BACKGROUND INFORMATION.) Since neither the U.S. nor state supreme courts have ruled assisted suicide to be unconstitutional, the question about what to do about the issue continues to remain before the Michigan legislature.

Two approaches to the issue of assisted suicide have dominated the Michigan legislature's response to the news that Dr. Kevorkian had helped Oregon resident Janet Adkins to die in northern Oakland County on June 4, 1990. One approach, which tends to be most strongly advocated by "pro-life" religious groups, is to completely prohibit and criminalize assisted suicide. The other, most often advocated by terminally ill people and "pro-choice" groups, is to regulate the practice, allowing it to exist under certain specified conditions (and, most recently, with the further condition that any legislative regulation be put before the voters of the state at a general election).

The criminalization approach to assisted suicide, in fact, was the first to be put into actual legislation when the 85th legislature reconvened the fall after Dr. Kevorkian assisted Janet Adkins to commit suicide in June 1990. (See BACKGROUND INFORMATION.) Though no legislation was enacted that session, similar legislation was immediately introduced in both the House and Senate at the beginning of the following, 1991-92, legislative session. A controversial compromise was enacted at the very end of the 86th legislature, using House Bill 4501 as the vehicle bill for enacted Public Act 270 of 1992, but incorporating criminal provisions similar to those included in the Senate bill that would have banned assisted suicide entirely. As introduced, House Bill 4501 proposed to establish a commission (the Michigan Commission on Death and Dying) which would have two years to develop and make legislative recommendations concerning "the voluntary self-termination of life." The House Judiciary Committee reported out a version of the bill that made some changes to the composition of the commission and placed the commission -- and responsibility for selecting commission members -- under the Legislative Council. The House Judiciary Committee did not act on the Senate proposal to prohibit and criminalize assisted suicide. However, while House Bill 4501 was before the full House, news came on November 23 that Dr. Jack Kevorkian had assisted in another suicide (that of Catherine Andreyev), and on the following day the House adopted floor amendments to the bill that added criminal provisions similar to those in Senate Bill 32 and that were to expire six months after the Michigan Commission on Death and Dying (which now was given 15 months instead of two years to finish its report) submitted its report to the legislature. The amended bill passed the House on the same day the criminal amendments were added (November 24, 1992), and expeditiously passed the Senate, which suspended its rules to give the bill immediate passage, on December 3, 1992. The bill was presented to, and signed by, the new governor on December 15, 1992, to become Public Act 270 of 1992.

Since the legislature did not, by a two-thirds vote, give Public Act 270 immediate effect, it would have gone into effect 90 days *sine die* (that is, 90 days after the 86th legislature adjourned for the last time), which meant a date of April 1, 1993. However, almost immediately after the 87th legislature convened, Senate Bill 211 was introduced to amend Public Act 270 to revise the exemption for licensed health care professionals who gave medications to relieve pain or discomfort from the crime of "assistance to suicide." The House substitute for the bill, among other things, re-wrote the act's title and added a February 25, 1993 effective date for each of the act's provisions. Senate Bill 211 also was acted upon expeditiously by the Senate once the bill was returned from the House: The Senate concurred in the House substitute and gave it immediate effect, and it was ordered enrolled, all on the new February 25, 1993, effective date. On March 3, the bill was presented to the governor, who signed it, and filed with the secretary of state to become Public Act 3 of 1993. This change in effective date would give rise to confusion about when -- or even whether -- the statutory ban against assisted suicide had lapsed because of the way the sunset of the criminal provisions of the act were contingent on the report of the Michigan Commission on Death and Dying.

The Michigan Commission on Death and Dying held its first meeting on July 30, 1993, and worked for months to develop recommendations against a backdrop of court activity that, among other things, threw the legal status of the commission into question. Though a majority of the commission could not come to an agreement on whether assisted suicide should be permitted or banned, it issued its final report, which reflected this disagreement, on June 8, 1994. (See BACKGROUND INFORMATION.) The commission sent its report to the legislature accompanied by a cover letter, dated June 16, 1994, in which the commission noted the "controversy about the legal status of the Commission and it Report, based on the ruling from the Court of Appeals that the Act [establishing the commission, namely, Public Act 270 of 1992] is unconstitutional, and the announced intention of the Supreme Court [on June 6, 1994] to review that ruling." (House Journal 59, June 21, 1994). The House of Representatives formally received the commission's report June 21, 1994, when the letter was printed in the House journal and the accompanying report was referred to the clerk for the record. The Senate, however, did not formally receive the commission's report.

As noted above, the change in the effective date of Public Act 270 by Public Act 3 of 1993 has resulted in some confusion over when -- or even whether -- the ban on assisted suicide expired, since continuation or expiration of the criminal provisions of the act was made contingent on the final report of the commission to the legislature. Public Act 270 called for the assisted suicide ban and criminal provisions to expire six months after the commission made its recommendations to the legislature under the relevant portion of the act. However, the act called for the commission to issue its report within 15 months after the act's effective date, which, under Public Act 3 of 1993, was February 25, 1993, and which would require the commission report to be issued by May 25, 1994. The commission, however, approved and sent its report after that date, so that the ban on assisting suicide, on one calculation, expired November 25, 1994, six months after the commission was supposed to issue its report. By another calculation, the ban expired December 8, 1994, six months after the commission actually approved its report. Similar, though perhaps weaker, cases could be made for various other expiration dates, as well as for the view that the ban never did expire because the commission never issued its report according to the terms of the act (because the Senate never formally accepted the report). Considerations of the applicable expiration date became a matter of some public concern in late November 1994, when it was reported that Dr. Kevorkian had apparently provided suicide assistance in the early morning hours of November 26 -- a few hours, that is, after his attorneys reportedly considered the ban to have expired on November 25. Since this reportedly was the first time in more than a year that Dr. Kevorkian had provided such assistance, and assuming that the ban on assisting suicide had indeed expired, some people called for reenactment of the ban.

Apart from the question of the date of the expiration of the ban on assisted suicide, however, questions about the constitutionality of the assisted suicide act were raised by three circuit court cases (see BACKGROUND INFORMATION.) that were ruled on by the Court of Appeals on May 10, 1994. The appeals court held Public Act 270 of 1992 to be unconstitutional under the state constitution for violating the constitutional prohibition (in Article 4, Section 24) against legislation having more than one purpose. However, on December 13, 1994, the state supreme court reversed the appeals court ruling, holding instead that the ban was constitutional. The 1994 supreme court ruling -- and the 1997 U.S. Supreme Court ruling -- means that legislation regulating the practice of assisted suicide is constitutional, and legislation has once again been introduced to do this.

More specifically, during the current 89th legislative session, conflicting bills once again have been introduced into both the House and Senate. (See BACKGROUND INFORMATION.) Senate Bill 200, introduced on February 13, 1997, by Senator William VanRegenmorter, would amend the Michigan Penal Code to prohibit assisting suicide and to provide criminal penalties. House Bill 5474, introduced by Representative Ted Wallace on January 14, 1998, would amend the Public Health Code to allow assisted suicide if approved by the voters of the state. The House Judiciary Committee has reported both bills, with an amendment to the Senate bill that also would require it to go before the voters of the state for approval or disapproval.

THE CONTENT OF THE BILLS:

Senate Bill 200 would amend the Michigan Penal Code (MCL 750.329a) to prohibit, and provide penalties for, assisting in a suicide or attempted suicide.

A person would be guilty of criminal assistance to the killing of an individual if the person knew that an individual intended to kill himself or herself and, with the intent to assist the individual in killing himself or herself, did any of the following:

* Provided the means by which the individual attempted or committed suicide.

* Participated in an act by which the individual attempted or committed suicide.

* Helped an individual plan to attempt or commit suicide.

Criminal assistance to the killing of an individual would be a felony, punishable by up to five years imprisonment, a maximum fine of $10,000, or both.

The bill would not apply to withholding or withdrawing medical treatment.

The bill's provisions would be repealed on December 1, 1998, unless the bill was submitted to the voters of this state at the general election held November 3, 1998 and a majority of the voters voted not to repeal the bill's provisions.

House Bill 5474 would amend the Public Health Code (MCL 333.5658 et al.) to add the Terminally Ill Patient's Right to End Unbearable Pain or Suffering Act. This act would set procedures whereby certain terminally ill patients could request and receive from a physician medication to end their lives. The act would not take effect unless submitted to and approved by a majority of the voters of this state at the general election held

November 3, 1998. If approved, the bill would take effect on January 1, 1999.

Legislative intent. The act would include specific statements of legislative intent indicating that by enacting its provisions, the legislature intended to give a competent, terminally ill, adult resident of this state, or a close relative, the right to end unbearable pain or suffering through the self-administration of medication to hasten death; and to provide safeguards and protect the legal rights of those individuals who choose to end their lives in such a fashion. In addition, the act would be intended to allow physicians to prescribe medication to hasten death under its provisions and to provide oversight for physicians who prescribe such medication and provide sanctions for those who violate the act's provisions.

Eligibility. The act would establish eligibility requirements for persons who wanted to receive medication to hasten their deaths. The requirements would include state residency, diagnosis of a terminal illness confirmed by a consulting physician, and a consultation with a psychiatrist.

More specifically, in order to request and receive prescription medication to end one's life a person would have to be a competent adult (18 years old or older) resident of this state who had been diagnosed by his or her attending physician as having a "terminal illness". In addition, patient would have to be "fully informed" and his or her decision to make the request would have to be voluntary.

Terminal Illness. The bill would define a terminal illness as a medically confirmed disease that was incurable and irreversible and that would, within reasonable medical judgment, end the patient's life within six months or less. This diagnosis and prognosis would have to be confirmed by a consulting physician who specialized and was actively practicing in the disease that had caused the patient to become terminal. The consulting physician would also have to be certified by the national professional organization for his or her specialty and be approved by his or her licensing board. Age or disability would not, in and of themselves or in combination, be sufficient to support a patient's request for medication to end his or her life without a terminal illness.

Informed decision. A patient's decision to request medication to end his or her life would have to be preceded by being fully appraised of all of the following, by either the attending or a consulting physician: the diagnosis and prognosis of his or her terminal illness, the potential risks and probable result of taking the medication prescribed to end the patient's life, the alternatives to ending the patient's life, including, but not limited to, comfort care, hospice care, and pain control, and that the patient could rescind his or her decision at any time and in any manner.

As soon as possible after a patient was diagnosed with a terminal illness, the attending physician or the consulting physician would be required to provide the patient with information regarding comfort care, hospice care, and pain management. The physician would have to ask the patient whether he or she had any questions regarding payment for treatment or for comfort care, hospice care, or pain control. If the patient had such questions, he or she would be referred to a professional who could identify possible financial assistance for the patient for answers to such questions.

In addition, if the patient asked, the physician would be required to provide a true copy of the act created by the bill and a copy of a booklet to be produced by the Department of Community Health. The department would be required to create this booklet within 60 days after the effective date of the act. The booklet would be created in consultation with the oversight committee that would be appointed under the act. The booklet would provide information about the availability of medication to end one's life, how to make a request and obtain medication to end one's life under the act, and alternatives, including, but not limited to, comfort care, hospice care, and pain control.

<u>Residency.</u> To qualify as a "resident" eligible to request and receive prescription medication to end one's life, a person would have to have had resided in the state for no less than six months immediately prior to his or her request for medication. Further, the parents, adult siblings, adult children, or a spouse of a resident would also be considered residents under the act even if they did not reside within the state. The act would require that a relative of a resident prove the relationship by presenting an affidavit attesting to the relationship to the attending physician. In such cases, a relative of a resident would be considered a resident of the county where the relative actually resided.

<u>Request for medication to end a patient's unbearable pain and suffering by ending his or her life in a "humane and dignified manner."</u> A request for medication to end a person's life could be made in writing or, if the person were unable to write, orally. The request would have to contain all of the following information:

*The patient's full name and address at the time of the request. If the patient was an inpatient or resident in a health facility, the address would be the patient's last known residential address.

* A statement that the patient believed that he or she was competent.

* A description of the terminal illness from which the patient was suffering.

* A statement that the request was being made voluntarily and without coercion.

* A statement that the patient had been informed by his or her attending physician that the terminal illness will likely end the patient's life within six months.

* A statement that the patient had been informed by the attending or consulting physician of comfort care, hospice care, and pain control.

* A statement that the patient understood that the request could be rescinded at any time and by any method.

An oral request would be required to be recorded on video. A written request would have to be signed, dated, and witnessed by at least two individuals. The witnesses would have to attest that to the best of their knowledge and belief the patient was rational and acted voluntarily. The patient's attending physician would be prohibited from signing as a witness and no more than one of the witnesses could be any of the following: a) related to the patient by blood, marriage, or adoption; b) knowingly entitled at the time of the request to control over a portion of the patient's estate upon the patient's death under a will or trust, or by operation of law; or c) an owner, operator, or employee of a health facility where the patient was a resident or was receiving treatment. If the patient was a patient in a health facility at the time of the request, one of the witnesses would be required to be an individual designated by the health facility, but could not be employed by or under contract to the health facility.

The attending or consulting physician could not prescribe medication to end the patient's life until after at least seven days had passed from the initial request, and the act's requirements, including verification of the patient's illness and mental state, had been met. After these conditions had been met the patient would be required to reiterate his or her request. If the second request were not rescinded, the request would be entered in the patient's medical record by the attending physician, who could then prescribe the medication to end the patient's life.

<u>Responsibilities of physicians and psychiatrists.</u> A physician or psychiatrist would be required to conform his or her conduct to the applicable standard of practice at all times while providing the services, making the determinations, and following the procedures authorized under the act's provisions.

If an attending or consulting physician were unwilling to perform one or more of the duties required under the act, including, but not limited to, providing the patient with a copy of the act and the department's booklet, prescribing the medication, or performing an examination, that physician would be required to inform the patient immediately of that fact and transmit a copy of the patient's relevant medical records to a physician of the patient's choice within 72 hours. The physician that the patient chose would become the patient's attending physician or consulting physician, as appropriate.

Physician licensing requirements. Beginning two years after the effective date of the act, a physician who provided services authorized under the act would have to meet certain requirements when applying for renewal of his or her license. For the first renewal of his or her license two years after the act's effective date, a physician would be required to have taken no less than 20 hours of continuing medical education in the theory and practice of comfort care, hospice care, pain control, sedation coma, removal of nutrition and hydration, psychiatric counseling, and the prescription of medication to end life as authorized by the act. The 20 hours of continuing education would have to be taken regardless of prior training and would be part of the 150 hours of continuing medical education required for physicians to renew their licenses. For every subsequent renewal of a physician's license, the physician would only need to have 4 of the 150 hours of continuing medical education on those issues.

Attending physician. An attending physician would have primary responsibility for care of the patient and treatment of the patient's disease. Before writing a prescription for medication to end a patient's life, the attending physician would be required to ensure that all of the steps set forth in the act had been carried out in accordance with act's provisions. However, if the consulting physician wrote the prescription, he or she would be have the same responsibility as the attending physician.

The attending physician would be required to refer the patient to a consulting physician, to require the patient to consult with a psychiatrist, and, immediately prior to writing the prescription, verify that the patient decision was informed and that he or she was acting voluntarily.

The attending physician would also be required to inform the patient of the following:

* the diagnosis and prognosis of the terminal illness,

* the potential risks and probable result of taking the medication prescribed to end the patient's life,

* the alternatives to ending the patient's life, including,

but not limited to, comfort care, hospice care, pain control, sedation coma, refusal of hydration and nutrition, and withdrawal of life-sustaining treatment, as appropriate, and

* that the patient could rescind his or her decision at any time and in any manner.

Consulting physician. The consulting physician would be required to examine the patient and the relevant medical records. If he or she agreed with the attending physician's diagnosis, the consulting physician would be required to confirm the diagnosis in writing in the patient's medical record. In addition, the consulting physician would be required to verify that the patient was competent, fully informed, and acting voluntarily.

Psychiatrist. The psychiatrist would be required to interview the patient and review the patient's relevant medical records. The psychiatrist would have to determine the following:

* That the patient had no diagnosable mental disorder.

* That the patient's request for medication to end his or her life was not the result of a distortion of the patient's judgment due to clinical depression or another mental illness.

* That the patient's request was reasoned, fully informed, and voluntary, as far as could reasonably be determined.
If so, then the psychiatrist would document the determination in the patient's medical record and issue a written statement of his or her determination to the patient.

Documentation. The attending physician would have final responsibility for making certain that all of the following were documented in writing in the patient's medical record:

* Each of the patient's oral and written requests to die.

*The physicians' offers to the patient to rescind the request.

*The attending physician's diagnosis and prognosis for the patient and the consulting physician's confirmation of that diagnosis and prognosis.

*The attending physician's determinations that the patient was competent, had made an informed decision, and was acting voluntarily in making that decision and the consulting physician's independent verification of those same determinations.

* The consulting physician's independent verification that the patient was informed regarding sedation coma, refusal of hydration and nutrition, and withdrawal of life-sustaining treatment, as appropriate.

*The written statement made by the psychiatrist.

*A note that the attending physician had met all of the act's requirements and indicating the steps that had been taken to carry out the patient's request, including, but not limited to, a notation of the medication prescribed, including the name of the medication, dosage, quantity prescribed and the instructions for use.

Most of this documentation from the patient's medical record would have to be kept by the physician for no less than three years. However, the portion of the patient's medical record containing the information about the medication that had been prescribed would have to be maintained for no less than five years.

Prescription/Medication. Under the act, the dispensing, prescription, or administration of a controlled substance in accordance with the act's provisions would be an exception to the requirement that controlled substances must be issued for a legitimate therapeutic purpose. The prescription for medication to end a patient's life would be written on the same official prescription form as prescriptions for controlled substances. Only a single dose of the medication in a quantity estimated to cause death could be prescribed on a prescription. The directions would only have to specify that the dose would hasten or cause death. The completed prescription form would be given to the patient. The prescription would include a statement noting that the prescription had been issued under the provisions of the act and a label with a prominent cautionary statement indicating that taking the prescribed dose was likely to cause death.

The prescription could be dispensed only to the patient or an agent of the patient with appropriate identification. Before dispensing the medication, a pharmacist would be required to confirm the prescription with the physician. The pharmacist would be required to sign the prescription form, forward it or transmit the information to the department, and retain the form or a copy as required by law. The form or information transferred to the department would not be considered a public record and would not be available for inspection by the public nor would it be subject to disclosure under the Freedom of Information Act.

Challenges. If the patient were still living, an action challenging a patient's decision to end his or her life or a determination that the patient was eligible to end his or her life would have to be brought in the circuit court for the county where the patient resided or was found. Such an action would be assigned to the chief judge of that circuit. Only people who were related to the patient could challenge the patient's decision or the determinations of eligibility under the act. People who could bring a challenge would include a patient's spouse, parent, adult sibling, adult child, or significant other (a person with whom the patient had a monogamous relationship for no less than one year).

As soon as practicable after the action had been filed, the circuit court would be required to issue a temporary restraining order prohibiting the prescription or dispensing, or both, of the requested medication or requiring the confiscation of that medicine. Such an order would not affect a patient's ability to obtain determinations from a physician or a psychiatrist with regard to the patient's fitness to end his or her life under the provisions of the act.

The court would be required to hold an expedited hearing within five days after the action was filed. The hearing would have to conclude within two days after its commencement and the court would have to render a decision within five days after hearing was completed. If the court failed to comply with the time schedule, either party could seek an emergency hearing in the court of appeals for a superintending control order to compel the circuit court's compliance.

The determinations of an attending physician and confirmation of those determinations by a consulting physician, along with a written statement from a psychiatrist, would create a rebuttable presumption that the determination was correct for the purposes of a legal proceeding involving the procedures set forth in the act.

Oversight committee. The governor would be required to appoint an oversight committee that would consist of 14 physicians and 3 members of the general public to review the operation of the procedures created by the act. The appointments would have to made no later than 90 days after the act's effective date. However, the failure of the governor to appoint committee members would not alter the effective date of the act.

The members of the committee would include the following:

* eight members, two from each state medical and osteopathic school, who would be chosen from nominees submitted by the highest executive officer of each school who was not opposed to complying with the act.

* six members, three from the Michigan State Medical Society and three from the Michigan Osteopathic Association Society, who would be chosen from nominees submitted by the highest executive officer of

each organization who is not opposed to complying with this act.

* three members from the general public.

Nominees could not be opposed to complying with the act. Those nominees who were not from the general public would be required to have practiced in their respective specialties for no less than ten years. At least one nominee from each medical school and professional organization would have to be a specialist in oncology.

Initial appointments would be staggered for terms of up to four years and members would be compensated for expenses arising from the performance of their official duties. Nine members of the committee would constitute a quorum for conducting business and the committee would become operative as soon as nine members were appointed. The director of the Department of Community Health would serve as the committee's executive secretary and be required to provide all the necessary administrative support to the committee members.

Committee responsibility. The committee would be required to meet at least twice a year. During the course of the year, the committee would review medical records from a random sample of no less than 25 percent of all deaths that occurred under the provisions of the act. The committee would review these records to determine the physicians' and psychiatrists' compliance with the provisions of the act and the applicable standards of practice. The random sample would be based upon the prescription copies or information sent to the department. Each case in the sample would have to be reviewed by at least two members of the committee. The members would then report their findings to the entire committee for consideration and decision.

If 25 percent of the members of the committee that voted on a particular case agreed that a physician had not complied with the act's requirements or with the applicable standard of practice, or both, the committee would be required to review additional medical records from that physician of other patients, if any, who died through the prescription of medication under the act.

The committee would have to agree upon procedures for review of records and materials and decision making that would incorporate appropriate protections. If the committee concluded that a health professional or facility had willfully failed to comply with, or recklessly disregarded, the requirements of the act, then the committee would prepare a report to that effect and submit it to the prosecuting attorney for the county where the professional practiced or where the facility was located.

If the committee determined that a physician might have negligently failed to comply with the applicable standards of practice in providing the procedures authorized under the act, the committee would be required to notify the physician in writing of its determination and provide the physician an opportunity for a hearing. The hearing would be conducted in the same fashion as a contested case hearing under the Administrative Procedures Act. The committee decision would be made by majority vote, after notice and an opportunity for a hearing. If the majority of the committee concluded that the physician negligently failed to comply with one or more of the applicable standards of practice, it could issue an order limiting or terminating the physician's ability to prescribe medication as authorized under the act. The physician could appeal the committee's decision by filing an appeal with the circuit court of the county where the physician has his or her primary place of practice.

The committee would also be required to create an annual report of the effect and operation of the act, including a statistical summary, without individual identifiers of the patients or physicians involved that would be made publicly available. The committee would also have to make available to the public any special statistical reports on the operation of act, without individual identifiers of the physicians or patients involved, that were created at the request of and submitted to the governor or legislature or were considered necessary to the committee.

The department would have the authority to use subpoenas to require attendance and testimony of witnesses and the production of evidence, including medical records and other clinical material, to assist the committee with its review and investigative functions. Witnesses for the committee would be paid the same fees and mileage as are paid to circuit court witnesses. Wilful failure to comply with a subpoena issued by the department would be subject to a fine of not more than $2,000 for each violation or each day that the violation continues. Failure or refusal to obey a subpoena could be taken before the circuit court for the thirtieth judicial circuit on application by the department director. The court could issue an order requiring the person to appear and produce evidence or give testimony as may be required for the committee. Failure to obey the order of the court could be punished as contempt.

The physicians, psychiatrists, pharmacists, or health facilities that participated in the procedures authorized under the act would be required to make patient medical records and any other clinical material available to the committee. At the department's request, the party with the records or materials would have 30 days or less to provide those records or materials. If the materials were not provided in a timely fashion, the department could compel delivery of the requested documents. The physician-patient privilege or any other health professional-patient privilege would not apply to the requested materials or to the department acting within the scope of its authority.

Patient medical records and other materials reviewed by the committee would be confidential. The records and materials would not be public records nor would they be open to inspection and would not be subject to disclosure under the Freedom of Information Act. The documents would have to be kept in a secure area, and transmitted to the committee members for review in a secure manner. The documents would be returned to the health professional or facility that had provided them as soon as the committee had no further need of them.

Legal effect. The death of a patient from use of properly prescribed medication to end his or her life in accordance with the act would be treated for legal purposes as having been caused by the patient's terminal illness. Such a death would not be considered a suicide or intentional death for the purpose of voiding an insurance policy on the patient's life.

Any written or oral provisions in a contract, will, or other agreement that attempted to affect whether an individual could make or rescind a request to end his or her life would be invalid. Further, any obligation owed under a currently existing contract could not be conditioned or affected by making or rescinding a request to die under the bill. In addition, making or rescinding a request under the act could not be used as a condition or to affect the sale, procurement, coverage, benefits, or issuance of a life, health, accident, or annuity policy or the rate charged for such a policy or certificate.

Prohibitions. The act would establish several crimes for either failing to follow the procedures set forth in the act or acting in a manner prohibited under the act.

Felonies. The act would make it a felony to willfully alter or forge a patient's request for medication under the act or to conceal or destroy a patient's rescission of that request with the intent or effect of causing the patient's death. It would also be a felony to coerce or exert undue influence on a patient to make a request to end his or her life or to destroy a rescission of such a request. These felonies would be punishable by imprisonment for any term of years up to life.

A physician who willfully, or with reckless disregard, failed to comply with the requirements of the act and at the request of one of his or her patients provided medication or other instrumentality for self-administration intended to cause or hasten death to that patient would be guilty of a felony punishable by imprisonment for no more than five years or a fine of not more that $50,000, or both.

The bill would specifically state that regardless of whether or not the purpose was to relieve pain and suffering, a nonphysician or unlicensed physician who administered, delivered or caused the administration or delivery of any medications, chemicals, or any other instrumentality, or apparatus for their delivery or use, to an individual for use in a manner that is substantially likely to cause or hasten death, would be guilty of a felony punishable by imprisonment for life or any term of years. However, once medication has been prescribed in accordance with the act, this felony would not apply to someone who, at the request of the patient, either filled or delivered the prescription, or supported, cradled, or made the patient comfortable while the patient administered the prescribed medication.

Misdemeanors. Filing a false affidavit of relation to a resident would be a misdemeanor punishable by imprisonment for not more than 90 days or a fine of not more than $10,000, or both.

A physician who refused to comply with the provision for retaining records for three years or who refused to transfer a patient who requested it would be guilty of a misdemeanor punishable by imprisonment for not more than 90 days or a fine of not more than $10,000, or both.

A pharmacist who failed to forward the prescription information or copy of the prescription as required under the act would be guilty of a misdemeanor punishable by a fine of not more than $1,000.

Miscellaneous. The act would not limit further liability for civil damages resulting from other negligent conduct or intentional misconduct, and the penalties imposed under the act would not preclude any criminal penalties applicable under other statutes, including criminal attempts.

Neither participation nor refusal to participate with a request to die in good faith compliance with the act's provisions would subject a person to civil or criminal liability or administrative disciplinary action. Nor could participation nor refusal to participate be used to subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty by a professional organization or association, a health facility, or other health care provider. However, a health facility could prohibit its staff from performing the procedures authorized by the act and could impose sanctions provided that the facility:

* Provided reasonable notice of the prohibition to its staff and the public, and that the prohibition applied only to the performance of procedures authorized under the act within the facility.

* If requested by a patient, within 48 hours provided for the transfer of the patient and his or her relevant medical records to a health facility that would allow the procedures authorized under the act.

A request for or provision of medication in good faith compliance with the act's provisions could not constitute negligence for any purpose of law and could not provide the sole basis for an appointment of a guardian or conservator.

If any portion of the act or the application of the act to a particular individual were found invalid by a court, that invalidity would not affect the remaining portions of the act that were not determined to be inoperable.

Repealer. The bill also would repeal Public Act 270 of 1992, which established the Commission on Death and Dying.

BACKGROUND INFORMATION:

Assisted suicide in the United States. According to the National Conference of State Legislatures, as of December 31, 1997, only one state, Oregon, permits assisted suicide, and this law was enacted through a voter-approved ballot initiative (Measure 16) in 1994. Thirty-five states have statutes that explicitly criminalize assisted suicide, nine states (including Michigan, under a 1994 state supreme court ruling) criminalize assisted suicide through common law, and three states have abolished the common law of crimes and do not have statutes criminalizing assisted suicide. In addition, in October 1996 the Ohio state supreme court ruled that assisted suicide is not a crime, while Virginia has a statute that imposes civil sanctions on persons assisting in a suicide, though there is not statute criminalizing the act and there is no clear case law on the issue.

In Oregon, the voter-approved Death With Dignity law has been challenged in court and through a legislative ballot initiative, but to date these challenges have been unsuccessful. Before Measure 16 could take effect, a federal district court in Eugene, Oregon, issued an injunction staying implementation of the law, but on March 3, 1997, the 9th Circuit Court upheld the Death With Dignity law. The measure was appealed to the U.S. Supreme Court (which issued a decision upholding the constitutionality of state laws banning assisted suicide in June 1997), but the court refused to hear the case, clearing the way for the Oregon law to take effect. The Oregon legislature also passed a law during the 1997 legislative session that repealed Measure 16 and put this repeal on the ballot (as Measure 51) for the November 4, 1997, general election. However, the proposed legislative repeal was rejected by the voters by a margin even greater than the initial measure allowing assisted suicide in 1994.

U.S. Supreme Court rulings on state bans. Two constitutional challenges, based on the Equal Protection and Due Process clauses of the 14th Amendment to the U.S. Constitution, were brought in New York state (*Vacco* v *Quill*) and Washington state (*Washington* v *Glucksberg*). Both the 2nd and 9th Circuit Courts ruled, respectively, that the state statutes banning assisted suicide were unconstitutional, but on June 26, 1997, the U.S. Supreme Court reversed these rulings, holding instead that state laws banning assisted suicide were constitutional. Thus, as the National Conference of State Legislatures' paper on physician-assisted suicide notes: *"As a result of these rulings, each individual state will have to address this issue in its legislature."*

Michigan legislation. Michigan legislation on "end-of-life" issues has encompassed a number of related topics, including durable power of attorney for health care (finally enacted in 1990, though first introduced in 1983), "living wills" or medical self-determination, refusing medical care, "do-not-resuscitate" orders (with legislation enacted in 1996, though first introduced in 1991), and proposals to, variously, prohibit assisted suicide (introduced from 1991 through the present), allow it (again, introduced from 1991 through the present), study it (Public Act 270 of 1992), and to forestall it through better pain management (a package of five laws enacted in 1994, and another package of pain management bills introduced in the current legislative session).

Report of the Michigan Commission on Death and Dying. The Michigan Commission on Death and Dying, which was created by Public Act 270 of 1992, issued its final report on June 8, 1994, two days after the state supreme court agreed to hear the two state appeals court rulings on four circuit court cases. The commission's final report consisted of a consensus report and three minority "position reports," none of which received approval from a majority of commission members.

The consensus report stated that "some permanent policy regarding assisted suicide should be enacted by the Legislature. The commission views the current situation, whereby the ban on assisting suicide is scheduled to sunset six months after this report is issued, as untenable." Consensus also was reached on recommendations for public education about advance health care directives ("living wills") and the right to treatment for pain and other distressing symptoms, and for legislative action to augment suicide prevention initiatives, to ensure that people inquiring about suicide be referred to experts who could help to alleviate suffering, to improve access to palliative care (care intended to relieve symptoms rather than to cure) and hospice service, and to modify the use of triplicate prescriptions for those with a terminal illness or severe pain. (Legislation in the form of Public Acts 232 through 236 of 1994 subsequently was enacted to address concerns regarding pain management and hospice care, and a further set of pain management bills, House Bills 4681 to 4686, has been introduced this session.)

The three minority "position reports", upon which the commission could not reach consensus, recommended, respectively, (1) decriminalization and regulation of "aid-in-dying" through the adoption of a model statute (supported by member-representatives of the American Civil Liberties Union, the Health Care Association of Michigan, Hemlock Society of Michigan, the Michigan Nurses Association, the Michigan Psychological Association, the Michigan Senior Advocates Council, the Michigan Division of the National Association of Social Workers, and the State Bar of Michigan), (2) the adoption of procedural safeguards if legalization were to occur (supported by the Health Care Association of Michigan, a 75-member anti-suicide group called the Michigan Association of Suicidology, the Michigan Council for Independent Living, the Michigan Head Injury Survivor's Council, the Michigan Hospice Organization, the Michigan Nurses Association, the Michigan Senior Advocates Council, and the Michigan Division of the National Association of Social Workers), and (3) making the ban on assisted suicide permanent (supported by Right to Life of Michigan, the Michigan Association of Suicidology, the Michigan Council for Independent Living, the Michigan Head Injury Survivor's Council, and the Prosecuting Attorneys Association of Michigan).

<u>Michigan court cases on assisted suicide</u>. On May 10, 1994, the Michigan Court of Appeals (Justices E. Thomas Fitzgerald, Clifford W. Taylor, and Donald E. Shelton) issued two opinions on four circuit court cases: the "declaratory judgment action" (*Hobbins* v *Attorney General*, case no. 93-306-178-CZ), the "Wayne County assisted suicide case" (*People* v *Kevorkian*, case no. 93-11482), the "Oakland County assisted suicide case" (*People* v *Kevorkian*, case nos. 93-129832-FH, 94-130248-FH), and the "Oakland County murder case" (*People* v *Kevorkian*, case no. 92-115190-FC).

In *Hobbins* v *Attorney General*, Wayne County Circuit Judge Cynthia D. Stevens found Public Act 270 of 1992 to be unconstitutional because it violated Article 4, Section 24 of the state constitution. Judge Stevens ruled that the act did not have a single object and that there was a change in its passage through the legislature. She also found a 14th Amendment due process right to commit suicide.

In a Wayne County assisted suicide case that involved the suicide of Donald O'Keefe, Wayne County Circuit Judge Richard C. Kaufman rejected Article 4, Section 24 challenges to Public Act 270, but found a 14th Amendment due process interest in the decision to end one's life and that the state law impermissibly burdened that interest.

In an Oakland County assisted suicide case involving the suicides of Merian Frederick and Ali Khalili, Oakland Circuit Judge Jessica Cooper discussed the potential privacy and liberty interests in ending one's life, and concluded that a person did have a right to commit suicide. Judge Cooper also found Public Act 270 unconstitutional because it violated Article 4, Section 24 of the state constitution.

Finally, in the Oakland County open murder case, in which an Oakland County grand jury indicted Dr. Kevorkian on two counts of murder (for assisting in the suicides of Sherry Miller and Marjorie Wantz on October 21, 1991, the suicides that came to light the day before the House of Representatives added floor amendments to House Bill 4501 temporarily banning and criminalizing assisted suicide), Oakland County Circuit Judge Donald F. Breck dismissed both counts of open murder on the ground that physician-assisted suicide was not a crime in Michigan.

The appeals court issued two decisions: in consolidated appeals of the first three cases, the court ruled, in divided opinions, that Public Act 270 of 1992 was invalid because it violated Article 4, Section 24 of the state constitution which states: "*No law shall embrace more than one object, which shall be expressed in its title. No bill shall be altered or amended on its passage through either house so as to change its original purpose as determined by its total content and not alone by its title.*" In the open murder case, it found that Dr. Kevorkian could be charged with murder under common law for assisting suicide.

However, on June 6, 1994, the state supreme court granted leave to appeal in all four lower court cases, and on December 13, 1994, ruled, in part, that the assisted suicide provisions of Public Act 270 were validly enacted and did not violate the Title-Object clause of the state constitution. The court further ruled that the Due Process clause of the U.S. Constitution did not encompass a fundamental right to commit suicide, with or without assistance, regardless of whether the assistant were a physician.

<u>The Merian's Friends' 1998 ballot proposal</u>. On October

22, 1993, Merian Frederick, 72, of Ann Arbor, committed suicide with the assistance of Dr. Kevorkian and in the presence of her minister and her son. Frederick was a widowed homemaker who had Lou Gehrig's disease (though Oakland County Medical Examiner Ljubisa Dragovic later said she was not in a terminal stage of the illness), reportedly could not speak, and had to be tube-fed. She died after inhaling carbon monoxide in an apartment that Dr. Kevorkian reportedly rented adjacent to his own in Royal Oak. Oakland County Prosecuting Attorney Richard Thompson charged Dr. Kevorkian with assisted suicide, but Dr. Kevorkian was acquitted of the charge.

A group known as the Merian's Friends Committee began a petition drive in July 1997 to put the right-to-die issue on the November 1998 ballot. Reportedly, the House Bill 5474 substitute that was reported out of the House Judiciary Committee on February 3, 1998, is largely based upon the Merian's Friends Committee petition. (The bill, however, does not contain the petition language that would amend the medical examiners act to prohibit county medical examiners from investigating a death under the Public Health Code unless the death occurred as a result of violence, nor language amending the Open Meetings Act to exempt the oversight committee created in the proposal from the act's provisions).

FISCAL IMPLICATIONS:

Fiscal information is not available.

ARGUMENTS:

For placing the proposals on the ballot:

Arguably, given the activities of Jack Kevorkian, Michigan, more than any other state in the union, has need of a clear and effective law regulating assisted suicide. Whether the regulation prohibits such actions or sets up a framework for allowing it under certain circumstances, a specific law is needed. Currently, the state of the law is so vague that conviction is almost impossible and one is able to assist people's deaths without regulation or fear of reprisal if it turns out that the "patient" wasn't terminally ill. Unfortunately, the legislature has been unable to reach an agreement on how to deal with this issue. Thus, it would be best to allow the voters to deal with this issue directly by placing the question on the ballot.

The issue of whether to allow assisted suicide should be left to the voters in a ballot proposal. Assisted suicide is an extremely personal issue. Such decisions should not be left to the legislature, where special interest groups are able to influence policy decisions to a far greater degree than ordinary citizens.

Those who argue that only the legislature is capable of properly weighing all the information needed to make decisions on such difficult topics are insulting the voters. The voters are not naive children who are incapable of rational decision making on difficult and emotional issues. When an issue like this is placed on the ballot it becomes a topic of daily conversation in the lives of most voters. People discuss the issue and learn more about it through conversation, reading materials, and other news sources. If this issue is placed on the ballot, the voters of this state will give it as much or more careful consideration than the issue will be given by the legislators.

Against placing the proposals on the ballot:

Assisted suicide is a life and death matter, too important to simply leave to a ballot initiative. The risk of harm to the most vulnerable citizens of the state demands that the legislature act on this issue, rather than placing it on the ballot. The elected officials of this state have a responsibility to deal with difficult issues like assisted suicide. Legislators are elected to make tough decisions about tough issues, not to shirk every difficult issue by putting it on the ballot. It would be improper for the legislature to avoid its responsibility on this issue and pass it on to the voters.

Further, the legislature has the time and opportunity to hold hearings and listen to testimony on this issue and make a fully informed decision. If the issue were placed on the ballot, the citizens will not have as full an opportunity to hear and weigh all of the evidence for and against assisted suicide. Besides, in a very real sense the people have already spoken on this issue by electing the senators and representatives for their districts.

For House Bill 5474:

The bill would create a sound regulatory framework to give certain terminally ill patients the right to end their lives. It would increase the options available to terminally ill patients and ensure that they were properly informed of those options. One of the greatest fears faced by patients who are dying is that of losing control of their own lives by becoming so entirely dependent on others that they lose their sense of dignity or by suffering unbearable pain. Providing an option so that the patient can end his or her life rather than to suffer the indignity of unbearable pain or inability to live as they once did allows a terminal patient a sense of control over his or her destiny. The knowledge that, in the end, he or she will be able to decide when enough is enough not only lowers the chance that the person will not end his or her life out of fear that he or she will not be capable of doing it later, it also allows the person the opportunity to live the remaining time as fully as possible knowing that in the end he or she will have the final say as to when and how death comes.

Not everyone dies peacefully in his or her sleep. Unfortunately, as medical science becomes more and more capable of keeping death at bay, an increasing number of people die painful and lingering deaths or are kept alive in situations where their physical or mental capacity is greatly diminished. Many people do not see the extension of their lives under such circumstances as a blessing but see it as something akin to torture.

There are a number of debilitating diseases that eventually kill those who contract them. Many people find the prospect of having their physical and/or mental capacity slowly disintegrate far more horrifying than the prospect of death itself. These people would prefer to die, than to live on after the disease has left them as a shell of what they once were. There is no good reason to deny them that option.

Against House Bill 5474:

Bias against the elderly, the ill, the severely disabled, and the poor, especially those dependent upon society, is not uncommon. How often has the sight of a severely disabled person provoked the response from persons without disabilities that they would never want to live like that? How often do the elderly express a desire not to become a "burden"? People without disabilities often perceive the lives of those "less well off" as less valuable, without even being conscious of doing so. The perception of the disabled, as with the elderly who are fearful of being a burden on their families, is evidence of how deeply held the belief is that the lives of certain groups are less valuable.

It is this unadmitted prejudice, masquerading as compassion, that raises the concerns of the disabled and other potential "at risk" groups. Suppose two people with the same terminal illness come to a physician seeking aid-in-dying. One person is severely disabled and the other still vigorous in spite of the disease. It is quite possible, even likely, that the disabled person’s decision to end his or her life would be met with support, while the other patient might be discouraged from taking such a step. The act does not deal with this very real risk of a double standard -- where the more disabled, elderly, or poor a patient is the more likely it is that he or she will not be discouraged from committing suicide.

There is also the risk that the emphasis on cost containment could lead to a lowered quality of life for persons with disabilities. Since the underlying motive for committing suicide is the belief that one’s "quality of life" is insufficient to warrant continued living, without better efforts to provide people with the support and accommodations they need to live a full life, legalized assisted suicide will create a compulsion for some to commit suicide, in order to escape a life that has been made intolerable more by social circumstances than physical conditions.

Against House Bill 5474:

There is a real risk that the regulatory framework set forth in House Bill 5474 could be perverted into more active euthanasia without even the permission of the patient/victim. According to testimony from a representative of the Department of Community Health, the Netherlands has shown what a slippery slope allowing assisted suicide can be. Between 1990 and 1995, the number of deaths by active intervention of physicians increased by 27 percent. A total of 1,000 people were killed by physicians without the patient’s consent and people were killed for reasons as insignificant as needing the bed for another patient.

Response:

According to the New England Journal of Medicine, the number of deaths from euthanasia and assisted suicide in the Netherlands amounted to about 1.9 percent of the total number of deaths in the country. Further, less than one third of those who requested physician assistance in dying actually received such assistance. Almost all of those who did receive assistance were terminally ill; most patients were expected to either die within a week (87 percent) or within a month (12 percent).

The number of deaths from euthanasia where the patient was not competent at the time the euthanasia was performed is even smaller (0.8 percent of the total deaths), more than half of them had expressed an interest in euthanasia while still competent and most were moribund at the time the euthanasia was carried out.

Even though these statistics do not prove that abuses do not occur in the Netherlands, it should be noted that any alleged abuses that might occur in the Netherlands could occur here as well, whether or not assisted suicide is made illegal.

For Senate Bill 200:

For the state to do anything other than ban assistance to suicide would be to shirk its responsibility to protect human life. To allow assistance to suicide would be to legalize the killing of another human being under conditions fraught with moral and ethical peril. To allow assistance to suicide would devalue human life, making life-or-death decisions subject to pressures imposed by societal biases regarding race, gender, age, or disability. Legalized assistance to suicide could encourage some people to perceive it to be their duty to commit suicide rather than burden family, friends, or society.

Even more frightening, legalization of assistance to suicide could encourage the practice of euthanasia, or "mercy killing," whereby one person decides that another person's life is not worth living. Euthanasia, in which a person deliberately administers a lethal agent, is quite different from allowing death to occur naturally by withdrawing medical treatment under a directive issued by the patient in advance.

People, particularly people under stress, may be too quick to perceive suicide as an option, even when they may yet be helped by psychological counseling or appropriate pain treatment. Banning assistance to suicide would help to ensure that alternatives were adequately considered; such considerations would be further fostered by recent legislation to promote and improve pain management techniques and access to them.

It must be the role of the state to provide alternatives to suicide and affirm the value of human life, not to diminish it.

For Senate Bill 200:

If assisted suicide is made legal, the pressures from the high cost of medical care, particularly for terminally ill patients, could lead to the conclusion that costs could be lowered by doing away with these patients. The onset of managed care and the emphasis on "cost containment" has already sparked allegations of lowered quality of care for patients and assertions that the managed care companies are more interested in profits than treating patients. It doesn't take a large stretch of the imagination to see how some managed care companies could use the option of assisted suicide as a means of controlling costs, either by simply euthanizing patients or by using subtler pressures (for example, limiting palliative care or other quality of life care that could make the terminal patient's life easier to endure).

Response:

The suggestion that managed care providers would attempt to control costs by killing patients or even limiting care so as to pressure them to choose assisted suicide is outrageous. Not only is the assertion that managed care companies would do such a thing insulting, it also makes no sense. Managed care companies compete against one another for customers in the open market and a managed care company that engaged in these practices would be hard pressed to keep customers. As with many allegations made against managed care companies, this supposed risk makes no sense. Is it possible that such abuses could occur? Certainly, almost anything is possible. Is it likely?

No, emphatically no. The same factors that prevent such abuses now will continue to work to the advantage and protection of the customers. In fact, given the lack of effectiveness in prosecuting assisted suicide cases, if this risk were real one would expect to see such abuses occurring even now.

Against Senate Bill 200:

The bill would be an inappropriate intrusion by the government into an intensely private matter. Rather than ban assistance to suicide, legislation should impose reasonable regulations, allowing assistance to be provided under procedural safeguards against abuse. Not all pain is treatable and people who seek relief from unbearable suffering should have humane methods available to them.

Against Senate Bill 200:

Except when the will of the people would be violative of the constitution, the legislature should not be able to enact laws that go completely against the will of the people. According to a survey performed in 1994-95 by the University of Michigan and Michigan State University, 66 percent of Michigan adults support legalization of physician aid in dying.

POSITIONS:

The Merian's Friends Committee supports House Bill 5474 and opposes Senate Bill 200. (2-3-98)

The American Civil Liberties Union opposes Senate Bill 200 and supports statutorily regulated physician aid-in-dying. (2-3-98)

The Patients Rights Organization - USA supports House Bill 5474 and opposes Senate Bill 200. (2-3-98)

Right to Life of Michigan supports Senate Bill 200 as it passed the Senate and opposes House Bill 5474. (2-3-98)

The Michigan Catholic Conference supports Senate Bill 200 as it passed the Senate and opposes House Bill 5474. (2-3-98)

American Disabled for Attendant Programs Today (ADAPT) supports Senate Bill 200 as it passed the Senate and opposes House Bill 5474. (2-3-98)

Not Dead Yet supports Senate Bill 200 as it passed the Senate and opposes House Bill 5474. (2-3-98)

The Department of Community Health supports Senate Bill 200 as it passed the Senate and opposes House Bill 5474. (2-3-98)

The Michigan Hospice Association supports Senate Bill 200 as it passed the Senate and opposes House Bill 5474. (2-3-98)

The American Association of Retired Persons has no position on the issue of assisted suicide. (2-3-98)

Analyst: S. Ekstrom/W. Flory
