Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536

SFA BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986
TDD: (517) 373-0543

Senate Bill 653 (as introduced 7-2-97)
Sponsor: Senator Gary Peters
Committee: Judiciary

Date Completed: 8-3-97

CONTENT

The bill would add Part 56b to the Public Health Code to create the "Terminally Ill Patient's Right To End Unbearable Pain Or Suffering Act". The bill would do all of the following:

- **Provide for a terminal patient's request for self-administered medication to end unbearable pain or suffering by ending his or her life. (An individual would not be qualified to make a request solely because of age or disability, or a combination of age and disability, other than a disability caused by a terminal illness.)**
- **Specify the responsibilities of attending physicians, consulting physicians, and psychiatrists.**
- **Provide for the prescription and dispensation of medication.**
- **Require the Department of Community Health (DCH) to develop and publish an informational booklet.**
- **Create a rebuttable presumption that a doctor's determination of terminal illness was correct, and provide for a legal challenge to that determination.**
- **Require the Governor to appoint an oversight committee to review the operation of Part 56b.**
- **Specify that the death of a patient in compliance with the bill would have to be classified, for legal purposes, as having been caused by the patient's terminal illness.**
- **Establish new requirements for physicians' license renewal and continuing education.**
- **Provide immunity from liability for a health care provider or other person for participating in procedures authorized by the bill or for not participating in those procedures.**
- **Specify criminal penalties for violations of the bill.**
- **Provide for the promulgation of rules and oversight activities of the DCH.**
- **Provide for the bill's severability on questions of constitutionality.**
- **Exclude actions taken under Part 56b from various existing prohibitions and regulations.**
- **Include failure to comply with Part 56b in various sanctions available under the Code.**
- **Express legislative intent regarding Part 56b.**

The bill also would repeal Public Act 270 of 1992, which established the Michigan Commission on Death and Dying and charged it with developing recommendations for the Legislature, within 15 months after that Act's effective date, on legislation concerning the "voluntary self-termination of life". Public Act 270 also prohibited, until six months after the Commission submitted its recommendations to the Legislature, "criminal assistance to suicide" and made that activity subject to felony penalties.

The bill could not take effect unless it was submitted to the qualified electors of the State of Michigan at the November 5, 1998, general election, in the same manner as provided by law for proposed amendments to the State Constitution, and was approved by a majority of the electors voting on the question. If approved by the electors, the bill would take effect on January 1, 1999.

Request

The bill states that, "A patient...may make a request...during the terminal period for medication for self-administration, the primary purpose of which is to end the patient's unbearable pain or

suffering by ending his or her life in a humane and dignified manner", if the patient met all of the following requirements:

-- He or she was competent and had made an informed decision.
-- The patient was determined by his or her attending physician and by a consulting physician to be suffering from a terminal illness.
-- The patient had made a voluntary expression of his or her wish to die by means of making a request under the bill pursuant to an informed decision.

"Patient" would mean an adult resident who was under the care of an attending physician and was being treated by that physician or by a consulting physician for a terminal illness. "Adult" would mean a person who was at least 18 years of age. A "resident" would be a person who resided in Michigan at the time of the request and who had resided in the State for at least six months immediately preceding the request. "Resident" would include a parent of a resident, adult sibling of a resident, adult child of a resident, or a spouse of one of those individuals who did not reside in Michigan, if the relationship to the resident were attested to by an affidavit of the resident presented to an attending physician. The parent, adult sibling, adult child, or spouse of one of those individuals would be considered a resident of the county of residence of the resident presenting the affidavit.

"Request" would mean a request for medication for self-administration, the primary purpose of which was to hasten or cause death and that met the bill's requirements. "Terminal period" would mean the last six months of life for a patient with a terminal illness, within reasonable medical judgment. "Medication" would mean one or more prescription drugs that can be taken orally or by nasogastric or gastrostomy tube. "Self-administration" would mean the insertion or ingestion of medication requested under the bill, including accompanying fluids, that was performed entirely under a patient's own effort. "Suffering" would mean the physical or mental torment caused by a terminal illness and that resulted from the progressive and serious loss of the ability to perform major life functions.

"Informed decision" would mean a decision by a patient to request a prescription for medication to end his or her unbearable pain or suffering by ending his or her life in a humane and dignified manner that was made after being fully informed by the attending physician or a consulting physician of all of the following:

-- The patient's medical diagnosis.
-- The patient's prognosis.
-- The potential risks associated with taking the medication to be prescribed.
-- The probable result of taking the medication to be prescribed.
-- The alternatives to taking the medication prescribed, including, but not limited to, comfort care, hospice care, and pain control.
-- That the patient could rescind the decision at any time by either written or oral communication or in any manner that communicated the same intent.

"Attending physician" would mean a physician who had primary responsibility for the care of the patient. "Consulting physician" would mean a physician who specialized in the disease that had caused a patient to become terminal, was actively practicing that specialty, and was certified by a national professional organization for that specialty and approved by that physician's licensing board. "Terminal illness" would mean an incurable and irreversible disease that was medically confirmed and that would, within reasonable medical judgment, result in the death of the patient within six months or less. "Voluntary" would mean that a decision was made by a patient's independent judgment without evidence of outside coercion, insofar as could be reasonably determined by the patient's attending physician or by a consulting physician or by a psychiatrist.

A patient's request could be in writing or, if he or she were unable to write, could be made orally. A request would have to contain all of the following information:

-- The patient's full name and his or her address at the time the request was made. If the patient were an inpatient or a resident in a health facility, the request would have to contain the patient's last known residential address.
-- A statement that the patient believed himself or herself to be competent.
-- A statement that the request was being made voluntarily and without coercion.
-- A description of the terminal illness from which the patient was suffering.
-- A statement that the patient had been informed by his or her attending physician that the terminal illness likely would cause death within six months or less.
-- A statement that the patient had been

informed by his or her attending physician or consulting physician regarding comfort care, hospice care, and pain control.
-- A statement that the patient understood that he or she could rescind the request at any time and by any method of communication.

The patient would have to sign and date a request that was made in writing. A written request would have to be witnessed by at least two individuals who attested that, to the best of their knowledge and belief, the patient was rational and was acting voluntarily. At least one of the witnesses would have to be someone who was not one of the following:

-- A relative of the patient by blood, marriage, or adoption.
-- Knowingly entitled at the time of the request to have control over a portion of the patient's estate upon his or her death under a will or trust, or by operation of law.
-- An owner, operator, or employee of a health facility in which the patient was receiving medical treatment or was a resident.

The patient's attending physician at the time of the request could not be a witness. If the patient were a patient in a health facility at the time of the request, one of the witnesses would have to be an individual designated by the health facility, but who was not employed by or under contract to it.

If the patient made an oral request, it would have to be recorded by video means. A patient could rescind a request at any time and in any manner by which he or she could communicate an intent to rescind the request, without regard to his or her mental or emotional state.

A request by a patient in compliance with the bill would not provide the sole basis for the appointment of a guardian or conservator.

Physicians' Responsibilities

As soon as possible after determining that a patient had a terminal illness, regardless of whether the patient had made a request under the bill, the attending physician or the consulting physician would have to do all of the following:

-- Upon request of the patient, provide him or her with a true copy of Part 56b and a copy of the booklet required under the bill to be produced by the DCH.
-- Inform the patient regarding comfort care, hospice care, and pain management.
-- Ask the patient whether he or she had questions regarding payment for the treatment the attending or consulting physician had provided or would provide for the terminal illness or payment for comfort care, hospice care, or pain control. If the patient had questions, the physician would have to refer the patient to a professional who could identify possible financial assistance for the patient.

In addition to complying with current requirements in the Code for communicating with a patient about treatment options for a terminal illness, a patient's attending physician would have to do all of the following in relation to a request, before writing a prescription under the bill:

-- Confirm the initial determination that the patient had a terminal illness, was competent, and was making the request voluntarily and pursuant to an informed decision.
-- Inform the patient of the attending physician's confirmation; the patient's prognosis; the potential risks associated with taking the medication to be prescribed under the request; the probable result of taking the medication; and the alternatives to making a request, 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.
-- Require the patient to consult with a psychiatrist.
-- Refer the patient to his or her consulting physician or, if none were involved, to another consulting physician who specialized in treating the terminal illness for medical confirmation of the diagnosis and for an independent determination that the patient was competent and made the request voluntarily and pursuant to an informed decision. If the patient's terminal illness were cancer, the attending physician would have to refer the patient to a consulting physician who specialized in oncology.
-- Inform the patient, at the time the request was made, that he or she had the right to rescind the request at any time and by any method of communication.
-- Immediately before writing the prescription, verify that the patient was making the request voluntarily and pursuant to an informed decision.

-- Fulfill the bill's medical record documentation requirements.
-- Ensure that all required steps were carried out in accordance with Part 56b before writing a prescription for medication under that part.

When a patient was referred to a psychiatrist, the psychiatrist would have to interview the patient and review his or her relevant records. If the psychiatrist determined both of the following, he or she would have to document that determination in the patient's medical record and issue the patient a written statement of the determination, which the patient would have to present to the attending physician:

-- That the patient had no diagnosable mental disorder or, if the patient did have a diagnosable mental disorder, that the request for medication under the bill was not the result of distortion of the patient's judgment due to clinical depression or another mental illness.
-- That the request was reasoned, fully informed, and voluntary, as far as could reasonably be determined.

An attending physician would have 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 by the bill. A licensed physician specializing in psychiatry who interviewed a patient would have to conform his or her conduct to the applicable standard of practice in making the determinations required in the bill.

After a patient was referred to a consulting physician, the consulting physician would have to examine the patient and his or her relevant medical records. If the consulting physician concurred with the attending physician, he or she would have to confirm, in writing in the patient's medical record, the attending physician's diagnosis and verify that the patient was competent and making the request voluntarily and pursuant to an informed decision. The consulting physician would have to conform his or her conduct to the applicable standard of practice in making these determinations. If the consulting physician wrote the prescription for the requested medication, he or she would have to assure that the bill's information, determination, and medical records requirements were met.

If an attending physician or a consulting physician were unwilling to perform one or more of the duties specified in the bill, including, but not limited to, giving a patient a true copy of Part 56b or of the DCH informational booklet, prescribing medication under the bill, or performing a required examination, the physician immediately would have to inform the patient of that fact and, within 72 hours, transmit a copy of the patient's relevant medical records to a physician of the patient's choice. The physician chosen by the patient would become the patient's attending or consulting physician, as appropriate.

An attending physician would have to document in writing, and file in a patient's medical record, and retain for at least three years, all of the following:

-- Each oral request made by the patient.
-- Each written request made by the patient.
-- The attending physician's diagnosis that the patient had a terminal illness, the prognosis, and the determination that the patient was competent and making the request voluntarily and pursuant to an informed decision.
-- The consulting physician's confirmation of the attending physician's diagnosis and prognosis, and the consulting physician's independent verification that the patient was competent and making the request voluntarily and pursuant to an informed decision and that the patient was informed regarding sedation coma, refusal of hydration and nutrition, and withdrawal of life-sustaining treatment, as appropriate.
-- The written statement from the psychiatrist consulted by the patient as required under the bill.
-- The attending physician's offer to the patient of an opportunity to rescind the request.
-- A note by the attending physician indicating that all requirements of Part 56b were met and the steps taken to carry out the request, including, but not limited to, a notation of the medication prescribed.

A physician could not establish a clinic that exclusively provided the procedures authorized by the bill.

Prescription

A patient who had made a request under the bill would have to reiterate the request after all of the communication and consultation requirements of the bill were met. At the time the patient made the second request, the attending physician would have to offer the patient an opportunity to rescind

the request. If the patient did not do so, the attending physician would have to enter the second request in the patient's medical record.

If at least seven days had passed since the initial request, the attending physician or the consulting physician would have to prescribe the medication to the patient, in writing, and the patient could obtain the medication for self-administration.

The prescription would have to meet all of the following requirements:

-- Be provided on the same official prescription form that is required under the Code for the prescription of Schedule 2 controlled substances. The attending physician would have to give the patient the official prescription form and enter in the patient's medical record the name of the medication, dosage, and quantity prescribed as well as instructions for its use. The attending physician would have to retain that part of the medical record for at least five years.
-- Be for only a single dose of the quantity of the medication estimated to cause death.
-- Contain directions that specified only the dose that would hasten or cause death.
-- Be labeled with a statement that the prescription was issued pursuant to the bill.
-- Be labeled with a prominent cautionary statement that administration of the prescribed dose would likely cause death.
-- Be dispensed only to the patient or to an agent of the patient with appropriate identification.

A pharmacist who filled a prescription under the bill would have to confirm the dose with the prescribing physician before dispensing the medication to the patient. The pharmacist would have to sign the official prescription form and forward it or transmit the information on it to the DCH, and retain the official prescription form or a true copy of it in compliance with the Code's requirements. The form or information transmitted to the DCH would not be a public record, would not be available for inspection by the public, and would not be subject to disclosure under the Freedom of Information Act.

DCH Informational Booklet

Within 60 days after the bill's effective date, the DCH, in consultation with the oversight committee appointed under the bill, would have to develop and publish a booklet that contained all of the following information:

-- The procedure for making a request and obtaining medication under the bill.
-- The availability of medication under the bill.
-- Alternatives to making a request under the bill, including, but not limited to, comfort care, hospice care, and pain control.

The DCH would have to make copies of the booklet available, upon request and without charge, to physicians who were subject to the bill.

Legal Challenge

A determination made by an attending physician and verified by a consulting physician under the bill in combination with a written statement from a psychiatrist, as required by the bill, would create a rebuttable presumption that the determination was correct for purposes of a legal proceeding involving the procedures outlined in the bill.

Only a patient's spouse, a parent, adult sibling, adult child, or significant other could bring an action to challenge a determination made by an attending physician, consulting physician, or psychiatrist. ("Significant other" would mean an individual who had had a monogamous-type relationship with a patient for at least one year.) If the patient were still living, the action would have to be brought in the circuit court for the county in which the patient resided or was found and be assigned to the chief judge of that circuit.

As soon as practicable after the action was filed, the circuit court would have to issue a temporary restraining order prohibiting the prescription or dispensing, or both, of the requested medication or requiring the confiscation of the requested medicine. The order would not affect obtaining the determinations made by an attending physician, a consulting physician, or a psychiatrist.

The court would have to hold an expedited hearing, within five days after the action was filed. The court would have to conclude the hearing within two days after it was commenced and render a decision within five days after the hearing was concluded. If the circuit court did not comply with that time schedule, either party to the action could seek an emergency hearing for a superintending control order from the Court of Appeals to compel compliance by the circuit court.

Oversight Committee

Within 90 days after the bill's effective date, the Governor would have to appoint an oversight committee of 14 physicians and three members of the general public to review the operation of Part 56b. Eight members, two from each State medical and osteopathic school, would have to be appointed from nominees submitted by the highest executive officer of each school who was not opposed to complying with the bill. Six members, three from Michigan State Medical Society and three from the Michigan Osteopathic Association Society, would have to be appointed from nominees submitted by the highest executive officer of each organization who was not opposed to complying with the bill. Three members would have to be appointed from the general public. The general public members could not be opposed to complying with the bill. The Governor's failure to appoint oversight committee members would not alter the effective date of Part 56b.

Each physician nominee would have to have practiced his or her specialty for at least 10 years. At least one nominee from each medical school and professional organization would have to be a specialist in oncology. A nominee could not be opposed to complying with the bill. Members would serve four-year, staggered terms. Nine members would constitute a quorum and as soon as nine members were appointed, the oversight committee would be operative. Members would be compensated for expenses incurred in the performance of official duties.

The DCH Director would serve as executive secretary to the committee, and would have to provide all necessary administrative support to members and obtain patient medical records for the committee's oversight activities.

The oversight committee would have to meet at least twice yearly and, during the course of the year, would have to review the patients' medical records of a random sample of at least 25% of all deaths occurring as a result of the operation of Part 56b during the preceding year. The committee would have to determine compliance by the attending physician, consulting physician, and psychiatrist with the requirements of the bill and with applicable standards of practice. The random sample would have to be based on the prescription copies or information sent to the DCH. At least two members of the committee would have to review each case and present findings to the entire committee for its consideration and decision.

If 25% of oversight committee members voting on a particular case determined that a physician had not complied with the requirements of Part 56b, or had negligently failed to comply with the applicable standards of practice in providing the procedures authorized by the bill, or both, the committee would have to review additional medical records, from the physician, of other patients, if any, whose deaths were a result of the bill.

All proceedings, minutes, conclusions, and actions of the oversight committee and patient medical records and other materials reviewed by the committee would be confidential, would not be public records, would not be open to inspection, and would not be subject to the Open Meetings Act or the Freedom of Information Act. The oversight committee would have to issue and make available to the public an annual report of the effect and operation of Part 56b, containing a statistical summary, without individual identifiers of patients or physicians. The committee also would have to make available any special statistical reports submitted to the Governor or Legislature on the operation of Part 56b, without individual identifiers, that the Governor or Legislature could require the committee to prepare or that were considered necessary by the committee.

Upon the request of the DCH, an attending physician, consulting physician, psychiatrist, pharmacist, or health facility that participated in the procedures authorized in the bill would have to make available, in a timely fashion, not to exceed 30 days, patient medical records and any other clinical material required by the committee. The following would not apply to a request for medical records, mental health records, or other clinical material requested under this provision or to the DCH acting within the scope of its authorization:

-- The physician-patient privilege created in the Revised Judicature Act.
-- Any other health professional-patient privilege created or recognized by law.

The DCH could compel delivery of the documents requested by the DCH or the committee by subpoena, if the documents were not provided in a timely fashion.

All patient medical records and other clinical material would have to be treated as confidential by the oversight committee, would have to be kept by the DCH in a secure area, would have to be transmitted to committee members for review in a secure manner, and would have to be returned to the health professional or health facility providing

the medical records and other clinical material as soon as the oversight committee had no further need for it.

If, as a result of reviewing patient medical records and other clinical material, the oversight committee determined, by procedures incorporating appropriate protections to be agreed upon by the committee, that a health professional or health facility had willfully failed to comply with, or recklessly disregarded, the bill's requirements, the oversight committee would have to prepare a report to that effect and submit it to the prosecuting attorney for the county in which the health professional practiced or in which the health facility was located.

If, after reviewing patient medical records and other clinical material, the oversight committee determined by procedures incorporating appropriate protections to be agreed up on by the committee, that a physician could have negligently failed to comply with the applicable standards of practice, the committee would have to notify the physician, in writing, of the determination and provide the physician with an opportunity for a hearing. The hearing would have to be conducted as a contested case hearing under the Administrative Procedures Act. If, after notice and an opportunity for a hearing, the oversight committee found by a majority vote that the physician negligently failed to comply with one or more applicable standards of practice in providing the procedures authorized by the bill, the committee could issue an order limiting or terminating the physician's ability to prescribe medication as authorized by the bill. An appeal from a final action of the committee would have be filed with the circuit court for the county in which the physician had his or her primary place of practice.

In the third year after the bill's effective date, and every five years after that, the oversight committee would have to undertake a survey, in collaboration with qualified epidemiologists at a State university, of the extent of compliance with the reporting requirements of Part 56b. The deliberations and proceedings of the oversight committee and epidemiologists would not be subject to the Open Meetings Act. Information collected in the course of the investigation would not be a public record, could not be made available for inspection by the public, and would be exempt from disclosure under the Freedom of Information Act. The oversight committee would have to make available to the public a report of the investigation, containing a statistical summary, without individual identifiers of patients or physicians. All information acquired for the survey would have to be treated as confidential by survey personnel, be kept by the survey director in a secure area, and be destroyed once the report was complete.

Death Classification

The death of a patient who ended his or her life after complying with Part 56b would have to be classified, for legal purposes, as having been caused by the patient's terminal illness. A patient's death could not be considered a suicide or an intentional death for the purpose of voiding a policy of insurance on the patient's life.

A provision in a contract, will, or other written or oral agreement would be invalid to the extent the provision would affect whether an individual could make or rescind a request under the bill or use medication prescribed under the bill, to end his or her life. The making or rescinding of a request under the bill, or the use of medication prescribed under the bill, could neither affect nor be a condition upon an obligation owing under an existing contract, or the sale, procurement, coverage, benefits, or issuance of a life, health, accident, or annuity policy, or the rate charged for a policy.

License Renewal & Continuing Education

Beginning two years after the bill's effective date, a physician who provided patients with the procedures authorized by the bill and who applied for the renewal of his or her license would have to present satisfactory evidence that, as part of the 150 hours of continuing medical education required under the bill for medical doctors and doctors of osteopathy, he or she had at least 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 authorized by Part 56b.

At a subsequent license renewal, a physician would have to present to the licensing board satisfactory evidence that, as part of the required 150 hours of continuing medical education, he or she had four hours of the type of continuing medical education described above.

Immunity from Liability

A health care provider or other person would not be subject to civil or criminal liability or administrative

disciplinary action for participating in the procedures authorized by the bill in good faith and in compliance with the bill or for not participating in those procedures. In addition, a health care provider who claimed immunity would have to have conformed his or her or the health facility's conduct to the applicable standard of practice for the conduct, procedures, or determinations undertaken under the bill. The bill specifies that Part 56b would not provide for or otherwise allow a lower standard of practice or care for patients with a terminal illness.

A professional organization or association or a health facility or other health care provider could not subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in the procedures authorized by the bill. A health facility could prohibit the procedures authorized by the bill, however, and impose one or more of those sanctions, if all of the following requirements were met:

-- The health facility had given reasonable notice of the prohibition to its staff and to the public.
-- If requested by a patient, the health facility provided a transfer of the patient, within 48 hours, along with a copy of the patient's relevant medical records at the time of the transfer, to another facility of the patient's choice that would allow the procedures.
-- The participation of health facility staff in the procedures outside the health facility was not considered a violation of the facility's prohibition.

Provision of medication by an attending physician in compliance with the bill would not constitute negligence or malpractice for any purpose of law.

Criminal Penalties

A nonphysician or unlicensed physician who administered, caused to be administered, delivered, or caused to be delivered medications, chemicals, or any other instrumentality, or the apparatus for their delivery or use, to an individual for use in a manner substantially likely to cause or hasten that individual's death, would be guilty of a felony punishable by imprisonment for a term of years up to life, regardless of whether the purpose was to relieve pain or suffering. Once medication had been prescribed under the bill, the sanction would not apply to a nonphysician health care provider, an employee of a health facility, or a patient's family member or friend who, at the patient's request, filled or delivered to the patient the prescription or who, at the patient's request, supported, cradled, or made the patient comfortable while the patient self-administered the prescribed medication.

A person who, without authorization of the patient, willfully altered or forged a request for medication under the bill or concealed or destroyed a rescission of a request with the intent or effect of causing the patient's death would be guilty of a felony punishable by imprisonment for a term of years up to life.

A person who coerced or exerted undue influence on a patient to make a request under the bill, or to destroy a rescission of a request, would be guilty of a felony punishable by imprisonment for a term of years up to life.

A physician who willfully, or with reckless disregard, failed to comply with the bill's requirements and who, at the request of a person under the physician's care, provided to that person medication or other instrumentality for self-administration that was intended to cause or hasten death would be guilty of a felony punishable by a maximum fine of $50,000, up to five years' imprisonment, or both.

A physician who willfully failed to comply with the bill's requirements regarding referral to a willing physician or retention of a patient's medical records would be guilty of a misdemeanor punishable by a maximum fine of $10,000, up to 90 days' imprisonment, or both.

A person who filed a false affidavit of relation to a resident would be guilty of a misdemeanor punishable by a maximum fine of $10,000, up to 90 days' imprisonment, or both.

A pharmacist who failed to forward to the DCH prescription information or a copy of the prescription provided to a patient, as required by the bill, would be guilty of a misdemeanor punishable by a maximum fine of $1,000.

Criminal penalties imposed by the bill would not preclude criminal penalties applicable under other statutes. The bill's criminal penalty provisions would not limit liability for civil damages resulting from other negligent or willful conduct.

DCH Oversight

The DCH could promulgate rules to implement Part 56b. In the conduct of the review and investigative functions of the oversight committee, the DCH could require by subpoena the attendance and testimony under oath of witnesses and the production of evidence, including medical records and other clinical material. Witnesses would have to be paid the same fees and mileage that are paid to witnesses in circuit courts.

In case of a failure or a refusal of a person to obey a subpoena issued by the DCH, the Ingham County Circuit Court, upon application by the DCH Director, could issue an order requiring the person to appear and produce evidence or give testimony that could be required for the oversight committee function. Failure to obey the order could be punished as contempt.

A person who willfully failed to comply with a subpoena would be subject to a maximum fine of $2,000 for each violation or day that a violation continued.

Severability

The bill specifies that, if any portion of the amendatory Act that added Part 56b to the Public Health Code, or the application of that part to any person or circumstance, were found to be invalid by a court, the invalidity would not affect the remaining portions or applications of Part 56b that could be given effect without the invalid portion or application, if remaining portions of the amendatory Act were not determined by the court to be inoperable. To this end, the amendatory Act that added Part 56b would be declared to be severable.

Exclusion of Part 56b from Prohibitions & Regulations

The dispensing, prescription, or administration of a controlled substance for use in procedures authorized under the bill would not be a violation of the Public Health Code's controlled substance delivery, possession, and use provisions.

The prescription, obtaining, attempting to obtain, and possession of a drug for use in the procedures authorized under the bill would not be a violation of the Code's prohibition against obtaining, attempting to obtain, or possessing a drug by means of a prescription for other than legitimate therapeutic purposes or as a result of a false, forged, or altered prescription.

Professional Sanctions

The bill would include failure to comply with Part 56b in the Public Health Code's list of actions for which a license or certification may be denied, limited, suspended, or revoked.

The bill would include violations of the physician responsibility and prescription provisions of Part 56b in provisions of the Code that allow DCH investigations into activities related to the practice of a health profession by a licensee, a registrant, or an applicant for a license or registration. A violation of those provisions of Part 56b would require license denial, revocation, restitution, probation, suspension, limitation, reprimand, or a fine.

Legislative Intent

The bill specifies that, "It is the intent of the legislature in enacting" Part 56b to do all of the following:

-- "Give a terminally ill adult who is competent and is a resident of this state or a close relative of a resident of this state the right to end unbearable pain or suffering through the self-administration of medication to hasten death."
-- "Provide safeguards and protect the legal rights of an individual who chooses to end his or her unbearable pain or suffering".
-- "Allow a physician to prescribe medication to hasten death" pursuant to Part 56b.
-- "Provide oversight for physicians who prescribe medication" under Part 56b.
-- "Provide sanctions for a physician or other individual who violates" Part 56b.

MCL 333.2844 et al.

Legislative Analyst: P. Affholter

FISCAL IMPACT

The bill would have an indeterminate impact on State Department of Community Health expenditures. The Department would incur minimal expenses, which could be absorbed within existing resources, for printing and posting the informational booklets required by the bill. The magnitude of the expense of providing administrative support to the oversight committee would depend on the number of cases reviewed by the committee, the number of violations identified, and the number of investigations and hearings conducted by the committee. The costs associated with this function probably could not be absorbed within existing resources as this would be a new

activity for the Department of Community Health. The Department of Consumer and Industry Services normally is responsible for monitoring and regulating physician conduct.

The bill also would have an indeterminate, yet likely minimal fiscal impact on the Department of Corrections. The new penalties proposed in the bill could result in increased jail or prison commitments for those individuals who violated the bill. While there are insufficient data at this time that might predict how many annual violations could occur, and what type of sanction would be imposed for each violation, the number is not expected to be significant.

Fiscal Analyst: P. Graham
M. Hansen

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