2nd Draft

Initiative #145
Access to Medical Aid-in-Dying Medication

Proposition ? proposes amending the Colorado statutes to:

- ♦ allow a terminally ill individual with a prognosis of six months or less to live to request and self-administer medical aid-in-dying medication in order to voluntarily end his or her life;

- ♦ authorize a physician to prescribe medical aid-in-dying medication to a terminally ill individual under certain conditions; and

- ♦ create criminal penalties for tampering with a person's request for medical aid-in-dying medication or knowingly coercing a person with a terminal illness to request the medication.

Summary and Analysis

Proposition ? creates the "Colorado End-of-Life Options Act," which allows individuals with a terminal illness to request from their physician and self-administer medical aid-in-dying medication (medication). To be eligible to request medication, the individual must:

- be a Colorado resident aged 18 or older;
- be able to make and communicate an informed decision to health care providers;
- have a terminal illness with a prognosis of six months or less to live that has been confirmed by two physicians, including the individual's primary physician and a second, consulting physician;
- be determined mentally capable by two physicians, who have concluded that the individual understands the consequences of his or her decision; and
- voluntarily express his or her wish to receive the medication.

Request process. To receive the medication, the individual must make two oral requests, at least 15 days apart, and one written request in a specific form to his or her primary physician. The written request must be witnessed by at least two other persons who attest that the requesting individual is mentally capable, acting voluntarily, and not being coerced into signing the request. One witness may not be a relative of the individual; an heir; or an owner, operator, or employee of a health care facility where the individual is receiving medical treatment or is a resident. Neither the primary physician nor the individual's qualified power of attorney or durable medical power of attorney, may be a witness to a written request.

Physician requirements. The primary physician is required to document that an individual requesting the medication has a terminal illness with a prognosis of

six months or less to live and meets all other eligibility criteria. The primary physician must provide full and specific information to the individual about his or her diagnosis and prognosis; alternatives or additional treatment opportunities, such as hospice or palliative care; and the potential risks and probable results associated with taking the medication. The primary physician must also inform the individual that he or she may obtain, but choose not to use the medication and may withdraw his or her request at any time. The primary physician must confirm, in private with the individual, that his or her request to receive medication was not coerced or influenced by any other person and is required to refer the individual to a consulting physician to confirm that the individual meets all eligibility criteria.

If either a primary or consulting physician believes the individual is not mentally capable of making an informed decision about receiving the medication, that physician must refer the individual to a licensed mental health professional before the request process may proceed. The mental health professional must communicate his or her findings in writing to the referring physician. If a person is found to be mentally incompetent, he or she is no longer eligible for medical aid-in-dying.

Dispensing of medical aid-in-dying medication. Medication may be dispensed when two physicians agree on the individual's prognosis. Immediately prior to writing a prescription for the medication, the primary physician must verify that the individual is making an informed decision and that the process has been completed properly. Health care providers, including physicians and pharmacists, who dispense medication are required to file a copy of the dispensing record with the state. Unused medication must be returned to the primary physician or to any other state or federally approved medication take-back program.

Death certificates. The death certificate of an individual who uses the medication must be signed by the primary physician or hospice medical director and must list the underlying terminal illness as the cause of death. Deaths resulting from medical aid-in-dying are not subject to investigation by the county coroner.

Voluntary participation by health care providers. Physicians and pharmacists are not obligated to prescribe or dispense the medication. If a health care provider is unable or unwilling to carry out an eligible individual's request for the medication and the individual transfers to a new provider, the initial provider is required to coordinate the transfer of medical records to the new provider. A health care facility may prohibit a physician employed or under contract with the facility from prescribing medication to an individual who intends to use the medication on the facility's premises. The facility must provide advance written notice of its policy to the physician and its patients. A health care facility may not discipline a physician, nurse, pharmacist, or other person for actions taken in good faith or for refusing to participate in any way.

Civil and criminal penalties. The measure creates a class 2 felony for tampering with a request for medication or knowingly coercing a person with a terminal illness to request the medication. Persons are immune from civil or criminal liability or professional disciplinary action unless they act with negligence, recklessness, or intentional misconduct.

Insurance, wills, contracts, and claims. Requesting or self-administering the medication does not affect a life, health, or accident insurance policy or an annuity and nothing in the measure affects advance medical directives. Insurers may not issue policies with conditions about whether individuals request medication.

> *For information on those issue committees that support or oppose the measures on the ballot at the November 8, 2016, election, go to the Colorado Secretary of State's elections center web site hyperlink for ballot and initiative information:*
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> http://www.sos.state.co.us/pubs/elections/Initiatives/InitiativesHome.html

Arguments For

1) Medical aid-in-dying allows a terminally ill person to avoid extended physical and emotional pain. Rather than having to take desperate actions to expedite death, such as refusing nutrition, the measure allows a dying individual to benefit from medical guidance when making end-of-life decisions. An individual's decision to request medical aid-in-dying is consistent with other end-of-life options, including do-not-resuscitate orders, or the withdrawal of life-sustaining measures at an individual's request.

2) Proposition ? balances the state's interest in public safety with a dying individual's desire to exert a degree of control over his or her last stage of life. It establishes safeguards by creating criminal penalties and ensuring that an individual's physician, family members, and heirs are not the only witnesses to requests for medication. The measure protects the individual by prohibiting any other person, including a physician, from making the decision to request medical aid-in-dying or from administering the medication. Further, by requiring that at least two physicians examine the individual and document his or her prognosis and mental capabilities, the measure establishes a process to ensure that an individual is capable of making an informed decision to end his or her life.

Arguments Against

1) Proposition ? creates opportunities for abuse and fraud. The protections in the measure do not go far enough to shield vulnerable people, especially those who are elderly, poor, or disabled, from family members and others who may benefit from their premature death. Proposition ? allows a family member or heir to be one of the witnesses to a request for the medication and does not go far enough to ensure that the individual is free from coercion. The measure does not require independent verification that the medication was taken voluntarily or under medical supervision. Further, it does not require the lethal medication to be monitored or stored in a safe location, potentially placing others at risk or leading to its misuse.

2) Medical aid-in-dying diminishes the value of life by suggesting that some lives are not worth living. Permitting its practice may lead to reduced emphasis on treating terminally ill individuals or from developing new options to provide care and pain relief to an individual at the end of his or her life. Additionally, physicians are forced to choose between medical ethics and a request to die from a person for whom they feel compassion. The measure compromises a physician's judgment by asking him or her to verify that an individual has a prognosis of six months or less to live, yet fails to recognize that diagnoses can be wrong and prognoses are estimates, not guarantees. The measure also requires that the physician or hospice director list the terminal illness or condition on the death certificate, which requires these professionals to misrepresent the cause of death.

Estimate of Fiscal Impact

State revenue and spending. Beginning in FY 2016-17, this measure may increase state revenue from criminal fines or, if individuals participating in medical aid-in-dying die in a public place, the state may receive revenue to reimburse any costs incurred. Any increases in revenue are assumed to be minimal. This measure also increases state spending by at least $27,874 and 0.3 FTE in FY 2016-17 and by at least $44,041 and 0.5 FTE in FY 2017-18 and future years. The measure requires the Department of Public Health and Environment to collect information about health care provider compliance and to prepare an annual report, requiring 0.5 FTE per year. First-year costs are prorated to assume a January 1, 2017, start date. This measure may also affect agencies within the Judicial Department related to any criminal or civil liability cases, as well as any claims by a state or local government for damages resulting from an individual choosing to end his or her life in a public space. To the extent that persons are convicted of one of the class 2 felony offenses created by the measure and that penalty is greater than what they would have been charged with otherwise, costs will increase for the Department of Corrections. Certain departments will also have rule-making and other costs associated with communicating with medical providers and insurance companies.

Local government impact. This measure may affect local governments in several ways. First, it may increase workload for district attorneys to prosecute any new criminal offenses under the measure. Second, training costs may be incurred for local governments that employ paramedics or other first responders. Third, similar to the state, local governments may incur costs to update rules and policies to communicate their intentions to participate or opt out of medical aid-in-dying at any hospitals, jails, or other facilities operated by the local government. Finally, if a person participating in medical aid-in-dying chooses to end his or her life in a public place, local governments may incur costs. To the extent that this occurs and the deceased person has assets, costs may be offset by an increase in revenue from the deceased person's estate. These impacts are assumed to be minimal.