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F I S C A L   I M P A C T   R E P O R T

SPONSOR Armstrong, D/ McCamley **ORIGINAL DATE** 2/1/17 **LAST UPDATED** 2/7/17 **HB** 171/aHHHC

SHORT TITLE End of Life Options Act **SB**

ANALYST Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY17	FY18	FY19	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	Minimal*	Minimal*	Minimal*	Minimal*	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases) *See "Fiscal implications below for possible costs and averted costs.

Duplicates, with minor exceptions, Senate Bill 252.

SOURCES OF INFORMATION
LFC Files

Responses Received From
New Mexico Medical Board (MB)
Attorney General's Office (AGO)
Board of Nursing (BN; to Senate Bill 252)

SUMMARY

Synopsis of Amendment

The House Health and Human Services Committee amendment modifies and simplifies the language in the last section of the bill, further clarifying the difference between assisted suicide, a fourth degree felony, and the immunity-protected aid in dying.

Synopsis of Original Bill

House Bill 171 would provide terminally ill but still mentally competent adults the option of having medical assistance in bringing about their own death. Currently it is illegal for a medical practitioner to provide a prescription that a patient might take to end hid/her life; this bill would sanction that practice, with multiple safeguards.

The attending health care provider would have to determine that the patient had the mental capacity to make the ultimate decision, that he/or she had a terminal illness, has made the request for aid without coercion from medical care personnel or from family members, can take the

prescribed medication, and has been fully informed about other options, including hospice care and palliative care. Risks and probable results of taking the medication prescribed would have to have been discussed with the patient, and the patient would have to take the medication on his/her own.

The legislation specifies that the death certificate would indicate the cause of death to be the underlying illness, not the medication the patient has taken. A form that can be used to inform the patient, form a basis for discussion between the patient and the medical care provider, and then possibly signed by the patient, is a resource that is made part of the bill.

Provisions in contracts, wills or agreements would have no effect on the options available to terminally ill people under the bill; likewise, obligations made by the patient under a contract would not be affected by provisions of the bill.

Legal immunity and immunity from license actions are given to health care providers, the patient's caregivers and any other person that "acts to assist the attending health care provider or patient" who acts in good faith to comply with the provisions of the bill.; applying neglect or adult abuse sanctions is expressly prohibited. On the other hand, medical care providers would incur no liability for being unwilling to participate in prescribing lethal medication; if there were a referral to another provider for that purpose, records are to be provided to the new health care provider.

There is a severability clause.

Section 30-2-4 NMSA 1978 is amended to exempt persons aiding patients dying in this way from those who would be considered to have committed suicide and be subject to felony prosecution. For purposes of this amendment, "adult,", "attending health care provider", "capacity", "medical aid in dying", "self-administer", and "terminal illness" are defined in the same way as in Section 3 of the bill, including the definition of "terminal illness" as "in accordance with reasonable medical judgment, will result in death within a reasonably foreseeable period of time."

FISCAL IMPLICATIONS

None identified by the agencies. Possible impacts could come from costs of the need to litigate portions of the provisions and costs averted from avoiding futile interventions in patients with state-supported health care.

SIGNIFICANT ISSUES

Oregon enacted a Death with Dignity Act in 1997, which was affirmed by a large majority of voters in a subsequent election. In the first 18 years after that, 1545 people had prescriptions written to aid in their dying, and 991 actually used those prescriptions. In the most recent year available, 2015, 132 people died having used these medications, but the proportion of deaths in this way was less than 0.4 per cent. Over 90 percent of patients dying in this way were receiving hospice care; over 90 percent died at home. The majority of patients had cancer, although amyotrophic lateral sclerosis (Lou Gehrig disease) and severe lung and heart disease were responsible for a moderate number of terminal illnesses so treated. Almost all patients died from use of a prescribed barbiturate. The results of the Oregon Health Authority's analysis of the data are in the attachment.

The proportion of patients dying with an assist from physician-prescribed medication thus remains low in Oregon. Physicians in Oregon are required to make a report to the Health Authority within ten days of the death, and are asked to specify what factors the physician believes led to the request. The most common reasons specified are loss of autonomy (93%), decreasing ability to participate in activities making life enjoyable (88.7%), and loss of dignity (50.3%). Inadequate pain control (23.7%) and financial concerns (2.9%) are far less common.

Several other states – California, Washington, and Vermont – have adopted variations of the "death with dignity" principle into statute; Montana allows physician aid in dying pursuant to a court order, but New Mexico's Supreme Court declined to affirm a lower court's decision to allow the practice in 2016, stating that the matter should be decided legislatively, not judicially. Many other states are considering legislation on the subject according to the National Conference of State Legislatures.

Both the Oregon statute and the New Mexico proposal specify that medical care providers must discuss options with patients before prescribing life-ending medications. This could be looked upon as a benefit of a death with dignity or End of Life Options act: that patients would be made aware of other options: advance directives, declining life prolonging care, palliative care and hospice care through having that discussion openly with their medical care providers as specified in this bill.

AGO notes that the 2009 Uniform health-care decisions act specified that physicians were immune from prosecution for withdrawing life support at a patient's request:

> The elements of the right to exercise self-determination over medical decision making are well recognized in both federal and state law. The UHCDA authorizes competent adults to terminate life sustaining treatment even if such termination would result in death. Competent adults can exercise the right to hasten death and can provide advance directives in anticipation of such a circumstance. § 24-7A-2(A). A physician who withdraws life sustaining medical treatment pursuant to the UHCDA is immune from criminal liability for such actions. § 24-7A-9(A) (1). A physician who administers pain medication to a patient, resulting in the natural hastening of death is also immune from liability under the Pain Relief Act, §24-2D-3.

The Medical Board indicates that "It should be noted that there is not necessarily support for aid in dying, even the NMMB and the medical community in general. There is a clear difference of opinion amongst practitioners. The American Medical Association, Ethical code for instance, states that "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." AMA Principles of Medical Ethics: I, IV, 5.7 Physician-Assisted Suicide. The NMMB has adopted the AMA Code of Ethics [which opposes physician aid in dying] as the ethical code NM physicians must follow. Thus any allowance for aid in dying must be codified in statute and similarly must be adopted in regulation."

DUPLICATES

Senate Bill 252, with the exception that the latter removes the definitions in Section 10, relying on those in Section 2 of the House and Senate Bills.

TECHNICAL ISSUES

"Death within a reasonable period of time" carries no time limit, although some have said that patients' expected remaining life is difficult for any person to determine.

Institutions' immunity from prosecution for either aiding in dying or refusing to aid in dying is not addressed.

BN comments that the definition of "assisting suicide" in the existing Section 30-2-4 NMSA 1978 is vague, and might apply to a pharmacist filling a prescription for the medication to be taken, or to the nurse working with the patient.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Terminally ill patients could continue to choose death through removal of life-prolonging treatment, but would not be able to avail themselves of prescribed medications for the purpose of causing their death.

LAC/jle/al/jle

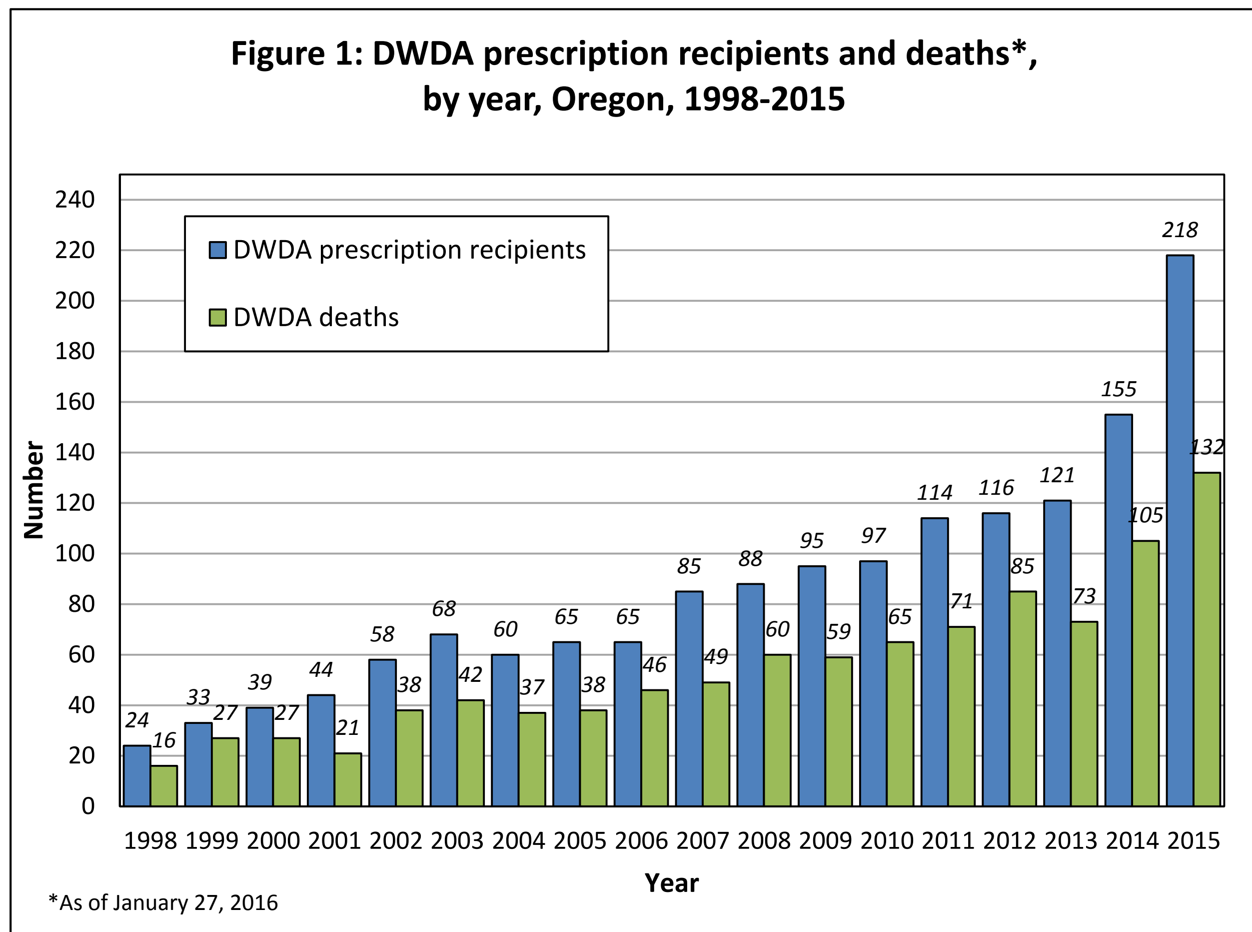
OREGON DEATH WITH DIGNITY ACT: 2015 DATA SUMMARY

Oregon Public Health Division
February 4, 2016

For more information:
http://www.healthoregon.org/dwd
Contact: DWDA.info@state.or.us

Introduction

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. Data presented in this summary, including the number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of the medications (DWDA deaths), are based on required reporting forms and death certificates received by the Oregon Public Health Division as of January 27, 2016. More information on the reporting process, required forms, and annual reports is available at: http://www.healthoregon.org/dwd.



Participation Summary and Trends

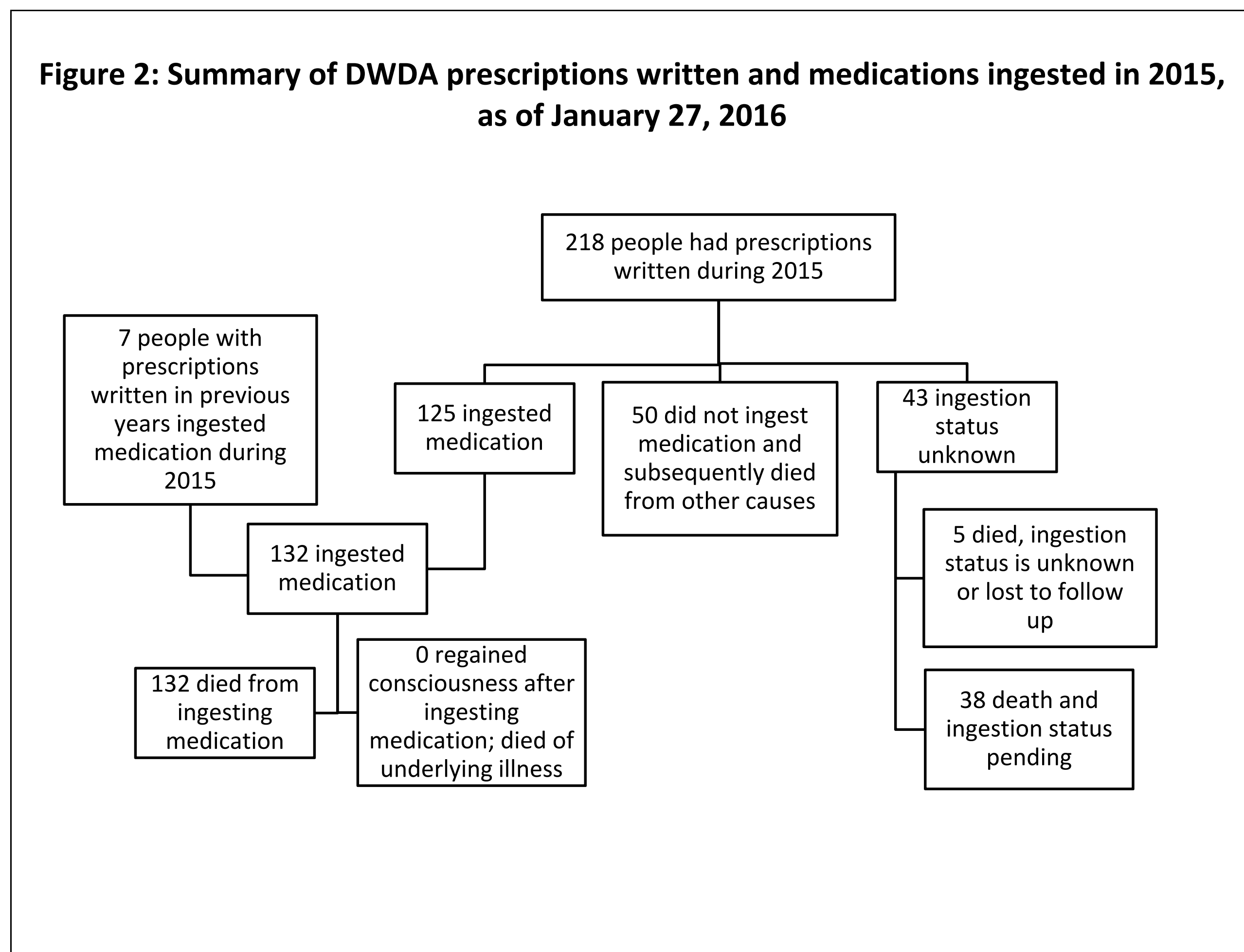
During 2015, 218 people received prescriptions for lethal medications under the provisions of the Oregon DWDA, compared to 155 during 2014 (Figure 1, above). As of January 27, 2016, the Oregon Public Health Division had received reports of 132 people who had died during 2015 from ingesting the medications prescribed under DWDA.

Since the law was passed in 1997, a total of 1,545 people have had prescriptions written under the DWDA, and 991 patients have died from ingesting the medications. From 1998 through 2013, the number of prescriptions written annually increased at an average of 12.1%; however, during 2014 and

2015, the number of prescriptions written increased by an average of 24.4%. During 2015, the rate of DWDA deaths was 38.6 per 10,000 total deaths.[1]

A summary of DWDA prescriptions written and medications ingested are shown in Figure 2. Of the 218 patients for whom prescriptions were written during 2015, 125 (57.3%) ingested the medication; all 125 patients died from ingesting the medication without regaining consciousness. Fifty of the 218 patients who received DWDA prescriptions during 2015 did not take the medications and subsequently died of other causes.

Ingestion status is unknown for 43 patients prescribed DWDA medications in 2015. Five of these patients died, but they were lost to follow-up or the follow-up questionnaires have not yet been received. For the remaining 38 patients, both death and ingestion status are pending (Figure 2).



[1] Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2014 (34,160), the most recent year for which final death data are available.

Patient Characteristics

Of the 132 DWDA deaths during 2015, most patients (78.0%) were aged 65 years or older. The median age at death was 73 years. As in previous years, decedents were commonly white (93.1%) and well-educated (43.1% had a least a baccalaureate degree).

While most patients had cancer, the percent of patients with cancer in 2015 was slightly lower than in previous years (72.0% and 77.9%, respectively). The percent of patients with amyotrophic lateral sclerosis (ALS) was also lower (6.1% in 2015, compared to 8.3% in previous years). Heart disease increased from 2.0% in prior years to 6.8% in 2015.

Most (90.1%) patients died at home, and most (92.2%) were enrolled in hospice care. Excluding unknown cases, most (99.2%) had some form of health care insurance, although the percent of patients who had private insurance (36.7%) was lower in 2015 than in previous years (60.2%). The number of patients who had only Medicare or Medicaid insurance was higher than in previous years (62.5% compared to 38.3%).

Similar to previous years, the three most frequently mentioned end-of-life concerns were: decreasing ability to participate in activities that made life enjoyable (96.2%), loss of autonomy (92.4%), and loss of dignity (75.4%).

DWDA Process

A total of 106 physicians wrote 218 prescriptions during 2015 (1-27 prescriptions per physician). During 2015, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements. During 2015, five patients were referred for psychological/ psychiatric evaluation.

A procedure revision was made in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. For 27 patients, either the prescribing physician or another healthcare provider was present at the time of death. Prescribing physicians were present at time of death for 14 patients (10.8%) during 2015 compared to 15.7% in previous years; 13 additional cases had other health care providers present (e.g. hospice nurse). Data on time from ingestion to death is available for only 25 DWDA deaths during 2015. Among those 25 patients, time from ingestion until death ranged from five minutes to 34 hours. For the remaining two patients, the length of time between ingestion and death was unknown.

Table 1. Characteristics and end-of-life care of 991 DWDA patients who have died from ingesting DWDA medications, by year, Oregon, 1998-2015

Characteristics	2015 (N=132)	1998-2014 (N=859)	Total (N=991)
Sex	N (%)[1]	N (%)[1]	N (%)[1]
Male (%)	56 (42.4)	453 (52.7)	509 (51.4)
Female (%)	76 (57.6)	406 (47.3)	482 (48.6)
Age at death (years)			
18-34 (%)	1 (0.8)	7 (0.8)	8 (0.8)
35-44 (%)	5 (3.8)	18 (2.1)	23 (2.3)
45-54 (%)	2 (1.5)	61 (7.1)	63 (6.4)
55-64 (%)	21 (15.9)	184 (21.4)	205 (20.7)
65-74 (%)	41 (31.1)	247 (28.8)	288 (29.1)
75-84 (%)	30 (22.7)	229 (26.7)	259 (26.1)
85+ (%)	32 (24.2)	113 (13.2)	145 (14.6)
Median years (range)	73 (30-102)	71 (25-96)	71 (25-102)
Race			
White (%)	122 (93.1)	831 (97.1)	953 (96.6)
African American (%)	0 (0.0)	1 (0.1)	1 (0.1)
American Indian (%)	0 (0.0)	2 (0.2)	2 (0.2)
Asian (%)	4 (3.1)	9 (1.1)	13 (1.3)
Pacific Islander (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	0 (0.0)	3 (0.4)	3 (0.3)
Two or more races (%)	1 (0.8)	3 (0.4)	4 (0.4)
Hispanic (%)	4 (3.1)	6 (0.7)	10 (1.0)
Unknown	*1*	*3*	*4*
Marital status			
Married (including Registered Domestic Partner) (%)	52 (39.7)	395 (46.1)	447 (45.3)
Widowed (%)	34 (26.0)	198 (23.1)	232 (23.5)
Never married (%)	9 (6.9)	69 (8.1)	78 (7.9)
Divorced (%)	36 (27.5)	194 (22.7)	230 (23.3)
Unknown	*1*	*3*	*4*
Education			
Less than high school (%)	7 (5.4)	51 (6.0)	58 (5.9)
High school graduate (%)	31 (23.8)	187 (21.9)	218 (22.2)
Some college (%)	36 (27.7)	224 (26.2)	260 (26.4)
Baccalaureate or higher (%)	56 (43.1)	392 (45.9)	448 (45.5)
Unknown	*2*	*5*	*7*
Residence			
Metro counties (Clackamas, Multnomah, Washington) (%)	64 (49.2)	361 (42.3)	425 (43.2)
Coastal counties (%)	7 (5.4)	63 (7.4)	70 (7.1)
Other western counties (%)	48 (36.9)	365 (42.7)	413 (42.0)
East of the Cascades (%)	11 (8.5)	65 (7.6)	76 (7.7)
Unknown	*2*	*5*	*7*
End of life care			
Hospice			
Enrolled (%)	118 (92.2)	747 (90.2)	865 (90.5)
Not enrolled (%)	10 (7.8)	81 (9.8)	91 (9.5)
Unknown	*4*	*31*	*35*
Insurance			
Private (alone or in combination) (%)	44 (36.7)	489 (60.2)	533 (57.2)
Medicare, Medicaid or other governmental (%)	75 (62.5)	311 (38.3)	386 (41.4)
None (%)	1 (0.8)	12 (1.5)	13 (1.4)
Unknown	*12*	*47*	*59*

Characteristics	2015 (N=132)	1998-2014 (N=859)	Total (N=991)
Underlying illness			
Malignant neoplasms (%)	**95 (72.0)**	**667 (77.9)**	**762 (77.1)**
Lung and bronchus (%)	23 (17.4)	154 (18.0)	177 (17.9)
Breast (%)	9 (6.8)	64 (7.5)	73 (7.4)
Colon (%)	7 (5.3)	54 (6.3)	61 (6.2)
Pancreas (%)	7 (5.3)	56 (6.5)	63 (6.4)
Prostate (%)	5 (3.8)	35 (4.1)	40 (4.0)
Ovary (%)	3 (2.3)	33 (3.9)	36 (3.6)
Other (%)	41 (31.1)	271 (31.7)	312 (31.6)
Amyotrophic lateral sclerosis (%)	**8 (6.1)**	**71 (8.3)**	**79 (8.0)**
Chronic lower respiratory disease (%)	**6 (4.5)**	**38 (4.4)**	**44 (4.5)**
Heart disease (%)	**9 (6.8)**	**17 (2.0)**	**26 (2.6)**
HIV/AIDS (%)	**0 (0.0)**	**9 (1.1)**	**9 (0.9)**
Other illnesses (%)[2]	**14 (10.6)**	**54 (6.3)**	**68 (6.9)**
Unknown	***0***	***3***	***3***
DWDA process			
Referred for psychiatric evaluation (%)	5 (3.8)	47 (5.5)	52 (5.3)
Patient informed family of decision (%)[3]	126 (95.5)	729 (93.2)	855 (93.5)
Patient died at			
Home (patient, family or friend) (%)	118 (90.1)	810 (94.6)	928 (94.0)
Long term care, assisted living or foster care facility (%)	9 (6.9)	37 (4.3)	46 (4.7)
Hospital (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	4 (3.1)	8 (0.9)	12 (1.2)
Unknown	*1*	*3*	*4*
Lethal medication			
Secobarbital (%)	114 (86.4)	466 (54.2)	580 (58.5)
Pentobarbital (%)	1 (0.8)	385 (44.8)	386 (39.0)
Phenobarbital/chloral hydrate/morphine sulfate mix (%)	16 (12.1)	0 (0.0)	16 (1.6)
Other (combination of above and/or morphine) (%)	1 (0.8)	8 (0.9)	9 (0.9)
End of life concerns[4]	**(N=132)**	**(N=859)**	**(N=991)**
Less able to engage in activities making life enjoyable (%)	127 (96.2)	758 (88.7)	885 (89.7)
Losing autonomy (%)	121 (92.4)	782 (91.5)	903 (91.6)
Loss of dignity (%)[5]	98 (75.4)	579 (79.3)	677 (78.7)
Losing control of bodily functions (%)	46 (35.7)	428 (50.1)	474 (48.2)
Burden on family, friends/caregivers (%)	63 (48.1)	342 (40.0)	405 (41.1)
Inadequate pain control or concern about it (%)	37 (28.7)	211 (24.7)	248 (25.2)
Financial implications of treatment (%)	3 (2.3)	27 (3.2)	30 (3.1)
Health care provider present (collected 2001-present)	**(N=132)**	**(N=789)**	**(N=921)**
When medication was ingested[6]			
Prescribing physician	15	133	148
Other provider, prescribing physician not present	13	243	256
No provider	6	81	87
Unknown	*98*	*332*	*430*
At time of death			
Prescribing physician (%)	14 (10.8)	121 (15.7)	135 (15.0)
Other provider, prescribing physician not present (%)	13 (10.0)	268 (34.7)	281 (31.2)
No provider (%)	103 (79.2)	383 (49.6)	486 (53.9)
Unknown	*2*	*17*	*19*

Characteristics	2015 (N=132)	1998-2014 (N=859)	Total (N=991)
Complications[6]	**(N=132)**	**(N=859)**	**(N=991)**
Regurgitated	2	22	24
Other	2	1	3
None	23	506	529
Unknown	*105*	*330*	*435*
Other outcomes			
Regained consciousness after ingesting DWDA medications[7]	0	6	6
Timing of DWDA event			
Duration (weeks) of patient-physician relationship			
Median	9	13	12
Range	1-1004	0-1905	0-1905
Number of patients with information available	*132*	*857*	*989*
Number of patients with information unknown	*0*	*2*	*2*
Duration (days) between 1st request and death			
Median	45	47	46
Range	15-517	15-1009	15-1009
Number of patients with information available	*131*	*859*	*990*
Number of patients with information unknown	*1*	*0*	*1*
Minutes between ingestion and unconsciousness[6]			
Median	5	5	5
Range	2-15	1-38	1-38
Number of patients with information available	*25*	*506*	*531*
Number of patients with information unknown	*107*	*353*	*460*
Minutes between ingestion and death[6]			
Median	25	25	25
Range (minutes - hours)	5mins-34hrs	1min-104hrs	1min-104hrs
Number of patients with information available	*25*	*511*	*536*
Number of patients with information unknown	*107*	*348*	*455*

1 Unknowns are excluded when calculating percentages.

2 Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease.

3 First recorded beginning in 2001. Since then, 40 patients (4.4%) have chosen not to inform their families, and 19 patients (2.1%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and 3 in 2013.

4 Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

5 First asked in 2003. Data available for 130 patients in 2015, 730 patients between 1998-2014, and 860 patients for all years.

6 A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.

7 Six patients have regained consciousness after ingesting prescribed medications, and are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (http://www.healthoregon.org/dwd) for more detail on these deaths.