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

SPONSOR SJC **ORIGINAL DATE** 2/02/17 **LAST UPDATED** 3/15/17 **HB**

SHORT TITLE End of Life Options Act **SB** 252/SJCS

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, House Bill 171.

SOURCES OF INFORMATION
LFC Files

Responses Received From
New Mexico Medical Board (MB)
Office of the Attorney General (OAG; to House Bill 171)
Board of Nursing (BN)

SUMMARY

Synopsis of Committee Substitute

Note: The Committee Substitute makes substantial changes to the original bill, including requirements for consultation with a second physician and with a mental-health consultation if any physician thinks there may be diminution in the patient's mental capacity, changes in the informed consent, a change in the expected duration of remaining life. A delay in filling the prescription for lethal medication is mandated. Patients must be counseled regarding all options for care available to dying patients. The paragraphs below incorporate these changes.

Senate Bill 252 would provide terminally ill (expected to die within six months) but still mentally competent adults, resident in New Mexico, 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 his/her life; this bill would sanction that practice, with multiple safeguards.

Two health care providers 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. If there were questions about the patient's mental capacity, a licensed mental health care provider would have to ascertain that there was no loss of mental capacity. Risks and probable results of taking the medication prescribed would have to have been discussed with the patient with other options explained, and the patient would have to take the medication on his/her own. There would be a mandatory 48-hour waiting period between the time the prescription was written and the time the prescription is filled.

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 is included that itself or in similar form is to be used to inform the patient, form a basis for discussion between the patient and the medical care provider, and then signed by the patient, to be initialed at each paragraph and signed by the patient and then witnessed by two individuals, one of whom cannot be a family member.

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.

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,", "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 six-month 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.

OAG 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 House Bill 171.

TECHNICAL ISSUES

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/sb/al