

# Lawmakers Guide: Drafting Aid-in-Dying Legislation



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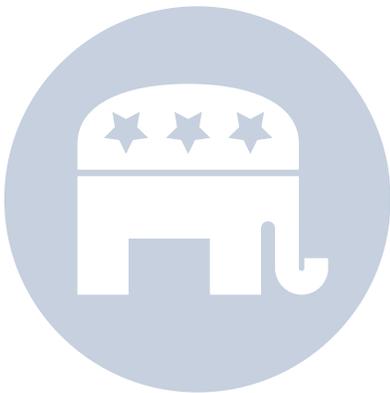
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**I don't think it's a true party-line issue for either side. It's a very personal issue, and I think it's something each member will have to vote their conscience on.**

– House Minority Leader Brian DelGrosso (R-Colorado)

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# SECTION I: Introduction

## Attention Lawmakers!

This brief resource is designed to provide up-to-date, reliable information about drafting and introducing legislation that supports the medical option of aid in dying.

*Compassion & Choices is committed to **working with legislators from every state and political party** who seek to honor their constituents by expanding options for people who are dying.*

This guide to drafting aid-in-dying legislation is offered in the spirit of partnership, and in the hope that we can build on the positive experiences of states and other jurisdictions where this option has been successfully enacted.

Legislation to authorize aid in dying is of great importance to voters who support its enactment in consistently large majorities, as measured by independent polling outlets such as [Gallup](#) (68% support in May of 2015) and [Harris](#) (74% support in November 2014). State-by-state polling also indicates majority support that cuts across demographics.

Legislators from all walks of life nationwide have stepped up to sponsor aid-in-dying bills. In 2014 and 2015 more than 200 individual elected leaders put their names on bills as sponsors or co-sponsors in at least 25 legislatures (including the Washington, D.C., City Council). These bills were proposed in every region of the country, including the Libertarian West, the Bible Belt, the Midwest and both coasts. This legislative movement has been covered by notable policy outlets including *Governing Magazine* and *Pew Stateline News*, as well as mainstream outlets such as *USA Today* and *The New York Times*.



More than  
**200 individual  
elected leaders**  
(co)sponsored  
**aid-in-dying  
legislation** in  
2014 and 2015.

**The New York Times**

**The Washington Post**

**LaOpinión**



Indeed, last year aid in dying received extraordinary media attention across the country. Major national outlets editorialized in support of aid in dying, including *The New York Times*, *The Washington Post*, *The Economist* and *La Opinión*. But more importantly for your work, in states where aid-in-dying laws have been drafted, newspaper editorial boards consistently endorse the legislation, including [\*The Newark \(NJ\) Star Ledger\*](#), [\*The Trenton \(NJ\) Times\*](#), [\*The Hartford \(CT\) Courant\*](#), [\*The Portland \(ME\) Press Herald\*](#), [\*The Bozeman \(MT\) Chronicle\*](#), [\*The Des Moines \(IA\) Register\*](#), [\*The Philadelphia \(PA\) Daily News\*](#), [\*The Denver \(CO\) Post\*](#), [\*The Los Angeles \(CA\) Times\*](#), and [\*The Sacramento \(CA\) Bee\*](#).

Noting the issue's broad support, mainstream broadcast and digital outlets have given it extensive, heartening attention including Katie Couric on Yahoo! News, Oprah Winfrey on OWN, *The View* on ABC, People.com and Diane Rehm on NPR, among others.

Your constituents will thank you for introducing and supporting legislation that authorizes the medical practice of aid in dying, and we thank you for recognizing that this bipartisan, popular issue deserves your attention next legislative session.

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**How each of us spends the end of our lives is a deeply personal decision, and that decision should remain with the individual as a matter of personal freedom and liberty, without criminalizing those who help to honor our wishes and ease our suffering. This law will honor that freedom with appropriate protections to prevent any abuse.**

– Senator Lois Wolk (D-California)

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# SECTION II: Public Opinion

## Broad Public Support

When introducing new legislation, or deciding whether to support a bill, understanding where the public stands is critical. Public opinion polls offer an important and reliable indication of majority support for aid in dying. It is always prudent to look at how an issue polls over time from a variety of sources and in a cross section of geography.

*The evidence shows that **aid in dying commands long-term, bipartisan majority support among American voters**. Independent pollsters such as [Harris](#), [Gallup](#) and [Pew](#) all put support for aid in dying somewhere between 65% and 75% nationwide.*

Perhaps more importantly, majority support for aid in dying is demonstrated across a range of demographics; chances are your district supports aid in dying. For example, [California voters](#) show significant majorities in every voter subgroup, including 70% among Latinos, 67% among African Americans and 69% among Asian-Pacific Islanders.<sup>1</sup> Similarly, in 2014 [New Jersey's PurplePoll](#) found 63% support among voters who are disabled and 55% support among Catholic voters.<sup>2</sup>

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**I have talked with a multitude of legislators.  
There is a lot of quiet support.**

– Senator Dan Zwonitzer (R-Wyoming)

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<sup>1</sup> [Goodwin Simon & Probolshy Research Poll, June 2015.](#)

<sup>2</sup> [Purple Strategies, February 2014.](#)

National Polls		State Polls	
	<p><b>2011</b> 67% Support Aid in Dying</p>	<p><b>2011</b> <b>HAWAII</b> 71% Support Aid in Dying</p>	
	<p><b>2012</b> 55% Support Aid in Dying</p>	<p><b>2012</b> <b>VERMONT</b> 74% Support Aid in Dying</p>	
<p>PewResearchCenter</p>	<p><b>2013</b> 62% Support Right to Die</p>	<p><b>2012</b> <b>NEW MEXICO</b> 65% Support Aid in Dying</p>	
	<p><b>2014</b> 74% Support Aid in Dying</p>	<p><b>2013</b> <b>MONTANA</b> 69% Support Aid in Dying</p>	
<p>GALLUP®</p>	<p><b>2015</b> 68% Support Aid in Dying</p>	<p><b>2015</b> <b>NEW JERSEY</b> 63% Support Aid in Dying</p>	
		<p><b>2015</b> <b>MARYLAND</b> 60% Support Aid in Dying</p>	
		<p><b>2015</b> <b>CONNECTICUT</b> 63% Support Aid in Dying</p>	
		<p><b>2015</b> <b>CALIFORNIA</b> 69% Support Aid in Dying</p>	

# SECTION III:

# Language

## Discussing Aid in Dying

***Elevator pitch:** When a dying person only has months, weeks or days to live and cannot be cured, we should honor and respect that person's decision to end their pain and suffering.*

### Key Terms and Definitions

Here is some of the key language that underpins Compassion & Choices' legal and medical framework for legislation:

**Aid in dying** – The medical practice that allows a mentally capable, terminally ill adult to legally request a prescription for a life-ending medication from their physician. The medication must be self-administered.

**Terminal illness** – An irreversible and incurable illness for which the medical expectation is death. The federal definition of “terminally ill” is a probable life expectancy of six months or less.

**Death with dignity** – While there are many ways to die with dignity, the term “death with dignity” refers to both a concept and a movement, in which people gain dignity from making their own medical decisions. In both cases it includes the ideas of limiting suffering and providing control and choice at the end of life. Usually death with dignity also includes the option to request a prescription for medication to advance the death of a terminally ill adult.

**Palliative care** – Sometimes called “comfort care,” palliative care is aimed at relieving a person's physical and sometimes emotional pain through medication, physical therapy, spiritual counseling or other methods, and with the understanding that the treatment is not intended to cure or prolong life.



To learn  
more visit:

[ItsNotAssistedSuicide.org](http://ItsNotAssistedSuicide.org)

### Inaccurate and Inappropriate Terms:

**Euthanasia** – The intentional ending of a person’s life, performed on a patient by a medical professional and usually by lethal injection. The medication is not self-administered, and the patient is not necessarily dying. Euthanasia is illegal everywhere in the United States and is not a practice Compassion & Choices supports.

**Suicide** – Choosing death over life, often due to an underlying condition such as depression, which if identified and properly treated can allow the person to live a full life. On the contrary, a terminally ill person is actively dying and therefore no longer choosing death over life, but rather one form of death over another.

**Physician-assisted suicide** – Apart from the incorrect reference to suicide, the medical protocols for aid in dying require the medication to be self-administered, making this term inaccurate on both counts.

### Medical, Faith and Disability-Rights Communities

Gathering support from key constituencies is critical to passing your bill. Here is some useful information that will assist you in this effort.

#### Medical support

Many leading national professional medical associations support aid in dying because it empowers physicians to respect their patients’ wishes. The American Public Health Association, the American College of Legal Medicine, the American Medical Women’s Association and the American Medical Student Association support open access to aid in dying. Also, a highly reliable [Medscape poll](#) of U.S. physicians in December 2014 found a majority (54%) of doctors now support medical aid in dying.

Significantly, after reviewing the California End of Life Option Act, the state’s medical association (the largest in the nation) decided to take a neutral position on death-with-dignity legislation. In a press release they said, “We believe it is up to the individual physician and their patient to decide voluntarily whether the End of Life Option Act is something in which they want to engage. Protecting that physician-patient relationship is essential.”



## Faith

Aid in dying isn't about playing God or trying to control nature; it's about honoring a dying person's decision to end their pain and suffering. Notable religious leaders support aid in dying because they believe God doesn't want people to suffer; their support for end-of-life options is rooted in their faith and not in spite of it.

[Archbishop Desmond Tutu](#) expounded, "I have been fortunate to spend my life working for dignity for the living. Now I wish to apply my mind to the issue of dignity for the dying. I revere the sanctity of life — but not at any cost ... People should die a decent death. For me that means having had the conversations with those I have crossed with in life and being at peace. It means being able to say goodbye to loved ones — if possible, at home."

Similarly, retired [Episcopal Bishop Gene Robinson](#) reasoned, "There is nothing innately good about allowing 'nature' to take its course in a prolonged and painful journey to an inevitable death. It doesn't make you a better person because you endured the indignity and trauma of it. You don't get extra stars for it ... Shouldn't the right to end one's life also be provided for those [terminally ill people] who would choose it?"

Many people who consider using aid in dying say that praying about the decision brought them closer to God, just as conversations about the decision brought them together as a family, and they view that intimacy as a miracle in and of itself.

Remember, an inclusive approach is always best. Our country is built on respect for religious diversity. As a lawmaker you should never be dismissive of or combative with faith communities.

## Protecting people who are vulnerable

Opponents of aid in dying may argue that death-with-dignity laws are subject to abuse and that these laws harm vulnerable populations, but the fact is there is simply no evidence or data to support any of these claims. A report published in the [Journal of Medical Ethics](#) about the Oregon Death With Dignity Act concluded: "Rates of assisted dying in Oregon showed no evidence of heightened risk for ... the physically disabled or chronically ill." In fact, there has not been a single documented case of abuse or misuse related to existing aid-in-dying laws, and no one has ever been charged with a crime. Since the implementation of the law in 1997, the Oregon Health Authority has collected comprehensive data about the implementation of the Death With Dignity Act. Seventeen annual reports, as well as a host of medical articles and other resources, are posted online.

*Both data and research indicate **the Oregon law works as intended**, with no evidence of harm to vulnerable populations.*

# SECTION IV:

# How the Law Works

## FAQ: The Medical Practice of Aid in Dying

While you should focus on the heart of the matter in any campaign speech — honoring and respecting a dying person’s decision to end their pain and suffering — understanding the medical realities is critical for your credibility. Sometimes people who don’t understand how aid in dying works fill in the blanks on their own and confuse the practice with euthanasia or assisted suicide. For those people, setting the record straight solidifies support.

### Who is eligible for aid in dying?

Aid in dying is not widely used or requested. To receive an aid-in-dying prescription from a doctor, people must be over 18, in the final stages of a terminal illness as confirmed by a second opinion, of sound mind, and they must take the medicine by themselves (self-administer).

### What if people change their minds?

One-third of people who receive a prescription for aid-in-dying medication choose not to take the medicine. Having the medication on hand provides them peace of mind by knowing they can end their pain and suffering should it become too great.

### How do people use aid-in-dying medication?

A terminally ill person must ask his or her doctor to prescribe the aid-in-dying medication. Pharmacies either prepare the medication to be mixed into a liquid — water is the best, most effective option — or people open capsules to mix into the liquid. Usually, the dying person drinks anti-nausea medication an hour prior to drinking the aid-in-dying medication. The aid-in-dying medication, which usually is a fast-acting barbiturate, causes a person to fall asleep into unconsciousness, and death usually follows quickly. It takes an average of five minutes for the person to become unconscious and 25 minutes to pass away.



#### Aid in dying authorized in:

Oregon  
Washington  
Montana  
Vermont

### **How well has aid in dying worked in the four states where it is already authorized?**

Aid in dying is currently authorized in Oregon, Washington, Montana, Vermont, and there has never been a single instance of reported abuse. In Oregon, end-of-life care has improved overall since the law's implementation, in large part due to the dialogue it encourages between people and their doctors. Hospice referrals are up, as is the use of palliative care. Oregon now has the lowest rates of in-hospital deaths and the highest rates of at-home deaths in the nation, and violent suicide among hospice patients has virtually disappeared. Almost two decades of rigorously observed and documented experience in Oregon show us the law has worked as intended, with none of the problems opponents had predicted.



**End-of-life care has improved overall since the law's implementation**

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**While there are many choices available right now that may be right for certain people, there is one more choice, not currently available, that deserves an honest discussion.**

– Assemblyman John Burzichelli (D-New Jersey)

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# SECTION V: Key Principles

## Key Principles for Drafting Your Bill

Compassion & Choices supports aid-in-dying legislation that includes the following key provisions, including key limitations below:

- » Legislation should explicitly authorize terminally ill, mentally capable adults with a prognosis of six months (expected to live six months or less) to request, receive and self-administer medication to advance the time of death if they so choose.
- » Legislation would apply only to terminally ill adults who are mentally capable to make their own healthcare decisions, are free from undue influence and coercion, and have a prognosis of six months.
- » Legislation should treat aid in dying as one of many choices under a medical standard of care that terminally ill adults may consider when determining what course of treatment they wish to pursue.
- » As part of a medical standard of care, anything that unduly limits or burdens an individual who wishes to obtain information or access aid in dying should be rejected. This includes:
  1. Erecting barriers to access the law by adding multiple request requirements or increasing waiting periods.
  2. Imposing outside legal institutions or procedures into the physician-patient decision-making process, e.g. probate courts or ethics committees.
  3. Diminishing a mentally capable, terminally ill adult's control by giving another individual veto power or mandatory surrogate decision-making authority.
  4. Treating all individuals who ask for aid in dying as if they are, or are likely to be, mentally ill, e.g. creating a presumption of mental illness to be overcome with psychiatric evaluation in all cases.
  5. Mandating that certain individuals be present when the medication is self-administered or that self-administration take place at a particular location.
  6. Compelling or preventing healthcare providers' participation in aid in dying.
  7. Preventing individuals from getting accurate, complete information about aid in dying by disallowing them to transfer their care from a nonparticipating physician to a participating one.

# SECTION VI:

# Resources

## Where to Learn More

Significant informational resources are available at the Compassion & Choices website, including detailed background information on many aspects of end-of-life care and choice.

Find downloadable PDF documents including “The Language of End-of-Life-Choice, Access to Care, Unwanted Medical Treatment” and more at: [CompassionAndChoices.org/newsroom](https://www.compassionandchoices.org/newsroom)

## Legislative Committee Hearings

Compassion & Choices can provide high-quality speakers to offer testimony for committee hearings; often, their stories are of a moving personal nature. Because our efforts are national, we can turn out grassroots supporters in every state and can organize expert speakers on a range of topics including current death with dignity laws, medical ethics, matters of faith and broader issues around end-of-life care.

Contact Compassion & Choices National Director of Political Affairs and Advocacy Jessica Grennan at [jgrennan@compassionandchoices.org](mailto:jgrennan@compassionandchoices.org) if you are planning a hearing.

# SECTION VII:

## Draft Oregon-Style Aid-in-Dying Legislation

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF \_\_\_\_\_:

### Section 1. Short title.

[Sections 1 through 17] may be cited as the "Patient Choice at End of Life Act."

### Section 2. Definitions.

As used in [sections 1 through 17], the following definitions apply:

(A) "Adult" means an individual 18 years of age or older.

(B) "Aid in dying" means the medical practice of a physician prescribing medication to a qualified individual, for which that individual may choose to self-administer to bring about a humane and dignified death.

(C) "Attending physician" means the physician who has primary responsibility for the care of an individual and treatment of the individual's terminal illness.

(D) "Capable" means that in the opinion of an individual's attending physician, consulting physician, psychiatrist or psychologist, the individual has the ability to make and communicate an informed decision to healthcare providers, including communication through a person familiar with the individual's manner of communicating if that person is available.

(E) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's illness.

(F) "Counseling" means one or more consultations as necessary between an individual and a psychiatrist or psychologist licensed in this state for the purpose of determining that the individual is capable and is not suffering from a psychiatric or psychological disorder or depression causing impaired decision making.

(G) "Healthcare provider" or "provider" means a person licensed, certified, or otherwise authorized or permitted by law to administer healthcare or dispense medication in the ordinary course of business or practice of a profession. The terms include a healthcare facility as governed by [state code].

(H) "Informed decision" means a decision by a terminally ill individual to request and obtain a prescription for medication that the individual may self-administer to end the individual's life that is based on an understanding and acknowledgment of the relevant facts and that is made after being fully informed by the attending physician of:

- (1) the individual's medical diagnosis and prognosis;
- (2) the potential risks associated with taking the medication to be prescribed;
- (3) the probable result of taking the medication to be prescribed;
- (4) the possibility that they may not choose to obtain the medication, or may obtain the medication but may decide not to take it; and
- (5) the feasible alternatives or additional treatment opportunities, including but not limited to comfort care, hospice care and pain control.

**(I)** "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the individual and the individual's relevant medical records.

**(J)** "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in this state.

**(K)** "Qualified individual" means an individual who has satisfied the requirements of [sections 1 through 17].

**(L)** "Self-administer" means some affirmative and voluntary act by a qualified individual to ingest the medication to bring about their own peaceful and humane death.

**(M)** "Terminal illness" means an incurable and irreversible illness that has been medically confirmed and will, within reasonable medical judgment, result in death within six (6) months.

### **Section 3. Right to request aid-in-dying medication.**

**(A)** A capable, terminally ill adult may make a request to receive a prescription for aid-in-dying medication if:

- (1) the individual's attending physician has determined the individual to be suffering from a terminal illness; and
- (2) the individual has voluntarily expressed the wish to receive a prescription for aid-in-dying medication.

**(B)** A person may not qualify under the provisions of [sections 1 through 17] solely because of age or disability.

### **Section 4. Request process – witness requirements.**

**(A)** An individual wishing to receive a prescription for aid-in-dying medication pursuant to this Act shall make one oral request and submit one written request to their attending physician.

**(B)** A valid written request for aid-in-dying medication under [sections 1 through 9] must be:

- (1) in substantially the form described in [section 9];
- (2) signed and dated by the individual seeking the medication; and
- (3) witnessed by at least two other individuals who, in the presence of the requestor, attests that to the best of their knowledge and belief the requestor is:
  - (a) capable;
  - (b) acting voluntarily and not being coerced to sign the request.

**(C)** One of the witnesses must be an individual who is not:

- (1) related to the requestor by blood, marriage or adoption;
- (2) at the time the request is signed, entitled to any portion of the requestor's estate upon death of the qualified individual under a will or any operation of law; or
- (3) an owner, operator, or employee of a healthcare facility where the requestor is receiving medical treatment or where the requestor resides.

**(D)** The requestor's attending physician may not be a witness to the signing of the written request.

## Section 5. Right to rescind request – requirement to offer opportunity to rescind.

(A) An individual may at any time rescind their request for aid-in-dying medication without regard to the individual's mental state.

(B) A prescription for aid-in-dying medication under [sections 1 through 17] may not be written without the attending physician offering the individual an opportunity to rescind the request.

## Section 6. Attending physician responsibilities.

(A) The attending physician shall:

- (1) make the initial determination of whether a requesting adult:
  - (a) is capable;
  - (b) has a terminal illness; and
  - (c) has voluntarily made the request for aid-in-dying medication pursuant to sections 3 and 4;
- (2) provide a standard of care under accepted medical guidelines;
- (3) ensure that the individual is making an informed decision by discussing with them:
  - (a) the individual's medical diagnosis and prognosis;
  - (b) the potential risks associated with taking the aid-in-dying medication to be prescribed;
  - (c) the probable result of taking the aid-in-dying medication to be prescribed;
  - (d) the possibility that they can choose to obtain the medication, but not take it; and
  - (e) the feasible alternatives or additional treatment opportunities, including but not limited to comfort care, hospice care, and pain control;
- (4) ensure that the individual's request does not arise from coercion or undue influence by another person;
- (5) counsel the individual about the importance of:
  - (a) having another person present when they take the aid-in-dying medication prescribed pursuant to [sections 1 through 17]; and
  - (b) not taking the aid-in-dying medication in a public place;
- (6) inform the individual that they may rescind the request for aid-in-dying medication at any time and in any manner;
- (7) offer the individual an opportunity to rescind the request for medication before prescribing the aid-in-dying medication;
- (8) verify, immediately prior to writing the prescription for medication, that the individual is making an informed decision;
- (9) ensure that all appropriate steps are carried out in accordance with [sections 1 through 17] before writing a prescription for aid-in-dying medication; and
- (10) dispense aid-in-dying medications directly, including ancillary medication intended to minimize the qualified individual's discomfort, if the attending physician:
  - (a) is registered as a dispensing physician with the board of medical examiners provided for in the [SDHC].
  - (b) has a current drug enforcement administration certificate; and
  - (c) complies with any applicable administrative rule; or
- (11) with the qualified individual's written consent, contact a pharmacist, inform the pharmacist of the prescription, and deliver the written prescription personally or by mail to the pharmacist, who shall dispense the medications to either the qualified individual, the attending physician or a person expressly designated by the qualified individual.

**Section 7. Death certificate.**

(A) Unless otherwise prohibited by law, the attending physician may sign the qualified individual's death certificate.

(B) The cause of death listed on an individual's death certificate who uses aid in dying will be the underlying terminal illness.

**Section 8. Informed decision required.**

(A) An individual may not receive a prescription for aid-in-dying medication pursuant to [sections 1 through 17] unless they have made an informed decision as defined in section 2. Immediately before writing a prescription for aid-in-dying medication under [sections 1 through 17], the attending physician shall verify that the individual is making an informed decision.

**Section 9. Form of request.**

A request for medication as authorized by [sections 1 through 8] must be in substantially the following form:

**REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER**

I, \_\_\_\_\_, am an adult of sound mind. I am suffering from \_\_\_\_\_, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment opportunities including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request, and I expect to die if I take the aid-in-dying medication prescribed. I further understand that although most deaths occur within three hours, my death may take longer, and my attending physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full responsibility for my actions.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

**DECLARATION OF WITNESSES**

We declare that the person signing this request:

- (a) is personally known to us or has provided proof of identity;
- (b) signed this request in our presence;
- (c) appears to be of sound mind and not under duress, fraud or undue influence; and
- (d) is not an individual for whom either of us is the attending physician.

\_\_\_\_\_  
 \_\_\_\_\_

Witness 1/Date

Witness 2/Date

NOTE: Only one of the two witnesses may be a relative (by blood, marriage, or adoption) of the person signing this request or be entitled to any portion of the person's estate upon death. Only one of the two witnesses may own, operate, or be employed at a healthcare facility where the person is a patient or where the person resides.

### Section 10. Standard of care.

(A) Physicians and medical personnel will provide medical services under this act that meet or exceed the standard of care for end-of-life medical care.

(B) Physicians shall inform terminally ill patients of all available options related to their care [under state statute].<sup>1</sup>

### Section 11. Effect on construction of wills, contracts and statutes.

(A) A provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for aid-in-dying medication, is not valid.

(B) An obligation owing under any currently existing contract may not be conditioned or affected by an individual making or rescinding a request for aid-in-dying medication.

### Section 12. Insurance or annuity policies.

(A) The sale, procurement or issuance of a life, health or accident insurance or annuity policy, or the rate charged for a policy may not be conditioned upon or affected by a person making or rescinding a request for aid-in-dying medication.

(B) A qualified individual's act of self-administering aid-in-dying medication may not have an effect upon a life, health or accident insurance or annuity policy other than that of a natural death from the underlying illness.

### Section 13. Immunities

(A) A person is not subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with [sections 1 through 17], including an individual who is present when a qualified individual self-administers the prescribed aid-in-dying medication.

(B) A healthcare provider or professional organization or association may not subject an individual to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with [sections 1 through 17].

(C) A request by an individual for or provision by an attending physician of medication in good faith compliance with the provisions of [sections 1 through 17] does not constitute neglect or elder abuse for any purpose of law, or provide the sole basis for the appointment of a guardian or conservator.

(D) (1) A healthcare provider may choose whether to participate in providing aid-in-dying medication to a qualified individual pursuant to [sections 1 through 17].

(2) If a healthcare provider is unable or unwilling to carry out an individual's request under [sections 1 through 17] and the individual transfers care to a new healthcare provider, the prior healthcare provider shall transfer, upon request, a copy of the individual's relevant medical records to the new healthcare provider.

(3) A healthcare facility may prohibit a physician from writing a prescription for aid-in-dying medication for a patient who is a resident in its facility and intends to use the medication on the facility's premises, provided the facility has notified the physician in writing of its policy with regard to the prescriptions.

<sup>1</sup> Insert bracketed language with the state statute citation if a state law exists that provides a 'right to information' for patients to be informed of all their treatment options.

(4) A healthcare facility or healthcare provider shall not subject a physician, nurse, pharmacist or other person to discipline, suspension, loss of license, loss of privileges or other penalty for actions taken in good faith reliance on the provisions of this chapter or refusals to act under this chapter.

(E) Nothing in this subsection will prevent a healthcare provider from providing an individual with healthcare services that do not constitute participation in [sections 1 through 17].

#### **Section 14. Liabilities.**

(A) Purposely or knowingly altering or forging a request for medication to end an individual's life without their authorization or concealing or destroying a rescission of a request for medication is punishable as a felony if the act is done with the intent or effect of causing the individual's death.

(B) Purposely or knowingly coercing or exerting undue influence on an individual to request medication for the purpose of ending their life or to destroy a rescission of a request is punishable as a felony.

(C) Nothing in [sections 1 through 17] limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(D) The penalties in [sections 1 through 18] do not preclude criminal penalties applicable under other law for conduct inconsistent with the provisions of [sections 1 through 16].

#### **Section 15. Penalties.**

(A) It is a felony for a person without authorization of the individual to purposely or knowingly alter, forge, conceal or destroy a written request for aid in dying.

(B) For purposes of this section, "purposely" and "knowingly" have the meaning provided in [Criminal Code Reference].

#### **Section 16. Construction.**

Nothing in [sections 1 through 17] may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with [sections 1 through 17] will not, for any purposes, constitute suicide, assisted suicide, mercy killing, homicide or elder abuse under the law.

#### **Section 17. Severability.**

If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect.

If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

#### **Section 18. Codification instruction.**

[Sections 1 through 17] are intended to be codified as an integral part of [State Statutory Reference], and the provisions of [State Statutory Reference] apply to [sections 1 through 17].

#### **Section 19. Effective date.**

[This act] is effective on passage and approval.



Care and Choice at the End of Life

[CompassionAndChoices.org](https://CompassionAndChoices.org)

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**Compassion & Choices** is the nation's oldest, largest and most active nonprofit working to improve care and expand choice for the end of life. We:

**Support** patients and families

**Educate** the public and professionals

**Advocate** across the nation

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