DATE FILED: May 19, 2016 5:22 PM

Colorado Supreme Court 2 East 14th Avenue Denver, CO 80203	
Original Proceeding Pursuant to § 1-40-107(2), C.R.S. (2015) Appeal from the Ballot Title Board	**▲COURT USE ONLY▲**
In the Matter of the Title, Ballot Title, and Submission Clause for Proposed Initiative 2015-2016 #145 ("Medical Aid in Dying") **Petitioners:** Michelle Stanford, Robin Stephens, and Renee Walbert, **v.** **Respondents:** Jaren Ducker and Julie Selsberg, **and** **Title Board:** Suzanne Staiert, David Blake, and Jason Gelender.	Supreme Court Case No.: 16SA151
Attorneys for Petitioner Michelle Stanford Thomas M. Rogers III, #28809 Hermine Kallman, #45115 LEWIS ROCA ROTHGERBER CHRISTIE LLP 1200 Seventeenth Street, Suite 3000 Denver, CO 80202 Phone: 303.623.9000 Fax: 303.623.9222 Email: trogers@lrrc.com hkallman@lrrc.com	

PETITIONER MICHELLE STANFORD'S OPENING BRIEF

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with all requirements of C.A.R. 28 and C.A.R. 32, including all formatting requirements set forth in these rules. Specifically, the undersigned certifies that:

The brief complies with C.A.R. 28(g).

☒ It contains 3,761 words.

The brief complies with C.A.R. 28(a)(7)(A).

☒ For the party raising the issue:
It contains under a separate heading (1) a concise statement of the applicable standard of appellate review with citation to authority; and (2) a citation to the precise location in the record, not to an entire document, where the issue was raised and ruled on.

☒ I acknowledge that my brief may be stricken if it fails to comply with any of the requirements of C.A.R. 28 and C.A.R. 32.

s/ Thomas M. Rogers III
Thomas M. Rogers III
Attorney for Petitioner Michelle Stanford

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Petitioner Michelle Stanford, through her undersigned counsel, hereby submits this Opening Brief:

STATEMENT OF ISSUES PRESENTED FOR REVIEW

Whether the title set by the Title Board for Proposed Ballot Initiative 2015-16 #145 ("Initiative 145" or the "Initiative") concerning allowing licensed physicians to prescribe medication that may be used by a terminally-ill patient to end his or her life by suicide fails to fairly reflect the true intent and meaning of the Initiative where it:

(a) fails to reflect that the measure mandates that committing suicide under the measure will not trigger suicide exceptions in life insurance contracts;

(b) fails to reflect that a health care facility may choose to prohibit a physician from aiding a terminally-ill patient's suicide on the health care facility's premises;

(c) fails to reflect that the measure changes Colorado law that prohibits assisting another to commit suicide;

(d) fails to reflect that it mandates a misrepresentation in official public records by requiring that the cause of death of the patient be listed as the terminal illness and not suicide.

STATEMENT OF THE CASE

Initiative 145 is the second of two substantially similar measures which seek to change Colorado law that prohibits aiding or assisting another to commit suicide. On April 6, 2016, the Title Board set title for a substantially similar measure, Initiative 124. Petitioner moved for rehearing and has appealed the actions of the Title Board in setting title for Initiative 124 in Case No. 16SA137. Briefing on Initiative 124 has not yet been completed.

This brief includes two arguments similar to those Dr. Stanford has asserted against Initiative 124 (the title must reflect that this is an assisted suicide measure and that the measure requires a misrepresentation in the patient's death certificate). It also contains two new arguments, discussed below, that were not raised in Dr. Stanford's appeal of Initiative #124.

Under Initiative 145, a physician may prescribe medication to a patient who has been diagnosed with terminal illness, with a prognosis of six months or less to live, which the patient may use to commit suicide. Initiative 145 is long and complicated. The following are the central features of the measure that are included in the title:

(1) A requirement that a physician confirm that the person has been diagnosed with a terminal illness with a prognosis of six months or less to live;

(2) A requirement that a physician confirm that the terminally-ill patient is mentally capable to make an informed decision;

(3) Granting immunity from civil and criminal liability to anyone who complies with the procedures established by the measure;

(4) Specifying that a physician's participation in an assisted suicide protocol is voluntary.

The following are additional central features that the Title Board erroneously omitted from the title:

(1) A change to Colorado law which prohibits aiding or assisting another to commit suicide;

(2) A requirement that the cause of the patient's death be misrepresented in official public records as the terminal illness and not suicide;

(3) A requirement that the patient's suicide shall not affect life insurance contracts by triggering suicide exceptions in those contracts;

(4) An exemption for health care facilities that oppose physician-assisted suicide allowing them to prohibit physicians from providing such assistance on those facilities' premises.

Dr. Stanford requests that this Court remand with instructions to revise the title to reflect all of its central features to allow the voters to make an informed choice.

STATEMENT OF FACTS

On March 25, 2016, Proponents Jaren Ducker and Julie Selsberg filed proposed Initiative 2015-2016 #145 with the Office of Legislative Council. A review and comment meeting was held under C.R.S. § 1-40-105(1) on April 8, 2016. Later that same day, Proponents submitted the Initiative to the Secretary of State for title setting.[1] On April 20, 2016, the Title Board set the Initiative's title. On April 27, 2016, Dr. Stanford timely filed a Motion for Rehearing on the basis that the title failed to reflect the central features of the Initiative. The Title Board held a rehearing on April 27, 2016 and denied the Dr. Stanford's motion except to the extent that the Board amended the title.[2] Dr. Stanford timely appealed the Title Board's denial of her motion.[3]

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[1] *See* Proposed Initiative 2015-16 #145, attached as Exhibit A.

[2] *See* Ballot Title and Submission Clause for #145, attached as Exhibit B:

> Shall there be a change to the Colorado revised statutes to permit any mentally capable adult Colorado resident who has a medical prognosis of death by terminal illness within six months to receive a prescription from a willing licensed physician for medication that can be self-administered to bring about death; and in connection therewith, requiring two licensed physicians to confirm the medical prognosis, that the terminally-ill patient has received information about other care and treatment options, and that

SUMMARY OF THE ARGUMENT

Initiative 145 is long and complicated (over 11 pages) and contains a number of central features. The Title Board chose several of those features to include in the title; however, it failed to include other, equally important features that must be included in the title to give the voters an opportunity to make an informed choice. Under the measure, a patient that has been diagnosed with an illness, with a prognosis of six months or less to live, may ask a licensed physician to prescribe medication that the patient may use to end his or her life by suicide.

> the patient is making a voluntary and informed decision in requesting the medication; requiring evaluation by a licensed mental health professional if either physician believes the patient may not be mentally capable; granting immunity from civil and criminal liability and professional discipline to any person who in good faith assists in providing access to or is present when a patient self-administers the medication; and establishing criminal penalties for persons who knowingly violate statutes relating to the request for the medication?

[3] Because, based on the e-filing date stamp on Dr. Stanford's petition (May 6, 2016), her appeal might appear untimely to the parties and to the Court, the undersigned provides the following background. Under C.R.S. § 1-40-107(2), the deadline to file an appeal was May 5, 2016. Dr. Stanford timely filed her petition with the Court on that day via ICCES and electronically and via U.S. Mail served the Attorney General's office (counsel for the Title Board) and Mr. Mark Grueskin (counsel for the Respondents). On May 6, 2016, the undersigned counsel was notified by the Clerk of the Court that Dr. Stanford had to refile the petition in this case, as it had already been initiated by another party's appeal to the title for Initiative #145. Accordingly, Dr. Stanford refiled her petition in this case on May 6.

Under most life insurance contracts, a person's suicide within the first year of the issuance of the policy precludes the payment of life insurance benefits. Initiative 145 would change the terms of those contracts, as well as the way insurers underwrite life and annuity policies, by mandating that a patient's death from taking aid-in-dying medication not be considered suicide and not trigger the suicide exception under the terms of the insurance policies. Yet, nowhere in the title is this important feature—one that will affect every person who sells or purchases life insurance in Colorado—reflected in the title.

The measure specifies that the medication prescribed by the physician must be self-administered; in other words, it may not be administered by anyone but the patient to cause the patient's death. Accordingly, there can be no dispute that the true intent and meaning of the Initiative is to provide a means to a terminally-ill patient to commit suicide. Yet, nowhere in the title are the words "assist" and "suicide" mentioned.

Further, The title fails to reflect that the Initiative mandates that the patient's death shall not be recorded as suicide on the patient's death certificate, thus requiring a misrepresentation in official public records.

Finally, the measure allows health care facilities, which, for any reason choose not to permit physician-assisted suicide, to prohibit any physician from engaging in such activity on the health care facility's premises.

The title should be revised to reflect these important features.

STANDARD OF REVIEW AND PRESERVATION

In reviewing the actions of the Title Board, the Court must ensure that the title fairly reflects the proposed initiative "so that petition signers and voters will not be misled into support for or against a proposition by reason of the words employed by the board." *Matter of Title, Ballot Title & Submission Clause, & Summary for 1997-98 No. 62*, 961 P.2d 1077, 1082 (Colo. 1998). While the Title Board is vested with considerable discretion in setting the title, the Court will reverse the Board's decision if a title is insufficient, unfair, or misleading. *See Matter of Title, Ballot Title & Submission Clause for 2015-2016 #73*, 2016 CO 24, ¶ 8. Dr. Stanford's challenge was raised below in her Motion for Rehearing.[4]

ARGUMENT

Proponents recognize that the act of self-administering deadly medication is, by definition, suicide. Thus, as a political tactic, Initiative 145 goes to great lengths to ensure that the patient's death not be recorded or treated as suicide, with

[4] *See* Exhibit C.

significant legal implications. *See In re Title, Ballot Title & Submission Clause, & Summary for 1999-2000 No. 37*, 977 P.2d 845, 846 (Colo. 1999) (the title must "convey to voters the initiative's likely impact"). Yet, nowhere in the title any of the provisions that specify that the patient's death should not be considered suicide— such as the cause of death on the death certificate, effect on the insurance contracts—are mentioned.

I. The title fails to reflect that the Initiative mandates that committing suicide in accordance with the procedures established in the measure will not trigger suicide exceptions in life insurance contracts.

Proposed section 25-48-115 of the Initiative provides, in relevant part:

> (1) The sale, procurement, or issuance of, or the rate charged for, any life, health, or accident insurance or annuity policy must not be conditioned upon, or affected by, an individual's act of making or rescinding a request for medical aid-in-dying medication in accordance with this article.
>
> (2) A qualified individual's act of self-administering medical aid-in-dying medication pursuant to this article does not affect a life, health, or accident insurance or annuity policy.

See Ex. A. Thus, the measure changes the way insurance contracts will be interpreted and applied in Colorado. Specifically, by requiring that the death of the patient from physician-assisted suicide not be considered a suicide under the terms of insurance contracts, the measure interferes with parties' contractual relationships by creating a legal fiction. Most life insurance contracts contain a

provision under which a person's suicide within the first year of the issuance of the policy precludes the payment of life insurance benefits.[5] Initiative 145 invalidates such provisions in case of a suicide under the terms of the measure. The Initiative also mandates that insurers not condition the issuance of benefits and the premiums charged for insurance on a person's decision to use aid-in-dying medication to commit suicide, which affects how insurers conduct their business and underwrite life insurance policies in Colorado, with potentially significant consequences on the overall rates charged for life insurance premiums for anyone applying for insurance in Colorado. Initiative 145's interference with existing contractual relationships and the insurance business is a central feature that must be reflected in the title.

In fact, the question of how a patient's act of suicide by taking aid-in-dying medication affects insurance is one of the "Frequently Asked Questions" in connection with the proposed measure, according to Death with Dignity, a

[5] *See* 20 Am. Jur. Proof of Facts 3d 227 ("One of the exclusions that appears almost universally in life insurance policies is the suicide exclusion."). Under Colorado law, benefits must be paid if death occurs by suicide after the first year of the policy. *See* C.R.S. § 10-7-109 ("The suicide of a policyholder after the first policy year of any life insurance policy issued by any life insurance company doing business in this state shall not be a defense against the payment of a life insurance policy . . . .").

nationwide organization behind the efforts to legalize assisted suicide. *See* Ex. C, at p. 7:

> [Q:] How does participation in death with dignity impact my insurance?
> [A:] Death with Dignity statutes specify that participation under them is not suicide. Therefore, your decision to end your life under a Death with Dignity statute has no effect on your life, health, or accident insurance or annuity policy.

This is not a minor implementation detail, but a significant provision that may guide voters in deciding whether to support the measure. In a split 2-1 decision, the Title Board erred in not including this provision in the title, rendering the title insufficient. The Title Board's decision should be reversed. *See In re #73*, 2016 CO 24, ¶ 8 (the Court will reverse a title "when a title is insufficient, unfair, or misleading").

II. The title fails to reflect that a health care facility may choose to prohibit a physician from writing a prescription for aid-in-dying medication for use on the health care facility's premises.

Proposed section 25-48-118 provides, in relevant part:

> (1) A health care facility may prohibit a physician employed or under contract from writing a prescription for medical aid-in-dying medication on the facility's premises. . . .

See Ex. A. This provision reflects that participation in the procedures to aid or assist a terminally-ill patient to commit suicide is voluntary, and a health care facility may choose not to participate by forbidding its physicians from prescribing

aid-in-dying medication. As the recent U.S. Supreme Court case, *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2759 (2014), and the surrounding national debate demonstrate, laws mandating actions that may otherwise be against persons', or even certain entities' beliefs have significant implications. Here, the Initiative has expressly provided that no such mandate exists for health care facilities. Voters are entitled to be apprised of that important feature of the proposed law.

In fact, the Initiative contains a second provision, in proposed section 25-48-117, which provides that participation in the proposed procedures is voluntary for a health care provider:

> (1) A health care provider may choose whether to participate in providing medical aid-in-dying medication to an individual in accordance with this article.

The Title Board considered that provision to be a central feature by including language in the title to reflect it. *See* Ex. B ("A change to the Colorado revised statutes to permit any mentally capable adult Colorado resident who has a medical prognosis of death by terminal illness within six months to receive a prescription from a **willing** licensed physician . . . .") (emphasis added). Likewise, the fact that a health care facility, such as a hospice, may choose not to permit

assisted suicide on its premises should be reflected in the title, as it is a central feature of the proposed law.

III. The title of the Initiative fails to properly identify the true intent and meaning of the Initiative: to establish procedures for terminally-ill patients to be able to end their lives by suicide.

Under Colorado law, it is illegal to aid another in committing suicide. *See* C.R.S. § 18-3-104(1)(b) (providing that a "person commits the crime of manslaughter if: . . . (b) [s]uch person intentionally causes or aids another person **to commit suicide**.") (emphasis added). Initiative 145 proposes a change to that law by creating procedures through which a physician may legally prescribe medication to a terminally-ill patient who may use it to commit suicide. *See* Ex. A, proposed § 25-48-103. The measure emphasizes that the medication to cause one's own death must be self-administered by the patient, which, by definition, means suicide. *See People v. Gordon*, 32 P.3d 575, 578-79 (Colo. App. 2001) ("Suicide is, by definition, the killing of oneself," and there is "a distinction between killing oneself and being killed by another.") (quoting *People v. Kevorkian,* 527 N.W.2d 714, n. 71 (Mich. 1994)); *see also* Black's Law Dictionary (9th ed.) (suicide is "the act of taking one's own life"). Colorado statute uses the term "suicide" in the very section for which the Initiative seeks to create an exception for persons aiding a terminally-ill patient to commit suicide. *Compare* C.R.S § 18-3-104(1)(b) *with*

proposed § 25-48-116(1) ("A person is not subject to civil or criminal liability or professional disciplinary action for acting in good faith under this article . . . .").

Nevertheless, the Title Board refused to use the word "suicide" or "assisted suicide"[6] in the title to accurately inform the voters of the true intent and meaning of the Initiative. Instead, the title employs a vague statement of the subject of the Initiative as follows:

> Shall there be a change to the Colorado revised statutes to permit any mentally capable adult Colorado resident who has a medical prognosis of death by terminal illness within six months to receive a prescription from a licensed physician for medication that can be self-administered to bring about death.

A petition signer or a voter would have to carefully parse the language above to discern what the measure is proposing. It is not immediately clear to the reader that the measure is proposing to legalize assisted suicide. By failing to refer to the word "suicide" or "assisted suicide"—common terms with which the voters are presumably familiar—the title is confusing and misleading as it does not inform the voter that Initiative 145 is a radical change to current law prohibiting such activity.

[6] "Assisted suicide" is defined as "[t]he intentional act of providing a person with the medical means or the medical knowledge to commit suicide." Black's Law Dictionary (9th ed.).

The fact that the words employed by the Title Board come from the Initiative itself is of no import. This Court has held that even where the measure is set forth in the title "virtually word for word," the title fails if it does not provide sufficient information to allow voters to determine intelligently whether to support or oppose the proposal. *See Matter of Title, Ballot Title, Submission Clause, & Summary by Title Bd. Pertaining to a Proposed Initiative on Obscenity*, 877 P.2d 848, 850 (Colo. 1994); *see also In re Title, Ballot Title & Submission Clause, & Summary for 1999-2000 No. 104*, 987 P.2d 249, 259-60 (Colo. 1999) ("mere repetition of language from the initiative to the titles and summary does not necessarily ensure that the voters will be apprised of the true intent and purpose of the initiative").

Initiative 145 is a long and complicated measure that, without dispute, seeks to change current law prohibiting persons from aiding or assisting another to commit suicide.[7] By employing words other than those commonly used—assisted suicide—the title creates confusion and leads the voter to believe that the measure does something other than legalize assisted suicide in certain circumstances. The

[7] *See Gordon*, 32 P.3d at 579 ("It is well accepted that 'aiding,' in the context of determining whether one is criminally liable for their involvement in the suicide of another, is intended to mean providing the means to commit suicide, not actively performing the act which results in death.").

title must be revised to include this commonly-known and used term to adequately apprise the voter of the measure's true intent and meaning.[8]

IV. The title fails to reflect a central feature of the Initiative—that the measure dictates that the cause of death on the person's death certificate shall be listed as the terminal illness and not suicide.

A death certificate is a legal document. *See Bernstein v. Rosenthal*, 671 P.2d 979, 981 (Colo. App. 1983) ("the death certificates are records of vital statistics"); *see also* C.R.S. § 25-2-110(1)(a) ("A certificate of death for each death, . . . that occurs in Colorado must be filed with the state registrar or as otherwise directed by the state registrar, within five days after the death occurs and prior to final disposition."). It must list the cause of death. *See* C.R.S. §§ 25-2-110(3); -110(4); -110(5).

The importance of the accuracy of the death certificate as a reliable official record is supported by this Court's adoption of C.R.E. 803(9), which provides that "[r]ecords or data compilations, in any form, of births, fetal deaths, deaths, or marriages, if the report thereof was made to a public office pursuant to requirements of law" are admissible in court and are exceptions to the rule against

[8] The Objector proposes the following revision to the title: "Shall there be a change to the Colorado Revised Statutes to permit a licensed physician to prescribe medication to any mentally capable adult Colorado resident who has a medical prognosis of death by terminal illness within six months to assist the patient to commit suicide . . . ."

hearsay. That is, such documents may be introduced as evidence for the truth of the matter asserted. *See* C.R.E. 801; *Bernstein*, 671 P.2d at 981 (the trial court properly relied on the death certificates in determining the cause of death); *see also* C.R.S. § 25-2-117(1) ("Any copy of the record of a birth or death, when properly certified by the state registrar or as otherwise directed by the state registrar to be a true copy thereof, shall be prima facie evidence in all courts and places of the facts therein stated.").

Initiative 145 mandates that the cause of death of the patient be misrepresented on the death certificate as the terminal illness. *See* Ex. A, proposed § 25-48-109. The voters are entitled to be apprised of the fact that by voting "yes" on the measure, they are agreeing that public records will be required to contain false information. Thus, proposed § 25-48-109 is a central feature of the Initiative, and the Title Board erred in failing to include it in the title. *See In re Proposed Initiated Constitutional Amendment of Educ., 1984*, 682 P.2d 480, 482 (Colo. 1984) (The title and the submission clause "presented to the public must fairly and succinctly advise the voters what is being submitted, so that in the haste of an election the voter will not be misled into voting for or against a proposition . . . .").

CONCLUSION

Petitioner respectfully requests that this Court determine that the title and submission clause set for the Proposed Initiative 2015-2016 #145 is inaccurate and fails to reflect its true intent and meaning and remand to the Title Board with instructions to redraft the title.

Respectfully submitted this 19th day of May, 2016.

LEWIS ROCA ROTHGERBER CHRISTIE LLP

s/ Thomas M. Rogers III
Thomas M. Rogers III
Hermine Kallman
Attorneys for Petitioner Michelle Stanford

CERTIFICATE OF SERVICE

I hereby certify that on May 19, 2016, a true and correct copy of the foregoing was served on the following via ICCES:

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BEFORE COLORADO STATE TITLE SETTING BOARD

In re Ballot Title and Submission Clause for 2015-2016 Initiative #145 ("Medical Aid in Dying")

DR. MICHELLE STANFORD, Objector.

MOTION FOR REHEARING

Pursuant to C.R.S. § 1-40-107, Objector, Dr. Michelle Stanford, a registered elector of the State of Colorado, through her legal counsel, Lewis Roca Rothgerber Christie LLP, submits this Motion for Rehearing of the Title Board's April 20, 2016 decision to set a title for 2015-2016 Initiative #145 ("Initiative"), and states:

I. The Title and Submission Clause Do Not Fairly Express the True Meaning and Intent of the Proposed State Law.

The title is confusing and fails to adequately reflect the central features of the Initiative:

1) The single subject of the Initiative fails to correctly and properly identify the true intent and meaning of the Initiative, which is permitting a licensed physician to prescribe medication that a patient may take to commit suicide.

2) The title fails to reflect that the measure dictates that despite the fact that death will occur due to suicide, the cause of death on the death certificate be listed as something other than suicide. *See* Section 109 of the proposed measure.

3) The title fails to reflect that the measure mandates that committing suicide under the measure will not trigger suicide exceptions in life insurance contracts. *See* Section 115 of the proposed measure; *see also* Exhibit A, Death with Dignity FAQs, p. 5.

4) The title fails to reflect that the Colorado Department of Public Health and Environment will be required to promulgate rules and oversee compliance with the requirements of the measure and publish an annual report. *See* Section 111 of the proposed measure.

5) The title fails to reflect that a health care facility may choose to prohibit a physician that it employs or contracts with from writing a prescription for aid-in-dying medication for use on the health care facility's premises. *See* Section 118 of the proposed measure.

EXHIBIT C

WHEREFORE, Objector respectfully requests that the Title Board set Initiative 145 for rehearing pursuant to C.R.S. § 1-40-107(1).

DATED: April 27, 2016.

s/Hermine Kallman
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FAQS

FAQs

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Some information on this page has been adapted from the FAQs by Oregon Department of Human Services, Washington State Department of Health, and Vermont Department of Health.

About Death with Dignity Organizations

WHAT IS THE DEATH WITH DIGNITY FAMILY OF ORGANIZATIONS?

Death with Dignity is an umbrella for the Death with Dignity National Center, which focuses on education, and Death with Dignity Political Fund, which focuses on political advocacy and lobbying.

- Learn more about us →

WHAT IS THE DEATH WITH DIGNITY NATIONAL CENTER AND WHAT DOES IT DO?

The National Center expands the freedom of all qualified terminally ill Americans to make their own end-of-life decisions, including how they die, by promoting Death with Dignity laws around the United States based on the groundbreaking Oregon model and by providing information, education, and support about Death with Dignity as an end-of-life option to patients, family members, legislators, advocates, healthcare and end-of-life care professionals, media, and the interested public.

WHAT IS THE DEATH WITH DIGNITY POLITICAL FUND AND WHAT DOES IT DO?

The Political Fun is a 501(c)4 nonprofit organization that acts as the political arm of the National Center. The Fund drafts Death with Dignity laws based on the Oregon model; campaigns, lobbies, and advocates for Death with Dignity legislation in the states that lack them; and defends Death with Dignity Acts against challenges. The Political Fund staff and volunteers authored, passed, and defended the Oregon law (1994/1997/2006); spearheaded the successful efforts to pass Death with Dignity statutes in Washington (2008), Vermont (2013), and California (2015); and led the Maine (2000), Hawaii (2002), and Massachusetts (2012) campaigns, which were all defeated by narrow margins.

HOW LONG HAVE DEATH WITH DIGNITY ORGANIZATIONS BEEN IN EXISTENCE?

The Death with Dignity family of organizations have been advancing physician-assisted dying policy reform for more than 20 years. The earliest predecessor organization, Oregon Right to Die, was established in 1993. In the current form, the Death with Dignity family of organization has been in existence since 2003.

EXHIBIT A

WHAT IS YOUR CHARITY EVALUATION RANKING?

Death with Dignity is a Better Business Bureau-accredited charity; we meet all of the BBB Wise Giving Alliance's Standards for Charity Accountability.

We do not meet Charity Navigator's criteria for evaluation. Charity Navigator only rates 501(c)(3) organizations with budgets over $1 million. The combined budget of our 501(c)(3) and 501(c)(4) organizations, the Death with Dignity National Center and Death with Dignity Political Fund, respectively, this year is $600,000.

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Death with Dignity as an End-of-Life Option

WHAT IS DEATH WITH DIGNITY?

Death with Dignity is an end-of-life option that allows a qualified person to legally request and obtain medications from their physician to end their life in a peaceful, humane, and dignified manner at a time and place of their choosing. Death with Dignity is governed by state legislation.

WHAT ARE SOME OTHER TERMS USED TO REFER TO DEATH WITH DIGNITY?

Death with Dignity is a term originating in the title of the Oregon statute governing the prescribing of life-ending medications to qualified terminally ill people; because our founders authored the Oregon law, our family of organizations bears its name and it's our preferred term for the practice. Other terms include physician-assisted death, physician-assisted dying, aid in dying, physician aid-in-dying, and medical aid-in-dying. Incorrect and inaccurate terms that opponents of Death with Dignity use include assisted suicide, physician-assisted suicide (PAS), and euthanasia.

- Learn more about terminology of assisted dying →

HOW CAN I GET DEATH WITH DIGNITY?

You can only get a prescription for life-ending medications in states with Death with Dignity laws. Currently only Oregon, Washington, and Vermont have physician-assisted dying statutes; the California statute, passed in October 2015, has yet to take effect. Physician-assisted dying is also legal in Montana, albeit not with a statute but with a state Supreme Court ruling.

To qualify under Death with Dignity laws, you must be an adult resident of a state where a Death with Dignity law is in effect (OR, WA, VT); mentally competent, i.e. capable of making and communicating your healthcare decisions; diagnosed with a terminal illness that will lead to death within six months, as confirmed by two physicians. The process entails two oral requests, one written request, waiting periods, and other requirements.

- Learn more about accessing Death with Dignity laws →

WHAT ARE THE RESIDENCY REQUIREMENTS FOR DEATH WITH DIGNITY?

You must provide adequate documentation to the attending physician to verify that you are a current resident of the state with a Death with Dignity statute. Factors demonstrating residency include, but are not limited to: a state-issued ID or driver license, a lease agreement or property ownership document showing that you rent or own property in the state, a state voter registration, or a recent state tax return. It is up to the attending physician to determine you have adequately established residency.

There is no length-of-residency requirement. You must simply be able to establish that you are currently a state resident.

HOW CAN I FIND A DOCTOR IN OREGON, WASHINGTON, OR VERMONT WHO WILL PRESCRIBE MEDICATIONS UNDER THE DEATH WITH DIGNITY LAW?

There are no lists of physicians who participate in Death with Dignity laws, for both confidentiality and safety reasons (participation in the law is strictly vountary).

You are more likely to find a participating physician in a non-faith-based hospital and in larger cities. End of Life Washington has compiled information about which activities each hospital in the state permits or restricts when a patient asks for assistance using the Act.

To find out if your doctor is willing to participate in the law, make an appointment with him or her to discuss your end-of-life goals and concerns, including the option available under Death with Dignity laws.

WHERE CAN I TAKE THE MEDICATION?

You can self-administer and ingest the medications at a place of your choosing, though the law advises your physician to ask you not to do so in a public place. Most people, about 90%, choose to take the medications at home; those who live in assisted-living or nursing home facilities tend to take them there.

If you take a dose prescribed under Death with Dignity laws outside the state where you obtained it, you will lose the legal protections afforded by the Death with Dignity law in question. For example, your death may be ruled a suicide under another state's law.

WHEN WILL I KNOW IT IS THE TIME TO TAKE THE MEDICATION?

No one can answer this question for you. People know when it's time, when they've detached from the day-to-day world, reached a point where their pain and suffering has robbed them of the quality of life they find essential, and they only want to be with the people they love. Typically, when people decide to take the lethal dose of medication, they and their families are expressing their love for each other and saying their goodbyes. It's a very emotional time, during which the love of family is the strongest and the most tender.

If you decide the time is not right, that's fine; it only means the Death with Dignity Act is working as intended. People derive comfort from simply knowing they have this option if they need it.

WHAT OPTIONS DO I HAVE IF MY STATE DOES NOT ALLOW DEATH WITH DIGNITY?

Every competent individual has a right to refuse medical therapies. You can voluntarily stop eating and drinking; you can also stop treatment or not start treatment at all. Hospice, palliative care, and palliative sedation are additional options you may have access to. Such measures can take anywhere from several days to several weeks to result in death and may include unanticipated and agonizing effects that often can only be palliated. Discuss your options with your physician.

- Learn more about alternatives to Death with Dignity →

WHAT HAPPENS WITH UNUSED MEDICATIONS?

One in three people who obtain medications under Death with Dignity laws choose not to use them. Anyone who chooses not to ingest a prescribed dose or anyone in possession of any portion of the unused dose must dispose of the dose in a legal manner as determined by the federal Drug Enforcement Agency. Physicians must report all prescriptions for lethal medications to their state's health department. In Oregon, pharmacists must be informed of the prescribed medication's ultimate use.

WHAT IS THE CURRENT STATE OF PHYSICIAN-ASSISTED DYING IN AMERICA?

The history of physician-assisted dying reaches back more than 100 years. The Death with Dignity movement itself started in earnest in the early 1990's. In the movement's first two decades, we defined the policy based on the Oregon model, defended it in legislatures and courts, and expanded it to additional states, including Washington, Vermont, and California. In our third decade we aim to accelerate the passage of Death with Dignity legislation around the US.

Today, our movement has more momentum than we've ever seen. While in the past, only two or three states at the time considered Death with Dignity bills, in the 2015 legislative session, no fewer than 24 states plus the District of Columbia, considered Death with Dignity. In all but one instance—California—bills failed. That's the way progress happens: victories beget more victories, and even our losses teach us the lessons we need to advance. Every step brings us closer to the day when a big majority of Americans will have what they are asking for: more freedom and control at the end of life.

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Death with Dignity legislation

WHAT IS DEATH WITH DIGNITY LEGISLATION?

Death with Dignity acts allow certain terminally ill adults to request and obtain a prescription for medication to end their lives in a peaceful manner. The acts outline the process of obtaining such medication as well as safeguards to protect both patients and physicians.

There is no state program for participation in Death with Dignity acts; people do not apply to state health departments. It is up to qualified patients and licensed physicians to implement the act on an individual, case-by-case basis.

Three states currently have Death with Dignity statutes in effect: Oregon since 1997, Washington since 2009 (the law was passed in 2008), and Vermont since 2013. The California End of Life Option Act, passed in 2015, has yet to take effect. In Montana, physician-assisted death is legal (since 2009) by the state Supreme Court ruling.

WHO CAN PARTICIPATE IN DEATH WITH DIGNITY LAWS?

Anyone who meets the eligibility criteria can access Death with Dignity laws. Participation in the law is strictly voluntary.

To qualify under Death with Dignity laws, you must be an adult resident of a state where a Death with Dignity law is in effect (OR, WA, VT; CA likely in 2016); mentally competent, i.e. capable of making and communicating your healthcare decisions; and diagnosed with a terminal illness that will lead to death within six months, as confirmed by two physicians. The process entails two oral requests, one written request, waiting periods, and other requirements.

- Learn more about accessing Death with Dignity laws →

CAN MY FAMILY MEMBER OR A PROXY REQUEST PARTICIPATION IN DEATH WITH DIGNITY ON MY BEHALF (FOR EXAMPLE, IF I AM IN A COMA OR SUFFER FROM ALZHEIMER'S DISEASE OR DEMENTIA)?

No. The law requires that you ask to participate voluntarily on your own behalf and meet all the eligibility criteria at the time of your request.

WHAT ARE THE RESIDENCY REQUIREMENTS FOR DEATH WITH DIGNITY?

You must provide adequate documentation to the attending physician to verify that you are a current resident of the state with a Death with Dignity statute. Factors demonstrating residency include, but are not limited to:

- a state-issued ID or driver license;
- a lease agreement or property ownership document showing that you rent or own property in the state;

- a state voter registration; or a recent state tax return.

It is up to the attending physician to determine you have adequately established residency.

There is no length-of-residency requirement. You must simply be able to establish that you are currently a state resident.

CAN I MOVE TO A DEATH WITH DIGNITY STATE IN ORDER TO PARTICIPATE IN THE LAW?

There is nothing in Death with Dignity statutes that prevents you from doing this (you must simply must be able to prove to the attending physician that you are currently a resident). However, relocating in and of itself, not to mention across state lines, is a challenge, particularly if you are terminally ill and if you are elderly (the median age of Death with Dignity participants is 72). No one should have to uproot to use Death with Dignity laws.

HOW DO DEATH WITH DIGNITY LAWS SAFEGUARD CONFIDENTIALITY?

Federal statutes, such as HIPAA protect confidentiality of patient records. While states with Death with Dignity laws do collect the names of patients in order to cross-check death certificates, the laws guarantee the confidentiality of all participating patients (as well as physicians) and this information is never released to to the public or media. The identity of participating physicians is coded, but the identity of individual patients is not recorded in any manner. In Oregon, approximately one year from the publication of annual reports, all source documentation is destroyed.

HOW DOES PARTICIPATION IN DEATH WITH DIGNITY IMPACT MY INSURANCE?

Death with Dignity statutes specify that participation under them is not suicide. Therefore, your decision to end your life under a Death with Dignity statute has no effect on your life, health, or accident insurance or annuity policy.

Death with Dignity acts do not specify who must pay for the services. Individual insurers determine whether the procedure is covered under their policies, just as they do with any other medical procedure. Federal funding, including Medicaid and Medicare, cannot be used for services rendered under these laws.

WHAT KIND OF PRESCRIPTION WILL I RECEIVE?

It is up to the physician to determine the prescription. To date, most patients have received a prescription for an oral dosage of a barbiturate (pentobarbital or secobarbital).

HOW MUCH DOES THE MEDICATION COST?

None of the Death with Dignity laws tell your physician exactly what prescription to give you, but all medications under these laws require the attending physician's prescription. Cost varies based on medication type and availability as well as the protocol used (additional medications must be consumed prior to the lethal medications at an extra cost). The following are only estimates as prices and availability change. The actual prescription depends on the physician and his/her assessment.

Pentobarbital in liquid form cost about $500 until about 2012, when the price rose to between $15,000 and $25,000. The price increase was caused by the European Union's ban on exports to the US because of the drug being used in capital punishment, a practice that is illegal and deemed deplorable there; many international pharmaceutical companies don't export the drug to the US for the same reason. Users then switched to the powdered form, which costs between $400 and $500. Pentobarbital's shortage also led to the use of a new drug cocktail developed in the Netherlands, which costs between $400 and $500.

The legal dose of secobarbital (brand name Seconal) costs $3,000 to $5,000.

Due to the increase in the cost of Seconal an alternate mixture of medication has been developed by physicians in Washington state. , is available to produce a lethal dose that is similar in results as Seconal. The cost of this alternate mixture of

phenobarbital, chloral hydrate, morphine sulfate, and ethanol is approximately $450 to $500. A compounding pharmacy will need to prepare the mixture.

WHAT ARE THE BENEFITS OF DEATH WITH DIGNITY LAWS FOR TERMINALLY ILL PEOPLE AND THEIR FAMILIES?

Death with Dignity legislation yields numerous direct and indirect benefits.

For the terminally ill, the greatest impact of Death with Dignity laws rests in *having the freedom to control their own ending*. Most people who obtain medications under these laws value being able to make their own decisions, including the where and when of their death; loss of autonomy is cited as the chief end-of-life concern.

The option to die a peaceful death at a time and place of their choosing also provides those who are terminally ill with *invaluable peace of mind*, which is especially important at the end of life (one in three people who obtain medications under Death with Dignity laws do not use them). Most people who are dying wish to die at home; while on the national level only about 20% of people die at home, 90% or more of people accessing the Oregon Death with Dignity Act do. The stringent safeguards in these laws also *protect patients* from possible abuse, coercion, and wrongful medical practice.

> *The relief from my terminally-ill patients and their families is palpable. I've helped families accept their family members' final wishes in the face of terrible illness. Aid in dying for terminal patients is an essential part of good, compassionate end of life care."*
> —NICHOLAS GIDEONSE, MD

Family members, too, derive peace of mind from being able to say goodbye to their loved ones and make peace with their dying rather than having to endure watching them die an often painful and agonizing death.

WHAT ARE THE BENEFITS OF DEATH WITH DIGNITY LAWS FOR PHYSICIANS?

For physicians, Death with Dignity laws codify and bring to light the common practice of giving life-ending medications to their patients. Death with Dignity legislation *protects physicians* by stipulating the steps they must follow and, provided they follow the law, by providing them with immunity from civil and criminal liability as well as professional disciplinary action.

WHERE DO PHYSICANS STAND ON DEATH WITH DIGNITY?

A 2014 Medscape survey found that 54% of medical doctors favor physician-assisted dying, up from 46% in 2010. Anecdotally, we also know that many physicians who support the end-of-life option are reluctant to declare so publicly for fear of repercussions in their workplace or medical community.

The American Medical Association opposes aid-in-dying laws. However, not only does the AMA represents a declining number of physicians (only about 1 in 3 doctors are AMA members), a 2011 survey of physicians conducted by Jackson & Coker found that 77% of physicians believe the AMA no longer reflects their views. In 2015, the California chapter of the AMA changed its position on physician-assisted dying from opposed to neutral, stating that they "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."

A number of medical associations have endorsed the Death with Dignity option, including the American Public Health Association, the American College of Legal Medicine, the American Medical Women's Association, the American Medical Student Association, and the Denver Medical Society.

For my patients who have used this law, I was honored that I could be with them every step of the way, ensuring that they were cared for, and that they had control of the final days of their lives. That's what death with dignity really means."

—NICHOLAS GIDEONSE, MD

DO DEATH WITH DIGNITY LAWS HAVE ANY BROADER, SOCIETAL EFFECTS?

Death with Dignity legislation leads to *improvements in end-of-life care.* In Oregon, the law has dramatically improved end-of-life care, particularly in pain management, hospice care, and support services for family members; Oregon consistently ranks as a top state in end-of-life care.

Reports show that up to 97% of people using Oregon's Death with Dignity law are on hospice at the time of death, as compared to 45% in the US overall, according to the National Hospice and Palliative Care Organization. Oregon has the best pain, palliative and hospice care in the nation because the law made physicians get better at diagnosing depression, pain management, and hospice referrals.

In addition, residents of states with Death with Dignity laws are better-versed in end-of-life care issues. A poll by National Journal and The Regence Foundation found residents in Oregon and Washington were more knowledgeable and supportive of a variety of end-of-life options, including hospice and palliative care, than most Americans. According to the same poll, support for Death with Dignity legislation has grown in both Oregon and Washington, and a 2012 poll found 80% of Oregonians support the Act.

Many healthy Oregonians and Washingtonians today discuss end-of-life issues with their doctors and increasingly demand active participation and decision making in their own end-of-life care. Oregon and Washington doctors, as a result, today work harder to prolong patients' lives and enhance quality of life, while respecting patients' final wishes when their suffering becomes intolerable. Because of the law's protections, most Oregonians know they won't face abandonment by their doctors when the suffering becomes unbearable and use of the law is requested.

The most significant impact of the death with dignity law in Oregon has been to improve the care for all dying patients, by increasing awareness among doctors, allowing an open and honest conversation, improving pain management and palliative care, and providing patients with a sense of control and peace of mind.

In the video below, end-of-life care experts in Oregon speak about the impacts of the Act:

The Oregon Death With Dignity Act experience

The experience in California has shown that the passage of a physician-assisted dying law, even before it takes effect, heightens the urgency of improving end-of-life care. Whereas conversations in the Golden State are only beginning, we are confident that the End of Life Option Act will ultimately lead to improvements in end-of-life care there.

These effects also occur in states without physician-assisted dying legislation where a campaign for passage took place, regardless of whether it succeeded. In Massachusetts, in 2012, media reported that interest in and preference for hospice rose in response to our campaign to get a bill passed in a ballot initiative.

HOW DO DEATH WITH DIGNITY LAWS PROTECT PATIENTS?

Death with Dignity laws contain a number of safeguards, protecting patients from abuse and coercion:

- Patients must meet stringent eligibility requirements, including being an adult, state resident, mentally competent, and having a terminal diagnosis with a 6-month prognosis.
- Only the patient him or herself can make the oral requests for medication, in person. It is impossible to stipulate the request in an advance directive, living will, or any other end-of-life care document.
- The patient must make two oral requests, at least 15 days apart.
- The written request must be witnessed by at least two people, who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request. One of the witnesses *cannot* be a relative of the patient by blood, marriage or adoption; anyone who would be entitled to any portion of the patient's estate; an owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident or the patient's attending physician.
- The patient must be deemed capable to take (self-administer and ingest) the medication themselves, without assistance.
- The patient may rescind the request at any time.
- Two physicians, one of whom is the patient's attending physician, familiar with the patient's case, must confirm the diagnosis. Each physician must be licensed by the state to practice medicine and certified to prescribe medications.
- If either physician determines the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, they must refer the patient for evaluation by a state licensed psychiatrist or psychologist to determine their mental competency. Medication cannot be prescribed until such evaluation determines the patient is mentally competent.

- The attending physician must mail or hand-deliver the prescription to the pharmacy.
- The patient must wait 48 hours from their written request to fill their prescription.
- The request process must be stopped stop immediately if there is any suspicion or evidence of coercion.
- The physicians must meet strict reporting requirements for each request.
- Anyone who falsifies a request, destroys a rescission of a request or who coerces or exerts undue influence on a patient to request medication under the law or to destroy a rescission of such a request commits a Class A felony. The law also does not limit liability for negligence or intentional misconduct, and criminal penalties also apply for conduct that is inconsistent with it.

Data and studies show these safeguards work as intended, protecting patients and preventing misuse. No evidence of coercion or abuse has been documented in the Oregon since 1998 and Washington since 2009, when these states' respective laws went into effect.

HOW MANY PEOPLE USE DEATH WITH DIGNITY LAWS?

In 2014, a total of 155 terminally-ill adult Oregonians received a prescription for medications under the provisions of the Oregon Death with Dignity Act, while 105 of them (67.7%) ingested the medications to die peacefully. This corresponds to 31 Death with Dignity Act deaths per 10,000 total deaths, or 0.31%.

Since 1998, the year in which the first person in Oregon took medication prescribed under the law, a total of 1,327 patients have received the prescription, of whom 859 (65%) ingested it and died. These figures continue to underscore not only that only a small number of people use the law but also that more than one third of those who received the medication took it, finding great comfort in merely knowing it was available to them. Oregon's Death with Dignity Act continues to work flawlessly and to provide ease of mind and relief to Oregonians facing the end of life.

In Washington, 176 individuals received medications in 2014, of whom 126 died after ingesting the medication, 17 died without having ingested the medication, and for the remaining 27 people who died ingestion status is unknown.

In all, roughly 1 in 3 people who receive medications under Death with Dignity laws decide not to use them.

WHO USES DEATH WITH DIGNITY LAWS?

People who access these laws tend to be well educated and have excellent health care, good insurance, access to hospice, and financial, emotional, and physical support. Most patients have cancer (69 percent in Oregon according to the latest report) or ALS (16 percent). Most people die at home and are enrolled in hospice care. Two out of three are aged 65 years or older; the median age at death is 72 years.

Excluding unknown cases, in 2014 all people using the Oregon law have some form of health care insurance, although the number of patients who had private insurance (40 percent) was lower in 2014 than in previous years (63 percent on average). The number of patients who had only Medicare or Medicaid insurance was higher than in previous years (60% compared to 36%).

As in previous years, the three most frequently mentioned end-of-life concerns were: loss of autonomy (91%), decreasing ability to participate in activities that made life enjoyable (87%), and loss of dignity (71%).

DO DEATH WITH DIGNITY LAWS OBLIGATE OR ENCOURAGE ANYONE TO USE THEM?

Participation in Death with Dignity laws is strictly voluntary, for both patients and physicians. No one is encouraged obligated to use them, they merely provide an option to those who wish to use it.

No one qualifies under Death with Dignity laws solely on the basis of age or disability. Many seniors and people with disabilities support Death with Dignity laws, not because they are disabled but because they are people.

Opponents of Death with Dignity laws like to allege that the mere existence of these laws encourages the elderly, people with disabilities, minorities, or poor, undereducated, uninsured and other marginalized persons to prematurely end their lives. Death with Dignity laws, however, provide a voluntary option to anyone who qualifies and wishes to voluntarily use it. No one is forced, obligated, or encouraged to use these laws; access to these laws by any one person does not preclude others from opting out.

DO PEOPLE MOVE TO STATES WITH DEATH WITH DIGNITY LAWS IN ORDER TO USE THEM?

Statistics about people moving to states with Death with Dignity laws in order to use those laws are not tracked; because only residency matters under Death with Dignity laws, annual reports released by the Oregon Department of Human Services and Washington State Department of Health do not contain information about how many individuals moved to the respective states in order to avail themselves of their Death with Dignity laws.

Anecdotally, there is evidence that people are forced to move from states without Death with Dignity laws to those that have these laws. It is our belief, and a reason for our work, that no one should have to move to use Death with Dignity as an end of life option.

CAN THE FEDERAL GOVERNMENT OVERTURN OREGON'S LAW?

The Bush administration in the early 2000s attempted to use the federal Controlled Substances Act to overturn the Oregon law, both through Congress and through the courts. However, since the CSA bans the use and trafficking of illegal drugs and regulates the use of legal narcotics for approved medical purposes, and the Oregon Death with Dignity Act specifies only the use of legal narcotics for physician-assisted dying because the Oregon law. In the United States, it is the states, not the federal government, that licenses physicians and determines what is and is not legitimate medical practice. In 2006, the US Supreme Court decided, in the case *Gonzales v. Oregon,* that the federal government overstepped his authority in seeking to punish doctors who prescribed drugs to help terminally ill patients end their lives. The Supreme Court said that the Oregon law supersedes federal authority to regulate physicians and that the Bush administration improperly attempted to use the CSA to prosecute Oregon physicians who assist in patient suicides.

Supporting Death with Dignity

HOW CAN I PROMOTE DEATH WITH DIGNITY IN MY COMMUNITY?

Anyone can be an advocate for Death with Dignity. From contacting your legislator to spreading the word on social media to sharing your story to volunteering, your voice matters.

Learn more about becoming a Death with Dignity advocate →

HOW CAN I FINANCIALLY SUPPORT DEATH WITH DIGNITY?

There are many ways you can contribute funds to promoting and passing Death with Dignity laws:

- Donate
- Match your donation
- Leave a legacy
- Give stock or mutual funds
- Shop on AmazonSmile

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Death With Dignity
520 SW 6th Avenue, Suite 1220
Portland, OR 97204
Contact Us

CERTIFICATE OF SERVICE

I hereby certify that on April 27, 2016, a true and correct copy of this **MOTION FOR REHEARING** was served on proponents via email and U.S. Mail as follows:

Jaren Ducker (via U.S. Mail)
200 N. High Street
Denver, CO

Julie Selsberg (via U.S. Mail)
2060 Jasmine Street
Denver, CO
Proponents

Mark G. Grueskin (via email)
1600 Stout Street, Suite 1000
Denver CO 80202
mark@rklawpc.com
Attorney for Proponents

s/Jonelle Martinez

Ballot Title Setting Board

DATE FILED: May 19, 2016 5:22 PM

Proposed Initiative 2015-2016 #145[1]

The title as designated and fixed by the Board is as follows:

A change to the Colorado revised statutes to permit any mentally capable adult Colorado resident who has a medical prognosis of death by terminal illness within six months to receive a prescription from a willing licensed physician for medication that can be self-administered to bring about death; and in connection therewith, requiring two licensed physicians to confirm the medical prognosis, that the terminally-ill patient has received information about other care and treatment options, and that the patient is making a voluntary and informed decision in requesting the medication; requiring evaluation by a licensed mental health professional if either physician believes the patient may not be mentally capable; granting immunity from civil and criminal liability and professional discipline to any person who in good faith assists in providing access to or is present when a patient self-administers the medication; and establishing criminal penalties for persons who knowingly violate statutes relating to the request for the medication.

The ballot title and submission clause as designated and fixed by the Board is as follows:

Shall there be a change to the Colorado revised statutes to permit any mentally capable adult Colorado resident who has a medical prognosis of death by terminal illness within six months to receive a prescription from a willing licensed physician for medication that can be self-administered to bring about death; and in connection therewith, requiring two licensed physicians to confirm the medical prognosis, that the terminally-ill patient has received information about other care and treatment options, and that the patient is making a voluntary and informed decision in requesting the medication; requiring evaluation by a licensed mental health professional if either physician believes the patient may not be mentally capable; granting immunity from civil and criminal liability and professional discipline to any person who in good faith assists in providing access to or is present when a patient self-administers the medication; and establishing criminal penalties for persons who knowingly violate statutes relating to the request for the medication?

Hearing April 20, 2016:
Single subject approved; staff draft amended; titles set.
Hearing adjourned 10:22 a.m.

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[1] Unofficially captioned **"Medical Aid in Dying"** by legislative staff for tracking purposes. This caption is not part of the titles set by the Board.

EXHIBIT B

Rehearing April 28, 2016:
Motion for Rehearing denied.
Hearing adjourned 12:16 p.m.

Final #145

Be it enacted by the people of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** article 48 to title 25 as follows:

ARTICLE 48

End-of-life Options

25-48-101. Short title. THE SHORT TITLE OF THIS ARTICLE IS THE "COLORADO END-OF-LIFE OPTIONS ACT".

25-48-102. Definitions. AS USED IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "ADULT" MEANS AN INDIVIDUAL WHO IS EIGHTEEN YEARS OF AGE OR OLDER.

(2) "ATTENDING PHYSICIAN" MEANS A PHYSICIAN WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE OF A TERMINALLY ILL INDIVIDUAL AND THE TREATMENT OF THE INDIVIDUAL'S TERMINAL ILLNESS.

(3) "CONSULTING PHYSICIAN" MEANS A PHYSICIAN WHO IS QUALIFIED BY SPECIALTY OR EXPERIENCE TO MAKE A PROFESSIONAL DIAGNOSIS AND PROGNOSIS REGARDING A TERMINALLY ILL INDIVIDUAL'S ILLNESS.

(4) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A PERSON WHO IS LICENSED, CERTIFIED, REGISTERED, OR OTHERWISE AUTHORIZED OR PERMITTED BY LAW TO ADMINISTER HEALTH CARE OR DISPENSE MEDICATION IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION. THE TERM INCLUDES A HEALTH CARE FACILITY, INCLUDING A LONG-TERM CARE FACILITY AS DEFINED IN SECTION 25-3-103.7 (1) (f.3) AND A CONTINUING CARE RETIREMENT COMMUNITY AS DESCRIBED IN SECTION 25.5-6-203 (1)(c)(I), C.R.S.

(5) "INFORMED DECISION" MEANS A DECISION THAT IS:

(a) MADE BY AN INDIVIDUAL TO OBTAIN A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION THAT THE QUALIFIED INDIVIDUAL MAY DECIDE TO SELF-ADMINISTER TO END HIS OR HER LIFE IN A PEACEFUL MANNER;

(b) BASED ON AN UNDERSTANDING AND ACKNOWLEDGMENT OF THE RELEVANT FACTS; AND

(c) MADE AFTER THE ATTENDING PHYSICIAN FULLY INFORMS THE INDIVIDUAL OF:

(I) HIS OR HER MEDICAL DIAGNOSIS AND PROGNOSIS OF SIX MONTHS OR LESS;

(II) THE POTENTIAL RISKS ASSOCIATED WITH TAKING THE MEDICAL AID-IN DYING MEDICATION TO BE PRESCRIBED;

(III) THE PROBABLE RESULT OF TAKING THE MEDICAL AID-IN-DYING MEDICATION TO BE PRESCRIBED;

(IV) THE CHOICES AVAILABLE TO AN INDIVIDUAL THAT DEMONSTRATE HIS OR HER SELF-DETERMINATION AND INTENT TO END HIS OR HER LIFE IN A PEACEFUL MANNER, INCLUDING THE ABILITY TO CHOOSE WHETHER TO:

(A) REQUEST MEDICAL AID IN DYING;

(B) OBTAIN A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION TO END HIS OR HER LIFE;

EXHIBIT A

(C) FILL THE PRESCRIPTION AND POSSESS MEDICAL AID-IN-DYING MEDICATION TO END HIS OR HER LIFE; AND

(D) ULTIMATELY SELF-ADMINISTER THE MEDICAL AID-IN-DYING MEDICATION TO BRING ABOUT A PEACEFUL DEATH; AND

(V)ALL FEASIBLE ALTERNATIVES OR ADDITIONAL TREATMENT OPPORTUNITIES, INCLUDING COMFORT CARE, PALLIATIVE CARE, HOSPICE CARE, AND PAIN CONTROL.

(6) "LICENSED MENTAL HEALTH PROFESSIONAL" MEANS A PSYCHIATRIST LICENSED UNDER ARTICLE 36 OF TITLE 12, C.R.S., OR A PSYCHOLOGIST LICENSED UNDER PART 3 OF ARTICLE 43 OF TITLE 12, C.R.S.

(7) "MEDICAL AID IN DYING" MEANS THE MEDICAL PRACTICE OF A PHYSICIAN PRESCRIBING MEDICAL AID-IN-DYING MEDICATION TO A QUALIFIED INDIVIDUAL THAT THE INDIVIDUAL MAY CHOOSE TO SELF-ADMINISTER TO BRING ABOUT A PEACEFUL DEATH.

(8) "MEDICAL AID-IN-DYING MEDICATION" MEANS MEDICATION PRESCRIBED BY A PHYSICIAN PURSUANT TO THIS ARTICLE TO PROVIDE MEDICAL AID IN DYING TO A QUALIFIED INDIVIDUAL.

(9) "MEDICALLY CONFIRMED" MEANS THAT A CONSULTING PHYSICIAN WHO HAS EXAMINED THE TERMINALLY ILL INDIVIDUAL AND THE INDIVIDUAL'S RELEVANT MEDICAL RECORDS HAS CONFIRMED THE MEDICAL OPINION OF THE ATTENDING PHYSICIAN.

(10) "MENTAL CAPACITY" OR "MENTALLY 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 HEALTH CARE PROVIDERS.

(11) "PHYSICIAN" MEANS A DOCTOR OF MEDICINE OR OSTEOPATHY LICENSED TO PRACTICE MEDICINE BY THE COLORADO MEDICAL BOARD.

(12) "PROGNOSIS OF SIX MONTHS OR LESS" MEANS A PROGNOSIS RESULTING FROM A TERMINAL ILLNESS THAT THE ILLNESS WILL, WITHIN REASONABLE MEDICAL JUDGMENT, RESULT IN DEATH WITHIN SIX MONTHS AND WHICH HAS BEEN MEDICALLY CONFIRMED.

(13) "QUALIFIED INDIVIDUAL" MEANS A TERMINALLY ILL ADULT WITH A PROGNOSIS OF SIX MONTHS OR LESS, WHO HAS MENTAL CAPACITY, HAS MADE AN INFORMED DECISION, IS A RESIDENT OF THE STATE, AND HAS SATISFIED THE REQUIREMENTS OF THIS ARTICLE IN ORDER TO OBTAIN A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION TO END HIS OR HER LIFE IN A PEACEFUL MANNER.

(14) "RESIDENT" MEANS AN INDIVIDUAL WHO IS ABLE TO DEMONSTRATE RESIDENCY IN COLORADO BY PROVIDING ANY OF THE FOLLOWING DOCUMENTATION TO HIS OR HER ATTENDING PHYSICIAN:

(a) A COLORADO DRIVER'S LICENSE OR IDENTIFICATION CARD ISSUED PURSUANT TO ARTICLE 2 OF TITLE 42, C.R.S.;

(b) A COLORADO VOTER REGISTRATION CARD OR OTHER DOCUMENTATION SHOWING THE INDIVIDUAL IS REGISTERED TO VOTE IN COLORADO;

(c) EVIDENCE THAT THE INDIVIDUAL OWNS OR LEASES PROPERTY IN COLORADO; OR
(d) A COLORADO INCOME TAX RETURN FOR THE MOST RECENT TAX YEAR.
(15) "SELF-ADMINISTER" MEANS A QUALIFIED INDIVIDUAL'S AFFIRMATIVE, CONSCIOUS, AND PHYSICAL ACT OF ADMINISTERING THE MEDICAL AID-IN-DYING MEDICATION TO HIMSELF OR HERSELF TO BRING ABOUT HIS OR HER OWN DEATH.
(16) "TERMINAL ILLNESS" MEANS AN INCURABLE AND IRREVERSIBLE ILLNESS THAT WILL, WITHIN REASONABLE MEDICAL JUDGMENT, RESULT IN DEATH.

25-48-103. Right to request medical aid-in-dying medication. (1) AN ADULT RESIDENT OF COLORADO MAY MAKE A REQUEST, IN ACCORDANCE WITH SECTIONS 25-48-104 AND 25-48-112, TO RECEIVE A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION IF:
(a) THE INDIVIDUAL'S ATTENDING PHYSICIAN HAS DIAGNOSED THE INDIVIDUAL WITH A TERMINAL ILLNESS WITH A PROGNOSIS OF SIX MONTHS OR LESS;
(b) THE INDIVIDUAL'S ATTENDING PHYSICIAN HAS DETERMINED THE INDIVIDUAL HAS MENTAL CAPACITY; AND
(c) THE INDIVIDUAL HAS VOLUNTARILY EXPRESSED THE WISH TO RECEIVE A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION.
(2) THE RIGHT TO REQUEST MEDICAL AID-IN-DYING MEDICATION DOES NOT EXIST BECAUSE OF AGE OR DISABILITY.

25-48-104. Request process - witness requirements. (1) IN ORDER TO RECEIVE A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION PURSUANT TO THIS ARTICLE, AN INDIVIDUAL WHO SATISFIES THE REQUIREMENTS IN SECTION 25-48-103 MUST MAKE TWO ORAL REQUESTS, SEPARATED BY AT LEAST FIFTEEN DAYS, AND A VALID WRITTEN REQUEST TO HIS OR HER ATTENDING PHYSICIAN.
(2)(a) TO BE VALID, A WRITTEN REQUEST FOR MEDICAL AID-IN-DYING MEDICATION MUST BE:
(I) SUBSTANTIALLY IN THE SAME FORM AS SET FORTH IN SECTION 25-48-112;
(II) SIGNED AND DATED BY THE INDIVIDUAL SEEKING THE MEDICAL AID-IN-DYING MEDICATION; AND
(III) WITNESSED BY AT LEAST TWO INDIVIDUALS WHO, IN THE PRESENCE OF THE INDIVIDUAL, ATTEST TO THE BEST OF THEIR KNOWLEDGE AND BELIEF THAT THE INDIVIDUAL IS:
(A) MENTALLY CAPABLE;
(B) ACTING VOLUNTARILY; AND
(C) NOT BEING COERCED TO SIGN THE REQUEST.
(b) OF THE TWO WITNESSES TO THE WRITTEN REQUEST, AT LEAST ONE MUST NOT BE:
(I) RELATED TO THE INDIVIDUAL BY BLOOD, MARRIAGE, CIVIL UNION, OR ADOPTION;
(II) AN INDIVIDUAL WHO, AT THE TIME THE REQUEST IS SIGNED, IS ENTITLED, UNDER A WILL OR BY OPERATION OF LAW, TO ANY PORTION OF THE INDIVIDUAL'S ESTATE UPON HIS OR HER DEATH; OR
(III) AN OWNER, OPERATOR, OR EMPLOYEE OF A HEALTH CARE FACILITY WHERE THE INDIVIDUAL IS RECEIVING MEDICAL TREATMENT OR IS A RESIDENT.

(c) NEITHER THE INDIVIDUAL'S ATTENDING PHYSICIAN NOR A PERSON AUTHORIZED AS THE INDIVIDUAL'S QUALIFIED POWER OF ATTORNEY OR DURABLE MEDICAL POWER OF ATTORNEY SHALL SERVE AS A WITNESS TO THE WRITTEN REQUEST.

25-48-105. Right to rescind request - requirement to offer opportunity to rescind. (1) AT ANY TIME, AN INDIVIDUAL MAY RESCIND HIS OR HER REQUEST FOR MEDICAL AID-IN-DYING MEDICATION WITHOUT REGARD TO THE INDIVIDUAL'S MENTAL STATE.
(2) AN ATTENDING PHYSICIAN SHALL NOT WRITE A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION UNDER THIS ARTICLE UNLESS THE ATTENDING PHYSICIAN OFFERS THE QUALIFIED INDIVIDUAL AN OPPORTUNITY TO RESCIND THE REQUEST FOR THE MEDICAL AID-IN-DYING MEDICATION.

25-48-106. Attending physician responsibilities. (1) THE ATTENDING PHYSICIAN SHALL:
(a) MAKE THE INITIAL DETERMINATION OF WHETHER AN INDIVIDUAL REQUESTING MEDICAL AID-IN-DYING MEDICATION HAS A TERMINAL ILLNESS, HAS A PROGNOSIS OF SIX MONTHS OR LESS, IS MENTALLY CAPABLE, IS MAKING AN INFORMED DECISION, AND HAS MADE THE REQUEST VOLUNTARILY;
(b) REQUEST THAT THE INDIVIDUAL DEMONSTRATE COLORADO RESIDENCY BY PROVIDING DOCUMENTATION AS DESCRIBED IN SECTION 25-48-102 (14);
(c) PROVIDE CARE THAT CONFORMS TO ESTABLISHED MEDICAL STANDARDS AND ACCEPTED MEDICAL GUIDELINES;
(d) REFER THE INDIVIDUAL TO A CONSULTING PHYSICIAN FOR MEDICAL CONFIRMATION OF THE DIAGNOSIS AND PROGNOSIS AND FOR A DETERMINATION OF WHETHER THE INDIVIDUAL IS MENTALLY CAPABLE, IS MAKING AN INFORMED DECISION, AND ACTING VOLUNTARILY;
(e) PROVIDE FULL, INDIVIDUAL-CENTERED DISCLOSURES TO ENSURE THAT THE INDIVIDUAL IS MAKING AN INFORMED DECISION BY DISCUSSING WITH THE INDIVIDUAL:
(I) HIS OR HER MEDICAL DIAGNOSIS AND PROGNOSIS OF SIX MONTHS OR LESS;
(II) THE FEASIBLE ALTERNATIVES OR ADDITIONAL TREATMENT OPPORTUNITIES, INCLUDING COMFORT CARE, PALLIATIVE CARE, HOSPICE CARE, AND PAIN CONTROL;
(III) THE POTENTIAL RISKS ASSOCIATED WITH TAKING THE MEDICAL AID-IN-DYING MEDICATION TO BE PRESCRIBED;
(IV) THE PROBABLE RESULT OF TAKING THE MEDICAL AID-IN-DYING MEDICATION TO BE PRESCRIBED; AND
(V) THE POSSIBILITY THAT THE INDIVIDUAL CAN OBTAIN THE MEDICAL AID-IN-DYING MEDICATION BUT CHOOSE NOT TO USE IT;
(f) REFER THE INDIVIDUAL TO A LICENSED MENTAL HEALTH PROFESSIONAL PURSUANT TO SECTION 25-48-108 IF THE ATTENDING PHYSICIAN BELIEVES THAT THE INDIVIDUAL MAY NOT BE MENTALLY CAPABLE OF MAKING AN INFORMED DECISION;
(g) CONFIRM THAT THE INDIVIDUAL'S REQUEST DOES NOT ARISE FROM COERCION OR UNDUE INFLUENCE BY ANOTHER PERSON BY DISCUSSING WITH THE INDIVIDUAL, OUTSIDE THE PRESENCE OF

OTHER PERSONS, WHETHER THE INDIVIDUAL IS FEELING COERCED OR UNDULY INFLUENCED BY ANOTHER PERSON;

(h) COUNSEL THE INDIVIDUAL ABOUT THE IMPORTANCE OF:

(I) HAVING ANOTHER PERSON PRESENT WHEN THE INDIVIDUAL SELF-ADMINISTERS THE MEDICAL AID-IN-DYING MEDICATION PRESCRIBED PURSUANT TO THIS ARTICLE;

(II) NOT TAKING THE MEDICAL AID-IN-DYING MEDICATION IN A PUBLIC PLACE;

(III) SAFE-KEEPING AND PROPER DISPOSAL OF UNUSED MEDICAL AID-IN-DYING MEDICATION IN ACCORDANCE WITH SECTION 25-48-120; AND

(IV) NOTIFYING HIS OR HER NEXT OF KIN OF THE REQUEST FOR MEDICAL AID-IN-DYING MEDICATION;

(i) INFORM THE INDIVIDUAL THAT HE OR SHE MAY RESCIND THE REQUEST FOR MEDICAL AID-IN-DYING MEDICATION AT ANY TIME AND IN ANY MANNER;

(j) VERIFY, IMMEDIATELY PRIOR TO WRITING THE PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION, THAT THE INDIVIDUAL IS MAKING AN INFORMED DECISION;

(k) ENSURE THAT ALL APPROPRIATE STEPS ARE CARRIED OUT IN ACCORDANCE WITH THIS ARTICLE BEFORE WRITING A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION; AND

(l) EITHER:

(I) DISPENSE MEDICAL AID-IN-DYING MEDICATIONS DIRECTLY TO THE QUALIFIED INDIVIDUAL, INCLUDING ANCILLARY MEDICATIONS INTENDED TO MINIMIZE THE INDIVIDUAL'S DISCOMFORT, IF THE ATTENDING PHYSICIAN HAS A CURRENT DRUG ENFORCEMENT ADMINISTRATION CERTIFICATE AND COMPLIES WITH ANY APPLICABLE ADMINISTRATIVE RULE; OR

(II) DELIVER THE WRITTEN PRESCRIPTION PERSONALLY, BY MAIL, OR THROUGH AUTHORIZED ELECTRONIC TRANSMISSION IN THE MANNER PERMITTED UNDER ARTICLE 42.5 OF TITLE 12, C.R.S., TO A LICENSED PHARMACIST, WHO SHALL DISPENSE THE MEDICAL AID-IN-DYING MEDICATION TO THE QUALIFIED INDIVIDUAL, THE ATTENDING PHYSICIAN, OR AN INDIVIDUAL EXPRESSLY DESIGNATED BY THE QUALIFIED INDIVIDUAL.

25-48-107. Consulting physician responsibilities. BEFORE AN INDIVIDUAL WHO IS REQUESTING MEDICAL AID-IN-DYING MEDICATION MAY RECEIVE A PRESCRIPTION FOR THE MEDICAL AID-IN-DYING MEDICATION, A CONSULTING PHYSICIAN MUST:

(1) EXAMINE THE INDIVIDUAL AND HIS OR HER RELEVANT MEDICAL RECORDS;

(2) CONFIRM, IN WRITING, TO THE ATTENDING PHYSICIAN:

(a) THAT THE INDIVIDUAL HAS A TERMINAL ILLNESS;

(b) THE INDIVIDUAL HAS A PROGNOSIS OF SIX MONTHS OR LESS;

(c) THAT THE INDIVIDUAL IS MAKING AN INFORMED DECISION; AND

(d) THAT THE INDIVIDUAL IS MENTALLY CAPABLE, OR PROVIDE DOCUMENTATION THAT THE CONSULTING PHYSICIAN HAS REFERRED THE INDIVIDUAL FOR FURTHER EVALUATION IN ACCORDANCE WITH SECTION 25-48-108.

25-48-108. Confirmation that individual is mentally capable - referral to mental health professional. (1) AN ATTENDING PHYSICIAN SHALL NOT PRESCRIBE MEDICAL AID-IN-DYING

MEDICATION UNDER THIS ARTICLE FOR AN INDIVIDUAL WITH A TERMINAL ILLNESS UNTIL THE INDIVIDUAL IS DETERMINED TO BE MENTALLY CAPABLE AND MAKING AN INFORMED DECISION, AND THOSE DETERMINATIONS ARE CONFIRMED IN ACCORDANCE WITH THIS SECTION.

(2) IF THE ATTENDING PHYSICIAN OR THE CONSULTING PHYSICIAN BELIEVES THAT THE INDIVIDUAL MAY NOT BE MENTALLY CAPABLE OF MAKING AN INFORMED DECISION, THE ATTENDING PHYSICIAN OR CONSULTING PHYSICIAN SHALL REFER THE INDIVIDUAL TO A LICENSED MENTAL HEALTH PROFESSIONAL FOR A DETERMINATION OF WHETHER THE INDIVIDUAL IS MENTALLY CAPABLE AND MAKING AN INFORMED DECISION.

(3) A LICENSED MENTAL HEALTH PROFESSIONAL WHO EVALUATES AN INDIVIDUAL UNDER THIS SECTION SHALL COMMUNICATE, IN WRITING, TO THE ATTENDING OR CONSULTING PHYSICIAN WHO REQUESTED THE EVALUATION, HIS OR HER CONCLUSIONS ABOUT WHETHER THE INDIVIDUAL IS MENTALLY CAPABLE AND MAKING INFORMED DECISIONS. IF THE LICENSED MENTAL HEALTH PROFESSIONAL DETERMINES THAT THE INDIVIDUAL IS NOT MENTALLY CAPABLE OF MAKING INFORMED DECISIONS, THE PERSON SHALL NOT BE DEEMED A QUALIFIED INDIVIDUAL UNDER THIS ARTICLE AND THE ATTENDING PHYSICIAN SHALL NOT PRESCRIBE MEDICAL AID-IN-DYING MEDICATION TO THE INDIVIDUAL.

25-48-109. Death certificate. (1) UNLESS OTHERWISE PROHIBITED BY LAW, THE ATTENDING PHYSICIAN OR THE HOSPICE MEDICAL DIRECTOR SHALL SIGN THE DEATH CERTIFICATE OF A QUALIFIED INDIVIDUAL WHO OBTAINED AND SELF-ADMINISTERED AID-IN-DYING MEDICATION.

(2) WHEN A DEATH HAS OCCURRED IN ACCORDANCE WITH THIS ARTICLE, THE CAUSE OF DEATH SHALL BE LISTED AS THE UNDERLYING TERMINAL ILLNESS AND THE DEATH DOES NOT CONSTITUTE GROUNDS FOR POST-MORTEM INQUIRY UNDER SECTION 30-10-606 (1), C.R.S.

25-48-110. Informed decision required. (1) AN INDIVIDUAL WITH A TERMINAL ILLNESS IS NOT A QUALIFIED INDIVIDUAL AND MAY NOT RECEIVE A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION UNLESS HE OR SHE HAS MADE AN INFORMED DECISION.

(2) IMMEDIATELY BEFORE WRITING A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION UNDER THIS ARTICLE, THE ATTENDING PHYSICIAN SHALL VERIFY THAT THE INDIVIDUAL WITH A TERMINAL ILLNESS IS MAKING AN INFORMED DECISION.

25-48-111. Medical record documentation requirements - reporting requirements - department compliance reviews - rules. (1) THE ATTENDING PHYSICIAN SHALL DOCUMENT IN THE INDIVIDUAL'S MEDICAL RECORD, THE FOLLOWING INFORMATION:

(a) DATES OF ALL ORAL REQUESTS;

(b) A VALID WRITTEN REQUEST;

(c) THE ATTENDING PHYSICIAN'S DIAGNOSIS AND PROGNOSIS, DETERMINATION OF MENTAL CAPACITY AND THAT THE INDIVIDUAL IS MAKING A VOLUNTARY REQUEST AND AN INFORMED DECISION;

(d) THE CONSULTING PHYSICIAN'S CONFIRMATION OF DIAGNOSIS AND PROGNOSIS, MENTAL CAPACITY AND THAT THE INDIVIDUAL IS MAKING AN INFORMED DECISION;
(e) IF APPLICABLE, WRITTEN CONFIRMATION OF MENTAL CAPACITY FROM A LICENSED MENTAL HEALTH PROFESSIONAL;
(f) A NOTATION OF NOTIFICATION OF THE RIGHT TO RESCIND A REQUEST MADE PURSUANT TO THIS ARTICLE; AND
(g) A NOTATION BY THE ATTENDING PHYSICIAN THAT ALL REQUIREMENTS UNDER THIS ARTICLE HAVE BEEN SATISFIED; INDICATING STEPS TAKEN TO CARRY OUT THE REQUEST, INCLUDING A NOTATION OF THE MEDICAL AID-IN-DYING MEDICATIONS PRESCRIBED AND WHEN.
(2)(a) THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT SHALL ANNUALLY REVIEW A SAMPLE OF RECORDS MAINTAINED PURSUANT TO THIS ARTICLE TO ENSURE COMPLIANCE. THE DEPARTMENT SHALL ADOPT RULES TO FACILITATE THE COLLECTION OF INFORMATION DEFINED IN SUBSECTION (1) OF THIS SECTION. EXCEPT AS OTHERWISE REQUIRED BY LAW, THE INFORMATION COLLECTED BY THE DEPARTMENT IS NOT A PUBLIC RECORD AND IS NOT AVAILABLE FOR PUBLIC INSPECTION. HOWEVER, THE DEPARTMENT SHALL GENERATE AND MAKE AVAILABLE TO THE PUBLIC AN ANNUAL STATISTICAL REPORT OF INFORMATION COLLECTED UNDER THIS SUBSECTION (2).
(b) THE DEPARTMENT SHALL REQUIRE ANY HEALTH CARE PROVIDER, UPON DISPENSING A MEDICAL AID-IN-DYING MEDICATION PURSUANT TO THIS ARTICLE, TO FILE A COPY OF A DISPENSING RECORD WITH THE DEPARTMENT. THE DISPENSING RECORD IS NOT A PUBLIC RECORD AND IS NOT AVAILABLE FOR PUBLIC INSPECTION.

25-48-112. Form of written request. (1) A REQUEST FOR MEDICAL AID-IN-DYING MEDICATION AUTHORIZED BY THIS ARTICLE MUST BE IN SUBSTANTIALLY THE FOLLOWING FORM:

REQUEST FOR MEDICATION TO END MY LIFE
IN A PEACEFUL MANNER

I,_____AM AN ADULT OF SOUND MIND. I AM SUFFERING FROM_____, WHICH MY ATTENDING PHYSICIAN HAS DETERMINED IS A TERMINAL ILLNESS AND WHICH HAS BEEN MEDICALLY CONFIRMED. I HAVE BEEN FULLY INFORMED OF MY DIAGNOSIS AND PROGNOSIS OF SIX MONTHS OR LESS, THE NATURE OF THE MEDICAL 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, PALLIATIVE CARE, HOSPICE CARE, AND PAIN CONTROL.
I REQUEST THAT MY ATTENDING PHYSICIAN PRESCRIBE MEDICAL AID-IN-DYING MEDICATION THAT WILL END MY LIFE IN A PEACEFUL 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 SERIOUSNESS 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, WITHOUT RESERVATION, AND WITHOUT BEING COERCED, AND I ACCEPT FULL RESPONSIBILITY FOR MY ACTIONS.

SIGNED: _____

DATED: _____

DECLARATION OF WITNESSES

WE DECLARE THAT THE INDIVIDUAL SIGNING THIS REQUEST:

IS PERSONALLY KNOWN TO US OR HAS PROVIDED PROOF OF IDENTITY;
SIGNED THIS REQUEST IN OUR PRESENCE;

APPEARS TO BE OF SOUND MIND AND NOT UNDER DURESS, COERCION, OR UNDUE INFLUENCE; AND

I AM NOT THE ATTENDING PHYSICIAN FOR THE INDIVIDUAL.

_____WITNESS 1/DATE

_____WITNESS 2/DATE

NOTE: OF THE TWO WITNESSES TO THE WRITTEN REQUEST, AT LEAST ONE MUST NOT:
BE A RELATIVE (BY BLOOD, MARRIAGE, CIVIL UNION, OR ADOPTION) OF THE INDIVIDUAL SIGNING THIS REQUEST; BE ENTITLED TO ANY PORTION OF THE INDIVIDUAL'S ESTATE UPON DEATH; OR OWN, OPERATE, OR BE EMPLOYED AT A HEALTH CARE FACILITY WHERE THE INDIVIDUAL IS A PATIENT OR RESIDENT.
AND NEITHER THE INDIVIDUAL'S ATTENDING PHYSICIAN NOR A PERSON AUTHORIZED AS THE INDIVIDUAL'S QUALIFIED POWER OF ATTORNEY OR DURABLE MEDICAL POWER OF ATTORNEY SHALL SERVE AS A WITNESS TO THE WRITTEN REQUEST.

25-48-113. Standard of care. (1) PHYSICIANS AND HEALTH CARE PROVIDERS SHALL PROVIDE MEDICAL SERVICES UNDER THIS ACT THAT MEET OR EXCEED THE STANDARD OF CARE FOR END-OF-LIFE MEDICAL CARE.
(2) IF A HEALTH CARE PROVIDER IS UNABLE OR UNWILLING TO CARRY OUT AN ELIGIBLE INDIVIDUAL'S REQUEST AND THE INDIVIDUAL TRANSFERS CARE TO A NEW HEALTH CARE PROVIDER, THE HEALTH CARE PROVIDER SHALL COORDINATE TRANSFER OF THE INDIVIDUAL'S MEDICAL RECORDS TO A NEW HEALTH CARE PROVIDER.

25-48-114. Effect on wills, contracts, and statutes. (1) A PROVISION IN A CONTRACT, WILL, OR OTHER AGREEMENT, WHETHER WRITTEN OR ORAL, THAT WOULD AFFECT WHETHER AN INDIVIDUAL

MAY MAKE OR RESCIND A REQUEST FOR MEDICAL AID IN DYING PURSUANT TO THIS ARTICLE IS INVALID.

(2) AN OBLIGATION OWING UNDER ANY CURRENTLY EXISTING CONTRACT MUST NOT BE CONDITIONED UPON, OR AFFECTED BY, AN INDIVIDUAL'S ACT OF MAKING OR RESCINDING A REQUEST FOR MEDICAL AID-IN-DYING MEDICATION PURSUANT TO THIS ARTICLE.

25-48-115. Insurance or annuity policies. (1) THE SALE, PROCUREMENT, OR ISSUANCE OF, OR THE RATE CHARGED FOR, ANY LIFE, HEALTH, OR ACCIDENT INSURANCE OR ANNUITY POLICY MUST NOT BE CONDITIONED UPON, OR AFFECTED BY, AN INDIVIDUAL'S ACT OF MAKING OR RESCINDING A REQUEST FOR MEDICAL AID-IN-DYING MEDICATION IN ACCORDANCE WITH THIS ARTICLE.

(2) A QUALIFIED INDIVIDUAL'S ACT OF SELF-ADMINISTERING MEDICAL AID-IN-DYING MEDICATION PURSUANT TO THIS ARTICLE DOES NOT AFFECT A LIFE, HEALTH, OR ACCIDENT INSURANCE OR ANNUITY POLICY.

(3) AN INSURER SHALL NOT DENY OR OTHERWISE ALTER HEALTH CARE BENEFITS AVAILABLE UNDER A POLICY OF SICKNESS AND ACCIDENT INSURANCE TO AN INDIVIDUAL WITH A TERMINAL ILLNESS WHO IS COVERED UNDER THE POLICY, BASED ON WHETHER OR NOT THE INDIVIDUAL MAKES A REQUEST PURSUANT TO THIS ARTICLE.

(4) AN INDIVIDUAL WITH A TERMINAL ILLNESS WHO IS A RECIPIENT OF MEDICAL ASSISTANCE UNDER THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S. SHALL NOT BE DENIED BENEFITS UNDER THE MEDICAL ASSISTANCE PROGRAM OR HAVE HIS OR HER BENEFITS UNDER THE PROGRAM OTHERWISE ALTERED BASED ON WHETHER OR NOT THE INDIVIDUAL MAKES A REQUEST PURSUANT TO THIS ARTICLE.

25-48-116. Immunity for actions in good faith - prohibition against reprisals. (1) A PERSON IS NOT SUBJECT TO CIVIL OR CRIMINAL LIABILITY OR PROFESSIONAL DISCIPLINARY ACTION FOR ACTING IN GOOD FAITH UNDER THIS ARTICLE, WHICH INCLUDES BEING PRESENT WHEN A QUALIFIED INDIVIDUAL SELF-ADMINISTERS THE PRESCRIBED MEDICAL AID-IN-DYING MEDICATION.

(2) EXCEPT AS PROVIDED FOR IN SECTION 25-48-118, A HEALTH CARE PROVIDER OR PROFESSIONAL ORGANIZATION OR ASSOCIATION SHALL NOT SUBJECT AN INDIVIDUAL TO ANY OF THE FOLLOWING FOR PARTICIPATING OR REFUSING TO PARTICIPATE IN GOOD-FAITH COMPLIANCE UNDER THIS ARTICLE:

(a) CENSURE;

(b) DISCIPLINE;

(c) SUSPENSION;

(d) LOSS OF LICENSE, PRIVILEGES, OR MEMBERSHIP; OR

(e) ANY OTHER PENALTY.

(3) A REQUEST BY AN INDIVIDUAL FOR, OR THE PROVISION BY AN ATTENDING PHYSICIAN OF, MEDICAL AID-IN-DYING MEDICATION IN GOOD-FAITH COMPLIANCE WITH THIS ARTICLE DOES NOT:

(a) CONSTITUTE NEGLECT OR ELDER ABUSE FOR ANY PURPOSE OF LAW; OR

(b) PROVIDE THE BASIS FOR THE APPOINTMENT OF A GUARDIAN OR CONSERVATOR.

(4) THIS SECTION DOES NOT LIMIT CIVIL OR CRIMINAL LIABILITY FOR NEGLIGENCE, RECKLESSNESS, OR INTENTIONAL MISCONDUCT.

25-48-117. No duty to prescribe or dispense. (1) A HEALTH CARE PROVIDER MAY CHOOSE WHETHER TO PARTICIPATE IN PROVIDING MEDICAL AID-IN-DYING MEDICATION TO AN INDIVIDUAL IN ACCORDANCE WITH THIS ARTICLE.
(2) IF A HEALTH CARE PROVIDER IS UNABLE OR UNWILLING TO CARRY OUT AN INDIVIDUAL'S REQUEST FOR MEDICAL AID-IN-DYING MEDICATION MADE IN ACCORDANCE WITH THIS ARTICLE, AND THE INDIVIDUAL TRANSFERS HIS OR HER CARE TO A NEW HEALTH CARE PROVIDER, THE PRIOR HEALTH CARE PROVIDER SHALL TRANSFER, UPON REQUEST, A COPY OF THE INDIVIDUAL'S RELEVANT MEDICAL RECORDS TO THE NEW HEALTH CARE PROVIDER.

25-48-118. Health care facility permissible prohibitions - sanctions if provider violates policy. (1) A HEALTH CARE FACILITY MAY PROHIBIT A PHYSICIAN EMPLOYED OR UNDER CONTRACT FROM WRITING A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION FOR A QUALIFIED INDIVIDUAL WHO INTENDS TO USE THE MEDICAL AID-IN-DYING MEDICATION ON THE FACILITY'S PREMISES. THE HEALTH CARE FACILITY MUST NOTIFY THE PHYSICIAN IN WRITING OF ITS POLICY WITH REGARD TO PRESCRIPTIONS FOR MEDICAL AID-IN-DYING MEDICATION. A HEALTH CARE FACILITY THAT FAILS TO PROVIDE ADVANCE NOTICE TO THE PHYSICIAN SHALL NOT BE ENTITLED TO ENFORCE SUCH A POLICY AGAINST THE PHYSICIAN.
(2) A HEALTH CARE FACILITY OR HEALTH CARE PROVIDER SHALL NOT SUBJECT A PHYSICIAN, NURSE, PHARMACIST, OR OTHER PERSON TO DISCIPLINE, SUSPENSION, LOSS OF LICENSE OR PRIVILEGES, OR ANY OTHER PENALTY OR SANCTION FOR ACTIONS TAKEN IN GOOD-FAITH RELIANCE ON THIS ARTICLE OR FOR REFUSING TO ACT UNDER THIS ARTICLE.
(3) A HEALTH CARE FACILITY MUST NOTIFY PATIENTS IN WRITING OF ITS POLICY WITH REGARD TO MEDICAL AID-IN-DYING. A HEALTH CARE FACILITY THAT FAILS TO PROVIDE ADVANCE NOTIFICATION TO PATIENTS SHALL NOT BE ENTITLED TO ENFORCE SUCH A POLICY.

25-48-119. Liabilities. (1) A PERSON COMMITS A CLASS 2 FELONY AND IS SUBJECT TO PUNISHMENT IN ACCORDANCE WITH SECTION 18-1.3-401, C.R.S. IF THE PERSON, KNOWINGLY OR INTENTIONALLY CAUSES AN INDIVIDUAL'S DEATH BY:
(a) FORGING OR ALTERING A REQUEST FOR MEDICAL AID-IN-DYING MEDICATION TO END AN INDIVIDUAL'S LIFE WITHOUT THE INDIVIDUAL'S AUTHORIZATION; OR
(b) CONCEALING OR DESTROYING A RESCISSION OF A REQUEST FOR MEDICAL AID-IN-DYING MEDICATION.
(2) A PERSON COMMITS A CLASS 2 FELONY AND IS SUBJECT TO PUNISHMENT IN ACCORDANCE WITH SECTION 18-1.3-401, C.R.S. IF THE PERSON KNOWINGLY OR INTENTIONALLY COERCES OR EXERTS UNDUE INFLUENCE ON AN INDIVIDUAL WITH A TERMINAL ILLNESS TO:
(a) REQUEST MEDICAL AID-IN-DYING MEDICATION FOR THE PURPOSE OF ENDING THE TERMINALLY ILL INDIVIDUAL'S LIFE; OR
(b) DESTROY A RESCISSION OF A REQUEST FOR MEDICAL AID-IN-DYING MEDICATION.

(3) NOTHING IN THIS ARTICLE LIMITS FURTHER LIABILITY FOR CIVIL DAMAGES RESULTING FROM OTHER NEGLIGENT CONDUCT OR INTENTIONAL MISCONDUCT BY ANY PERSON.
(4) THE PENALTIES SPECIFIED IN THIS ARTICLE DO NOT PRECLUDE CRIMINAL PENALTIES APPLICABLE UNDER THE "COLORADO CRIMINAL CODE", TITLE 18, C.R.S., FOR CONDUCT THAT IS INCONSISTENT WITH THIS ARTICLE.

25-48-120. Safe disposal of unused medical aid-in-dying medications. A PERSON WHO HAS CUSTODY OR CONTROL OF MEDICAL AID-IN-DYING MEDICATION DISPENSED UNDER THIS ARTICLE THAT THE TERMINALLY ILL INDIVIDUAL DECIDES NOT TO USE OR THAT REMAINS UNUSED AFTER THE TERMINALLY ILL INDIVIDUAL'S DEATH SHALL DISPOSE OF THE UNUSED MEDICAL AID-IN-DYING MEDICATION EITHER BY:
(1) RETURNING THE UNUSED MEDICAL AID-IN-DYING MEDICATION TO THE ATTENDING PHYSICIAN WHO PRESCRIBED THE MEDICAL AID-IN-DYING MEDICATION, WHO SHALL DISPOSE OF THE UNUSED MEDICAL AID-IN-DYING MEDICATION IN THE MANNER REQUIRED BY LAW; OR
(2) LAWFUL MEANS IN ACCORDANCE WITH SECTION 25-15-328, C.R.S. OR ANY OTHER STATE OR FEDERALLY APPROVED MEDICATION TAKE-BACK PROGRAM AUTHORIZED UNDER THE FEDERAL "SECURE AND RESPONSIBLE DRUG DISPOSAL ACT OF 2010", PUB.L.111-273, AND REGULATIONS ADOPTED PURSUANT TO THE FEDERAL ACT.

25-48-121. Actions complying with article not a crime. NOTHING IN THIS ARTICLE AUTHORIZES A PHYSICIAN OR ANY OTHER PERSON TO END AN INDIVIDUAL'S LIFE BY LETHAL INJECTION, MERCY KILLING, OR EUTHANASIA. ACTIONS TAKEN IN ACCORDANCE WITH THIS ARTICLE DO NOT, FOR ANY PURPOSE, CONSTITUTE SUICIDE, ASSISTED SUICIDE, MERCY KILLING, HOMICIDE, OR ELDER ABUSE UNDER THE "COLORADO CRIMINAL CODE", AS SET FORTH IN TITLE 18, C.R.S.

25-48-122. Claims by government entity for costs. A GOVERNMENT ENTITY THAT INCURS COSTS RESULTING FROM AN INDIVIDUAL TERMINATING HIS OR HER LIFE PURSUANT TO THIS ARTICLE IN A PUBLIC PLACE HAS A CLAIM AGAINST THE ESTATE OF THE INDIVIDUAL TO RECOVER THE COSTS AND REASONABLE ATTORNEY FEES RELATED TO ENFORCING THE CLAIM.

25-48-123. No effect on advance medical directives. NOTHING IN THIS ARTICLE SHALL CHANGE THE LEGAL EFFECT OF:
(1) A DECLARATION MADE UNDER ARTICLE 18 OF TITLE 15, C.R.S., DIRECTING THAT LIFE-SUSTAINING PROCEDURES BE WITHHELD OR WITHDRAWN;
(2) A CARDIOPULMONARY RESUSCITATION DIRECTIVE EXECUTED UNDER ARTICLE 18.6 OF TITLE 15, C.R.S.; OR
(3) AN ADVANCE MEDICAL DIRECTIVE EXECUTED UNDER ARTICLE 18.7 OF TITLE 15, C.R.S.