

**Committee on Public Health
Bill Summary**

Bill No.	H2505
Title:	<i>An Act relative to end of life options</i>
Sponsor:	Representative Jim O’Day
Committee:	Public Health
Hearing Date:	April, 2, 2025
Similar Matters:	S1486 (identical)
Prior History:	Refile of H2246; Referred to Public Health Committee; Accompanied S1331
Reporting Deadline:	June 1, 2025; extended to July 1, 2025

Current Law:

- **M.G.L. Chapter 111§70E** outlines a patient’s medical rights, including the right to informed consent.
- **M.G.L. Chapter 111§227** pertains to palliative care and end-of-life options and:
 - mandates that attending health care practitioners of those with a terminal condition must offer the patient information and counseling regarding palliative care and end-of-life options;
 - states that nothing in the section shall be construed to permit a health care professional to offer to provide information about assisted suicide or prescribing medication to end life; and
 - defines palliative care as “a health care treatment, including interdisciplinary end-of-life care and consultation with patients and family members, to prevent or relieve pain and suffering, and to enhance the patient’s quality of life, including hospice care.”
- **M.G.L. Chapter 190B, Article V, Section 5-101** is the Definitions and Inclusions section of the Uniform Probate Code’s article on Protection of Persons Under Disability and their Property. It defines “Guardian ad litem” as “a person or organization appointed under sections 1-404 and 5-106 of this code” (Section 1-404

- and 5-106 provide further details on the description and role of a guardian ad litem) and “Incapacitated person” as “an individual who for reasons other than advanced age or minority, has a clinically diagnosed condition that results in an inability to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance.”
- **M.G.L. Chapter 201D§1** outlines legislation regarding health care proxies. It defines health care proxy as “a document delegating to an agent the authority to make health care decisions, executed in accordance with the requirements of this chapter.”
 - **M.G.L. Chapter 201D§12** states that nothing in Chapter 201D shall be construed to constitute, condone, authorize, or approve suicide or mercy killing, or to permit any affirmative or deliberate act to end one’s own life other than to permit the natural process of dying.
 - **105 CMR 141.203** outlines members and responsibilities of interdisciplinary teams at hospices.

Summary:

This bill would allow terminally ill Massachusetts residents to request medical aid in dying from a physician.

- “Medical Aid in Dying” means “the practice of evaluating a request, determining qualification, performing duties in sections 6, 7, and 8, and providing a prescription to a qualified patient pursuant to this chapter.”
- “Terminally ill” means “having a terminal illness or condition which can reasonably be expected to cause death within 6 months, whether or not treatment is provided.”

Patients may rescind their request at any time and can decide whether or not to take the medication. Any unused medication must be disposed of lawfully.

To be prescribed such medication:

- The attending physician must make an initial determination of whether an adult patient is a mentally capable adult, making an informed decision, a resident of Massachusetts, terminally ill (to be confirmed by a consulting physician), acting voluntarily and not under duress, fraud, or undue influence;
- the patient must not be suffering from a psychiatric or psychological disorder or depression causing impaired judgement (as determined by a licensed mental health professional);
- the patient must make both an oral and a written request, the latter of which requires two qualifying witnesses.

The attending physician must recommend that the patient notify the patient’s family or any person who plays a significant role in an individual's life, as well as counsel the patient about the

importance of: (a) having another individual present when taking the medication and (b) not taking the medication in a public place.

The attending physician can sign the patient's death certificate, noting that the cause of death was the patient's underlying terminal disease. Self-administering the aid in dying medication shall not constitute suicide or impact any life, health, or accident insurance or annuity policies, and actions taken by health care providers and patient advocates pursuant to this legislation will not constitute elder abuse, neglect, assisted suicide, mercy killing, or homicide under any civil or criminal law. This law does not authorize anyone to end a patient's life by lethal injection, mercy killing, assisted suicide, or active euthanasia.

Health care providers may choose whether to participate in providing a qualified patient medical aid in dying medication. A health care provider, professional organization, or association may not penalize an individual for providing aid in dying medication or refusing to do so. If a patient's provider cannot or will not carry out a patient's request, and the patient transfers care to a new health care provider, the prior provider shall transfer, upon request, a copy of the patient's relevant medical records to the new provider. Health care providers must disclose to consumers, upon request, written policies outlining the extent to which they refuse to participate. The disclosure must notify a patient that the refusing provider will refer patients to another willing provider and that the cost of transferring records will be borne by the transferring provider. Any health care entity that prohibits health care providers from qualifying, prescribing, or dispensing medication pursuant to this chapter while they are performing duties for the entity shall provide notice of such policy to the public via its website.

This bill would add a new chapter, 201G, to the General Laws, which includes the following 21 sections:

SECTION 1 defines terms that apply to the entire chapter including "adult," "attending physician," "consulting physician," "counseling," "guardian," "health care entity," "health care provider," "incapacitated person," "informed decision," "licensed mental health care professional," "medical aid in dying," "medically confirmed," "medical aid in dying medication," "mentally capable," "palliative care," "patient," "physician," "qualified patient," "resident," "self-administer," and "terminally ill."

SECTION 2 pertains to a terminally ill patient's right to request medical aid in dying and obtain a relevant prescription. A patient must make two requests to receive the prescription, one oral and one written to their attending physician. The patient may:

- voluntarily make an oral request for medical aid in dying and get a prescription for relevant self-administered medication if the patient is: (1) a mentally capable adult, (2) a Massachusetts resident, and (3) determined to be terminally ill by their attending physician; and

- within 15 days of making the oral request, submit a written request for medical aid in dying and a prescription for relevant self-administered medication if the patient: (1) has met the requirements under this subsection, (2) has been determined to be terminally ill by a consulting physician, and (3) has had no less than fifteen days pass after making the oral request.

Patients cannot not qualify for medical aid in dying medication under this Chapter if they have a guardian or solely because of age or disability.

SECTION 3 establishes the process for written requests.

- (a) A valid written request must be witnessed by at least two individuals who, in the presence of the patient, attest that said patient is: (1) personally known to the witnesses or has provided proof of identity; (2) acting voluntarily; and (3) is not being coerced to sign the request.
- (b) At least one of the witnesses must be an individual who is not: (1) a relative through blood, marriage, or adoption; (2) entitled to any portion of the patient's estate upon death at the time of the request; (3) financially responsible for the patient; and (4) an owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.
- (c) The patient's attending physician cannot be a witness.

SECTION 4 provides text for the patient's written request for medical aid in dying medication and witness declaration.

SECTION 5 establishes a patient's right to rescind the request at any time without regard to their mental state, as well as a requirement that the attending physician offer a patient the opportunity to rescind their request for the medication before it is prescribed.

SECTION 6 outlines the responsibilities of the attending physician when prescribing medical aid in dying medication. These responsibilities include:

- determining if the patient: (i) is a resident of Massachusetts, (ii) is terminally ill, (iii) is mentally capable, and (iv) has voluntarily made the required oral and written requests for medical aid in dying;
- ensuring the patient is making an informed decision by discussing: (i) the medical diagnosis, (ii) patient's prognosis, (iii) potential risks of taking the medication to be prescribed, (iv) probable result of taking the medication to be prescribed, and (v) feasible alternatives and additional treatment options, including, but not limited to, palliative care and hospice care;
- referring the patient to a consulting physician to medically confirm the diagnosis and prognosis and to determine that the patient is mentally capable and acting voluntarily;
- referring the patient for counseling pursuant to Section 8;
- ensuring that Section 6-8 are followed;

- having a prior clinical relationship with the patient unless the patient's attending physician is unwilling to participate;
- recommending the patient notify the patient's family or any person who play a significant role in the individual's life;
- recommending that the patient completes a Medical Order for Life-Sustaining Treatment form.
- counseling the patient about the importance of (i) having another individual present when taking the medication prescribed under this Chapter and (ii) not taking the medication in a public place;
- informing the patient that they may rescind the request at any time and in any manner;
- verifying, immediately prior to writing the prescription, that the patient is making an informed decision;
- educating the patient on how to self-administer the medication;
- fulfilling the medical record documentation requirements of Section 13;
- ensuring all steps are completed pursuant to this chapter before prescribing and
- dispensing medications, including ancillary medications intended to minimize the qualified patient's discomfort, directly to the patient or, with the qualified patient's written consent, contacting a pharmacist who will dispense the medications directly to the qualified patient, the attending physician, or an expressly identified agent of the qualified patient. Medications shall not be dispensed by mail or other courier form.

Section 6 also allows the attending physician to sign the patient's death certificate on which the cause of death will be the underlying terminal disease.

SECTION 7 specifies that a consulting physician must do the following before a patient may be considered a qualified patient under the chapter:

- examine the patient and the patient's relevant medical records;
- confirm in writing the attending physician's diagnosis of terminal illness; and
- verify the patient is mentally capable, acting voluntarily, and has made an informed decision.

SECTION 8 requires the attending physician to refer a patient who has requested medical aid in dying medication to counseling to see if they have a psychiatric or psychological disorder or depression that is causing impaired judgment and to ensure that the patient is not being coerced. A licensed mental health care professional must review the patient's relative medical history and then submit a final written report to the attending physician. Medical aid in dying medication cannot be prescribed if the patient is suffering from any one of the aforementioned conditions.

SECTION 9 requires the attending physician to verify that the qualified patient made an informed decision immediately prior to issuing a prescription for medical aid in dying medication.

SECTION 10 requires the attending physician to recommend that the qualified patient notify the patient's family or any person who plays a significant role in an individual's life about the patient's request for medical aid in dying medication request; however, medical aid in dying medication cannot be denied because a patient declines or is unable to notify family or any person who plays a significant role in an individual's life.

SECTION 11 mandates the patient's medical record contains: (1) the determination and basis for determining that the patient is qualified pursuant to this chapter to receive medical aid in dying medication; (2) all oral requests by a patient for medical aid in dying medication; (3) all written requests by a patient for medical aid in dying medication made pursuant to sections 3 to 5 inclusive; (4) the attending and consulting physicians' respective diagnoses, prognoses, and determinations that the patient is mentally capable, acting voluntarily, and made an informed decision; (5) a report of the outcome and determinations made during counseling; (6) the attending physician's offer to the qualified patient to rescind their request for medical aid in dying medication; (7) other care options that were offered to the patient, including, but not limited to hospice and palliative care; and (8) the attending physician's note indicating completion of this chapter's requirements and the steps taken to fulfill the request, including a notation of the medication prescribed.

SECTION 12 requires any unused medical aid in dying medication to be disposed of lawfully. The medication dispenser must inform the patient how to dispose of the medication lawfully.

SECTION 13 requires physicians to record the number of requests for medical aid in dying medication, number of prescriptions written, number of requests rescinded, number of qualified patients who took the medication under this chapter, the general demographic and socioeconomic characteristics of patients, and any physical disability of the patient. DPH must analyze this data and annually issue a public report of its findings. Except as otherwise required by law, information collected by DPH will not be public record and will not be available for public inspection.

SECTION 14 states that no contract or agreement can affect whether an individual makes or rescinds a request for medical aid in dying medication under this chapter; requesting or rescinding a request shall not provide the sole basis for the appointment of a guardian or conservator; self-administering the medical aid in dying medication shall not constitute suicide or impact life, health, or accident insurance or annuity policies; actions taken by health care providers or other persons pursuant to the chapter will not be considered elder abuse, neglect, assisted suicide, mercy killing, or homicide; persons, health care providers or health care entities shall not be subject to criminal liability, licensing sanctions or other professional disciplinary

action for actions taken in good faith compliance with this act; nor shall state regulations, documents, and reports refer to the practice in this chapter as “suicide” or “assisted suicide.”

SECTION 15 states that health care providers or health care entities may choose not to practice medical aid in dying. This section also prohibits a health care provider or health care entity from subjecting an individual to censure, discipline, suspension, loss of license, privileges, or membership, or another penalty for participating or refusing to participate in providing medical aid in dying medication to a qualified patient. If a provider is unable or unwilling to carry out a patient’s request under this chapter and the patient transfers care to a new provider, the initial provider must transfer, upon request, a copy of the patient’s relevant medical records to the new provider. Health care entities that prohibit health care providers from qualifying, prescribing, or dispensing medication pursuant to this chapter while they perform duties for said entity shall provide notice of such policy to the public by posting the information on its website. Health care providers and health care entities must maintain and disclose their written policies outlining the extent to which they refuse to participate in providing qualified patients medical aid in dying medication upon request. The DPH commissioner must develop and publish a standard form for health care providers and entities to disclose said written policies. Any individual, upon request, shall be provided a consumer disclosure from a nonparticipating provider that must include, at minimum, information about the Massachusetts End of Life Options Act, the specific services related to medical aid in dying in which the health care provider and health care entity refuses to participate, differences between institution-wide objections and those that might be raised by individual providers who are employed by the provider, how the nonparticipating provider will refer and transfer patients to a provider, and how the cost of transfer will be covered by the transferring provider.

SECTION 16 states that purposely or knowingly altering or forging a request for medical aid in dying medication without permission of the patient or destroying or concealing a rescission of such a request shall be punishable as a felony if done with the intent or effect of causing the patient’s death. It also states that an individual who coerces or exerts undue influence on a patient to either request medical aid in dying medication or to destroy a request rescission shall receive no more than 3 years in state prison, no more than two and a half years in house of correction, or a fine of no more than \$1,000, or both fine and imprisonment. Nothing in this chapter limits further liability for civil damages from other negligent conduct or intentional misconduct by an individual; the penalties in the chapter do not preclude criminal penalties applicable under other law for conduct inconsistent with this chapter.

SECTION 17 states a governmental entity that incurs costs resulting from a qualified patient self-administering medical aid in dying medication in a public place may submit a claim against the patient’s estate to recover costs and reasonable attorney fees related to enforcing the claim.

SECTION 18 requires an emergency medical provider, upon finding a person who has self-administered medical aid in dying medication, to follow resuscitation protocol unless a Medical Order for Life-Sustaining Treatment or do-not-resuscitate form are found.

SECTION 19 states that nothing in this chapter shall be construed as authorizing a physician or any other individual to end a patient's life by lethal injection, mercy killing, assisted suicide, or active euthanasia.

SECTION 20 directs DPH to promulgate regulations to implement the provisions of this chapter.

SECTION 21 if any part of this chapter is determined to be invalid, all valid parts that can be severed from the invalid part must remain in effect. If any part of this chapter is found to be invalid in one or more of its applications, said part shall remain in effect for all remaining valid applications that are severable from the invalid applications.