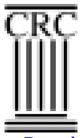
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CRC Memorandum

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STATEWIDE BALLOT ISSUES

Three issues will be put before the voters on the November 3, 1998 statewide ballot. Proposal A is a constitutional amendment, Proposal B is a statutory initiative, and Proposal C is a general obligation bond issue, for which voter approval is necessary.

For the ballot language and other information, visit our web site at:
http://www.crcmich.org/publicat/98ballot.html

Proposal A
Constitutional Amendment to Replace Term "Handicapped" with "Disabled"

Proposal A was placed on the ballot by the Michigan Legislature and would amend Article VIII, Section 8, of the Michigan Constitution to change the reference from "handicapped" to "disabled."

The section presently reads

> Section 8. Institutions, programs and services for the care, treatment, education or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously *handicapped* shall always be fostered and supported. [Emphasis added.]

The highlighted word, "handicapped," would be replaced with the word "disabled."

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Proposal B
Terminally Ill Patient's Right to End Unbearable Pain and Suffering Act (Physician-Assisted Suicide)

Proposal B is an initiated statute, placed on the ballot as a result of petitions circulated by Merian's Friends, a group established to promote the legalization of physician-assisted death in Michigan. The purpose of Proposal B is to guarantee to terminally ill, mentally competent adults the right to self-administer medication to hasten death and to permit physicians to prescribe such medication.

Summary of Proposal B

Eligibility Criteria. To receive lethal medication under the provisions of this act, a person would have to meet the following criteria:

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Proposal C
Clean Michigan Initiative Bonds

Proposal C would authorize the sale of $675 million of general obligation bonds to finance environmental and natural resources protection programs. A package of five bills (Public Acts 284 through 288 of 1998) provides the authorization for the proposal and describes the disposition of the proceeds of the bond sale.

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Citizens Research Council of Michigan
http://www.crcmich.org
38200 West 10 Mile • Suite 200 • Farmington Hills, Michigan 48335-2806 • (248) 474-0044 • Fax (248) 248-0090 • E-Mail: crcmich@mich.com
1502 Michigan National Tower • Lansing, Michigan 48933-1738 • (517) 485-9444 • Fax (517) 485-0423 • E-Mail: crcmich2@mich.com

Proposal A (continued)

The change would create no programmatic or budgetary consequences. It is being proposed as a part of an effort to make the nomenclature contained in the laws of the State of Michigan conform with current conventions and with federal laws, such as the Americans With Disabilities Act.

Proposal B (continued)

Residency. Must be a resident of Michigan for at least six months. Parents, adult siblings, adult children, and spouse of a Michigan resident are also eligible, even if not actually residents themselves.

Terminal Illness. Must be diagnosed with "an incurable and irreversible disease that is medically confirmed and that will, within reasonable medical judgment, result in the death of the patient within 6 months or less." Diagnosis must be made by the patient's attending physician and confirmed by a consulting physician who specializes in the disease that has caused the patient to become terminal.

Competency. Must be 18 years of age or older. Must be determined by a psychiatrist to be able to make personal medical decisions based on an understanding of the relevant aspects of current medical circumstances, an understanding of the benefits, risks, and likely consequences of the alternatives available under the act, and the ability to arrive at "an independent and sustained decision" based on rational choice.

Voluntary, Informed. Request must be initiated by the patient, without evidence of outside coercion, who is informed as to 1) medical diagnosis; 2) prognosis; 3) potential risks and probable result of taking the medication to be prescribed; 4) alternatives, including, but not limited to, comfort care, hospice care, pain control, sedation coma, refusal of hydration and nutrition, and withdrawal of life-sustaining treatment; and 5) ability to rescind the decision at any time or in any way.

Age or disability alone would be insufficient to support a patient's request.

Procedure. The proposed act provides for the following procedure:

Information. After determining that a patient is terminal, the physician must inform the patient of the available options including comfort care, hospice care, and pain management. If the patient requests, the physician must supply information on lethal medication.

Request. The patient would make the request in writing or orally (if orally, videotaping would be required). The request is to be witnessed by two individuals to attest to the rational and voluntary nature of the request. The attending physician could not be a witness and one of the witnesses could not be related by blood, marriage, or adoption; knowingly entitled to control over a portion of the estate; or the owner, operator, or employee of a health care facility utilized by the patient.

Waiting Period. A seven-day waiting period is required from the time of the patient's request until the prescription is written. The patient must then reiterate the request. If the patient does not rescind the request, the physician is to issue the prescription.

Responsibilities:

Attending Physician. Responsible for seeing that the steps outlined in the act are carried out.

If the patient's physician is unwilling to perform one or more of the duties under the act, a referral to another physician must be made within 72 hours.

Consulting Physician. Must verify that the patient is terminal and is making the request voluntarily and pursuant to an informed decision.

Psychiatrist. Must determine 1) that the patient has no diagnos-

able mental disorder, or, if one exists, that it has not distorted the patient's judgment, and 2) that the request is reasoned, fully informed, and voluntary.

Prescription. Dispensing, prescribing, or administering a controlled substance under the provisions of the act would be made an exception to the requirement that controlled substances be issued only for legitimate therapeutic purposes. The prescription is to be written on the same official prescription form required for the prescription of controlled substances. The prescription could be for no more than a single dose in a quantity estimated to cause death and the directions would specify only that the dose would hasten or cause death.

The prescription could be dispensed only to the patient or an agent of the patient and the pharmacist would be required to confirm the prescription with the physician before dispensing it. The pharmacist would be required to sign the form and forward it or transmit the information to the Michigan Department of Community Health. Reporting of the prescription, then, is the mechanism by which the State is notified of activity under the act. A report thus transmitted, however, would not be considered a public record and would not be subject to disclosure under the Freedom of Information Act.

Challenges. A challenge to a decision by a patient under this act could be brought only by a close relative or significant other in circuit court. The proposed act outlines an expedited procedure for resolving any such challenge.

Oversight Committee. The governor would be required to appoint an oversight committee composed of 17 members:

8 from medical or osteopathic schools (2 from each one in the state)

3 from the Michigan State Medical Society

3 from the Michigan Osteopathic Association Society

3 from the general public

Nominees could not be opposed to complying with the provisions of the act.

Duties. The committee would meet twice a year and would review a random sample of not less than 25 percent of the deaths occurring under the act during the preceding year. If 25 percent of the committee members conclude that the procedures of the act had not been complied with in a specific case, a further review is required. If it is determined that the failure to comply was the result of reckless disregard for the provisions of the act, the committee shall prepare a report and forward it to the prosecuting attorney in the county in which the professional practices or in which the health facility is located. If the failure is deemed to be negligent, a hearing will occur at which the physician's right to issue prescriptions under the act could be terminated.

The committee would prepare an annual report on the effect and operation of the act, including a statistical summary without individual identifiers.

Medical Education. The proposed statute would impose certain medical licensing requirements on physicians providing services under the act. For the first renewal of a license, a physician would be required to have taken at least 20 hours of continuing medical education in the theory and practice of comfort care, hospice care, pain control, sedation coma, removal of nutrition and hydration, psychiatric counseling, and the prescription of medication to end life as authorized by the proposed act. Subsequent renewals of licenses would require four hours in these subjects.

Legal Effect. The proposed act would require that the legal cause of a death occurring under its provisions would be the terminal illness, not the physician-assisted death. In addition, a death under the act would not be considered a suicide with respect to voiding a life insurance policy and no contracts could make, rescind, or be affected by a decision to die under the provisions of the act.

Crimes: Felonies. The act would create the following felonies:

- Nonphysician or unlicensed

physician who administers medications, chemical, or other instrumentalities to cause or hasten death. Up to life imprisonment.

- Altering or forging a patient's request for medication or concealing or destroying a patient's rescission with the intent to cause the patient's death. Up to life imprisonment.
- Coercing or exerting undue influence on a patient to make a request or destroy a rescission. Up to life imprisonment.
- Physician who supplies medication or other instrumentality to cause death without complying with the act. Up to five years in prison; fine up to $50,000.

Crimes: Misdemeanors. The act would create the following misdemeanors:

- False affidavit of relationship to a Michigan resident
- Physician unwilling to perform a duty under the act and willfully fails to refer a patient to another physician, or fails to retain records for at least three years
- Failure of a pharmacist to forward prescription information to the Michigan Department of Community Health.

Background

National Status. Approximately three-fourths of the states (38), including Michigan, outlaw physician-assisted suicide by statute. In another six states, it is illegal under common law. In five states, the law is unclear in that there is no explicit statute or the state has eliminated common law crimes. Only one state, Oregon, currently authorizes physician-assisted suicide by statute, having done so through ballot initiative in 1994, which was reaffirmed by the voters in 1997.

According to a report by the Oregon Health Division, as of mid-August, 1998, 10 individuals had received medication under the act (Death With Dignity Act), with eight using it for the intended purpose. The remaining two individuals died naturally, without having taken the medication. The Division reported "full compliance with the act."

U. S. Supreme Court Rulings. In June 1997, the U. S. Supreme Court held (Washington *v.* Glucksberg; Vacco *v.* Quill) that state prohibition of assisted suicide does not violate either the Equal Protection Clause or the Due Process Clause of the U. S. Constitution. The import of these rulings was that the issue is one for state legislatures to decide.

Proposed Federal Legislation. Bills have been introduced in Congress (H. R. 4006; S. 2151) under the title "Lethal Drug Abuse Prevention Act of 1998." The proposed act would authorize the Drug Enforcement Administration to suspend or revoke the license to prescribe federally controlled substances of any physician or pharmacy who "has intentionally dispensed or distributed a controlled substance with a purpose of causing, or assisting in causing, the suicide or euthanasia of any individual." The bill would not cover the use of federally controlled substances in alleviating pain or discomfort, "even if the use of the controlled substance may increase the risk of death."

Because the use of federally controlled substances is contemplated under the provisions of Proposal B, it is likely that passage of the federal law would render Proposal B, and any similar laws in other states, inoperative.

Michigan Law. On September 1, 1998, Public Act 296 of 1998 became effective, making it a felony, punishable by up to five years in prison, a maximum fine of $10,000, or both, to knowingly assist in a suicide by--

Providing the means by which an individual attempts or commits suicide

Participating in an act by which an individual attempts or commits suicide

Helping an individual plan or commit suicide.

The act does not apply to withholding or withdrawing medical treatment.

While Proposal B does not explicitly repeal Act 296, it clearly would conflict with its provisions

if it were to be approved by the voters. In such a case, the Michigan Constitution is silent as to whether Proposal B would prevail, although there is a strong presumption that, to the extent that courts could not reconcile the two, the provisions of Proposal B would supersede those of Act 296.

Issues

Proposal B raises fundamental issues of personal and medical ethics that highlight the tension between society's interest in the sanctity of life and the individual's right to self-determination.

Respecting Physician-Assisted Death Generally. Means of ending life in a medical context include:

- Withdrawal of nutrition and hydration
- Withdrawal of medical treatment
- Physician-assisted suicide (in which the patient self-administers lethal dose of prescribed medication)
- Euthanasia (in which the physician administers lethal dose of medication)

The U. S. Supreme Court has recognized (Cruzan *v.* Missouri Department of Health, 1990) that an individual has a right to refuse medical treatment or the artificial provision of nutrition and hydration ("passive death"). Physician-assisted suicide and euthanasia ("active death") are much more controversial and, at least with respect to physician-assisted suicide, are in legal ferment, at present.

Physician-assisted suicide is also viewed by some as part of a continuum of pain control measures. The provision in the proposed federal statute (Lethal Drug Abuse Prevention Act) that exempts from its coverage use of a controlled substance for the purpose of alleviating pain, even if the risk of death is increased, is an example of the difficulty in clearly demarcating the borderline between pain control and assisted dying.

Arguments For Legalization of Physician-Assisted Suicide. The primary argument in favor of legalization of physician-assisted death is that individuals should have the ability to make a determination regarding the timing and manner of their own deaths in order to minimize pain and suffering and to retain as much dignity as possible. To the extent that physician assistance brings structure and comfort to this process, it should be available.

In addition, by legalizing physician-assisted death and providing a regulatory process, safeguards against abuse are established and a mechanism for ending the unregulated activity that has characterized the more highly publicized instances of physician-assisted death can be made available.

Arguments Against Legalization of Physician-Assisted Suicide. First, all life is valuable and society has an interest in protecting and affirming life, even in its final stages.

Second, the availability of physician-assisted suicide may create in the minds of some a perceived "duty to die" in order to spare family and loved ones the stress of financial and emotional burdens created by end of life care, which can be extensive.

Third, physicians trained to prolong life may have serious ethical problems in prescribing medication intended to cause death.

Finally, to the extent that physician-assisted death is an effort to control pain, other methods of pain management exist and should be more aggressively pursued. Improvements in end-of-life care should be made in order to remove the incentives for termination of life.

Respecting Proposal B. Beyond the general arguments regarding physician-assisted suicide, Proposal B raises certain issues related to the specific language and provisions of the proposal.

Eligibility. Proposal B limits eligibility to mentally competent, terminally ill adults. Not covered are those with major non-terminal disabilities or mental impairment that would prevent them from rationally choosing physician-assisted death. Coverage of these individuals would undoubtedly include some who

might wish to act under the provisions of Proposal B, but would create additional controversy.

Physician Mandates. A physician who is unwilling to perform a duty under the act and willfully fails to refer a patient to another physician within 72 hours can be guilty of a misdemeanor. Opponents of Proposal B argue that this requirement is excessively stringent and could impose unreasonable burdens on physicians.

Terminology. Important terms in Proposal B raise definitional questions, if not problems. Whether a patient is "terminally ill" within the meaning of the proposal depends on the judgment of two physicians who may, depending on specific circumstances, have greater or lesser ability to forecast the outcome of a particular disease. Moreover, could a patient become terminal by foregoing treatment?

"Suffering" is defined in the proposal as "physical or mental torment caused by a terminal illness," clearly a subjective concept.

"Dose that will hasten or cause death" relies on an understanding of the amount of a controlled substance that will be effective in accomplishing the desired result. This understanding may not be uniformly distributed within the medical community.

A psychiatrist must determine whether a patient's request "is reasoned, is fully informed, and is voluntary." Any of these terms can be troublesome. For example, how informed must an individual be in order to be "fully informed?" In determining whether a decision is "voluntary," at what point would encouragement or support by a family member become coercion?

These and other terminological uncertainties in the proposal may be unavoidable in the crafting of a statute that addresses an issue of this nature, but, if Proposal B is adopted, many questions of this sort may be anticipated.

Legal Cause of Death. Proposal B would require that the legal cause of a death under the act be the terminal illness, not the lethal dose of medication, and is not to be considered a suicide for the purpose of voiding a life insurance policy.

In nearly all states, an insurance company may deny payment of a claim on a life insurance policy if the cause of death is suicide and if the claim is made within a certain period after the effective date of the policy (in Michigan, two years). The reason for this provision is to prevent life insurance from becoming an incentive for the commission of suicide. It is unclear whether the Proposal B provision regarding life insurance would have much effect. If a policy were more than two years old, the cause of death would be irrelevant. If it were less than two years old and was purchased without disclosing a known terminal illness, payment could be denied on that basis.

Conclusion

Few issues ever voted on by the Michigan electorate have probed such ethical and philosophical depths as Proposal B. Regardless of the outcome of the vote on this issue, the debate on end-of-life questions is certain to continue.

Proposal C (continued)

The Michigan constitution permits the state to engage in long-term borrowing (longer than one year) if the amounts and purposes are specified by public acts adopted by at least a two-thirds vote of the legislature and approved by a majority of the voters at any general election.

Public Act 288 of 1998 establishes the Clean Michigan Initiative Bond Fund within the state treasury. The proceeds from the sale of general obligation bonds will be deposited in the fund and disbursements made from the fund to finance the costs in the following areas, subject to dollar limits as indicated:

Response Activities at Facilities. The largest category of funding ($335 million), response activities include corrective actions to address leaking underground storage tanks and Department of Environmental Quality activities at facilities to address public health and environmental problems and to promote redevelopment of sites. Grants and loans may be provided to local governments and brownfield redevelopment authorities (up to $20 million) and grants for municipal landfills are included in the funding (up to $12 million).

Waterfront Improvements. A $50 million waterfront redevelopment grants program would be established by the Department of Environmental Quality. Funding would be used for demolition of buildings and facilities along a waterfront, acquisition and assembly of waterfront property, and public infrastructure and facility improvements. All uses of funding would have to be consistent with an approved waterfront redevelopment plan.

Remediation of Contaminated Sediments. Funding ($25 million) would be used for activities to clean up, remove, contain, treat, and destroy contaminated lake and river sediments.

Nonpoint Source Pollution Prevention. The Department of Environmental Quality would establish a $50 million grants program for nonpoint source pollution prevention and control projects and wellhead protection projects. The grants would be available to local units of government and tax exempt programs under section 501(c)(3) of the Internal Revenue Code. Nonpoint source pollution is defined as water pollution from diffuse sources, including runoff of contaminated precipitation or snowmelt that infiltrates groundwater or is discharged into surface waters. Also included is runoff and wind-caused soil erosion into surface waters. Wellhead protection projects would be aimed at protecting aquifer recharge areas and plugging abandoned wells. Local government units receiving grants would have to contribute at least 25 percent to the cost of a project.

Water Quality Monitoring. A $90 million clean water fund would be created to finance, as a first priority, programs identified as priorities by the Department of Environmental Quality (as described in Act 278 of 1998). Also eligible for funding are water pollution control activities, wellhead protection activities, and storm water treatment protection and activities.

Pollution Prevention Programs. Funding ($20 million) would be used for pollution prevention program activities under the overall direction of the Department of Environmental Quality. A program using the expertise of retired engineers and scientists for pollution prevention would receive $10 million of the funding. The remaining funding would be divided equally between a program providing loans to small businesses needing assistance to implement pollution prevention recommendations and general pollution prevention activities implemented by the department.

Abate Lead Hazards. Funding ($5 million) would be used by the Department of Community Health for remediation and physical improvements to structures in order to abate or minimize exposure of persons to lead hazards.

State Park Infrastructure Improvements. Funding ($50 million) would be used by the Department of Natural Resources for improvements, with installation or upgrading of drinking water systems or rest room facilities being the first priority.

Local Recreation Projects. The Department of Natural Resources would establish a $50 million local recreation grant program for the improvement or replacement of existing public recreation facilities, the development of new facilities, and recreation improvements that will attract tourists. This program would augment existing local recreation program resources available from the Michigan Natural Resources Trust Fund.

Implementation Costs. Not more than three percent of the bond issue may be appropriated to the Departments of Environmental Quality and Natural Resources to cover costs incurred by them that are directly associated with the completion of the projects.

Existing State Debt

The state issues both general obligation debt, pledging the full faith and credit of the state, and special purpose debt, which generally pledges a specific revenue source(s) for payment of principal and interest. Special purpose debt is by far the largest category of debt and includes: transportation; special authorities, such as housing and hospital finance; higher education student loans; municipal bond financing; economic development; and financing state and university buildings (See **Table 1**).

Table 2 summarizes the components of general obligation state debt for 1997. Passage of Proposal C would approximately double the total outstanding general obligation debt.

Historically, Michigan's use of long term debt has been moderate in comparison with other states. In fiscal year 1996, the latest year for which data are available for all states, the Michigan per capita long-term debt was $1,425, almost 28 percent below the national average of $1,966. In that year, Michigan ranked below 23 other states in per capita debt.

Table 1
Outstanding State Debt
(September 30 of Each Year, $ in millions)

Year	General Obligation	Special Purpose	Total
1980	$439.1	$2,353.2	$2,792.3
1985	241.7	5,501.6	5,743.3
1990	187.7	7,619.5	7,807.2
1995	706.0	11,073.3	11,779.3
1997	655.2	12,187.6	12,842.8
Percent Increase 1980-97	49.2	417.9	359.9

Source: Michigan Department of Treasury

Table 2
Outstanding General Obligation Debt
September 30, 1997
($ in millions)

Issue	Total Issued	Outstanding Balance
School Loan Bonds	$180.0	$174.4
Water Pollution Bonds	200.0	9.0
Recreation & Environmental Protection Bonds	587.7	471.7
Totals	$967.7	$655.2

Source: Michigan Department of Treasury