



# DISABILITIES LAW PROGRAM

COMMUNITY LEGAL AID SOCIETY, INC.

100 W. 10th Street, Suite 801

Wilmington, Delaware 19801

(302) 575-0660 TTY (302) 575-0696 Fax (302) 575-0840

www.declasi.org

## MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Legislative Initiatives

Date: May 30, 2017

Consistent with past practice, I am forwarding analyses of six (6) legislative initiatives well in advance of the June 8 SCPD P&L Committee meeting and prior to publication of the June Register of Regulations. Given time constraints, the analyses should be considered preliminary and non-exhaustive.

### 1. H.B. No. 171 (Speech/Language & Audiology Practitioner Licensing)

This legislation was introduced on May 11, 2017. It was released from the House Administration Committee on May 17 and placed on the Ready List. The 11-page bill includes several discrete revisions to the State licensing law covering the practice of speech/language pathology, audiology, and hearing aid dispensing.

I have the following observations.

First, the bill (lines 9-12 and 71-73) eliminates the current requirement for regulating audiology aides and speech pathology aides. The synopsis provides the following rationale for striking the requirement:

This Bill also strikes references to audiology and speech pathology aides because the Board does not license or regulate these professions.

The Board's admission that it does not regulate audiology and speech pathology aides is troubling. State law has contemplated such regulation for at least 44 years. See S.B. No. 195 from 127<sup>th</sup> General Assembly approved in 1973. All subsequent revisions to the law have included an expectation of regulating audiology and speech pathology aides. See, e.g., S.B. No. 282 from 133<sup>rd</sup> General Assembly approved in 1986. Current law explicitly requires the Board to "(e)valuate the credentials of all persons applying ...to act as audiology aides or speech pathology aides, in order to determine whether such persons meet the qualifications set forth in this chapter" (lines 9-12, 71-73, and 106-108). That requirement has been in the Board's enabling law for at least 17 years. See S.B. No. 214 from 140<sup>th</sup> General Assembly approved in 2000.

Delaware law includes board licensing or regulation of "aides" in many analogous contexts, including the following:

- occupational therapy assistant [24 Del.C. §§2002(5) and 2006(a)(6)]
- physical therapy assistant [24 Del.C. §§2602(9) and 2605(a)]
- dental assistant and auxiliary personnel [24 Del.C. §§1101(3)(4) and 1106(a)(1)(2)]
- physician assistant [24 Del.C. §§1770A (2) and 1773].

H.B. No. 171 is highly deferential to the American Speech/Language and Hearing Association (ASHA) (lines 142-153 and 247-254). Indeed, the bill strikes all educational and clinical practice requirements for speech/language pathologists in favor of simply licensing anyone with ASHA certification (lines 142-151). ASHA guidance on regulating speech/language aides and audiology aides is instructive. ASHA adopted the attached model licensing bill in 2014 which explicitly requires (§1.05) not merely the regulation, but the actual licensing of audiology and speech/language aides:

(4) Any person not eligible for licensure as an audiologist or not eligible for authorization to practice as an intern, who assists in the practice of audiology under the supervision of a licensed audiologist must be licensed as an audiology assistant. No person shall practice as an audiology assistant or represent himself/herself as an audiology assistant in this state, unless such person is licensed in accordance with this Act.

(5) Any person not eligible for licensure as a speech-language pathologist or not eligible for authorization to practice as an intern, who assists in the practice of speech-language pathology under the supervision of a licensed speech-language pathologist must be licensed as a speech-language pathology assistant. No person shall practice as a speech-language pathology assistant or represent himself/herself as a speech-language pathology assistant in this state, unless such person is licensed in accordance with this Act.

ASHA also authorizes such aides/assistants to become associate members of ASHA. See attached ASHA overview, “Speech-Language Pathology Assistants”.

According to ASHA, thirty-three (33) states either license or register the above support personnel operating in non-school settings. See attached table, “Support Personnel Excluding School Settings”. Nineteen (19) states require them to have a Bachelor’s Degree or equivalent and eighteen (18) require them to have at least an Associate’s Degree or equivalent. Id. In school settings some states have degree or certification requirements. See attached table, “Support Personnel Requirements in School Settings”. For example, Maryland has very robust standards which require at least a college degree in a speech-language pathology assistant program from an accredited institution and an aggregate of 100 hours of clinical observation and clinical assisting hours. See attached ASHA summary of Maryland requirements.

If the current Delaware law requiring the regulation of audiology and speech-language pathology aides is repealed, the result is a huge void in standards. Unlike some states, the Delaware Department of Education does not have certification standards for such aides. See attached list of certifications. Likewise, such aides do not meet the standards for a paraeducator permit. See 14 DE Admin Code 1517.

Licensing requirements typically provide the public with several protections, including the following:

- supervision standards
- limits on the number of assistants supervised by one audiologist/speech-language pathologist
- disclosure to persons receiving services that the practitioner is an “assistant”
- background checks
- degree and clinical practicum requirements
- application of practice standards.

See, e.g., attached model ASHA law, §§1.04 and 4.02.

Historically, there has been a “massive shortage of speech-language pathologists” in Delaware. See attached March 16, 2016 UDaily article. Delaware established a new degree program to turn out local therapists and address the “dead zone of services for Delawareans”. Id. Lack of credentialing of speech-language therapy aides may exacerbate the shortage of speech-language services in Delaware since qualified aides will have an incentive to practice in states that recognize their credentials.

Second, H.B. No. 171 is internally insistent at lines 101-105 and 150-151. The former contemplates the Board designating the national tests “to be taken by all persons applying for licensure...”. The latter section strikes the national testing requirement for speech-language pathologists.

Third, H.B. No. 171 is internally inconsistent at lines 101-105 and lines 240-268. The former requires applicants based on reciprocity to “have achieved a passing score on all parts of the designated national examination in the applicant’s specialty”. The latter authorizes issuance of a license based on reciprocity with no testing.

Fourth, lines 180-182 categorically preclude issuance of a license for any applicant who “excessively used or abused drugs” in the past. This includes excessive use of legal substances such as alcoholic beverages (lines 17-18 and 311-312) in the distant past. There is no time limit so the use could have been 50 years ago. Indeed, lines 311-312 strikes the current requirement that the drug use be current or within the past 2 years in favor, in effect, of a “forever disqualification” standard. There is no authorization for a waiver akin to that applicable to criminal convictions (lines 183-199). This manifestly violates federal law. See attached SAMHSA overview of legal rights of individuals with past drug/alcohol problems, pp. 4, 5, and 11-12. See also the attached Title II ADA regulation, 28 C.F.R. §35.131, which recites in pertinent part as follows:

(2) A public entity shall not discriminate on the basis of illegal use of drugs against an individual who is not engaging in current illegal use of drugs and who -

(I) Has successfully completed a supervised drug rehabilitation program or has otherwise been rehabilitated successfully;...

Drug or alcohol use in the distant past may have no relationship to an individual’s current ability to provide audiology and speech-language pathology services.

Fifth, there is some “tension” between lines 145-146 and 262-264. The former section eliminates all degree requirements for applicants for a speech-language pathologist license. The latter retains degree requirements for anyone applying for a license based on reciprocity with a degree from a foreign school even if the applicant is ASHA-certified (lines 142-144).

Sixth, the current law literally authorizes disciplinary action (including monetary penalties described at line 343) against a licensee based on physical disability. Discipline is authorized by anyone who meets the following standard:

(10) Has a physical condition such that the performance of speech/language pathology, audiology or dispensing of hearing aids is or may be injurious or prejudicial to the public” (lines 329-330).

The justification for discipline can be based on amorphous and speculative grounds, *i.e.*, performance “may be prejudicial to the public”. Indeed, discipline is authorized even if the licensee is on inactive status (line 291). This “overbroad” standard ostensibly violates the Americans with Disabilities Act (ADA). See 28 C.F.R. §35.130.

The Council may wish to consider sharing the above observations with policymakers; CDS; the ACLU; and the Hearing Loss of Association of America, Delaware Chapter.

## 2. S.B. No. 85 (Student Discipline)

This legislation was introduced on May 17, 2017. As of May 30, it awaited action by the Senate Education Committee. It borrows some provisions from legislation (S.B. No. 239) which was introduced near the end of the 2015-16 legislative session.

The bill is designed to encourage public schools to reduce disproportionate discipline of certain subpopulations and to compile and publish discipline data. The preamble touts the benefits of non-punitive disciplinary responses consistent with restorative justice practices (lines 1-9). The Department of Education (DOE) would publish a report based on data from three consecutive school years covering various forms of discipline imposed on students by individual schools (lines 40-46). Schools whose data exceeds certain thresholds would develop and implement a remedial plan (lines 47-61). Based on a DOE annual data report, public schools whose data on suspensions exceed certain thresholds would be required to take certain remedial action (lines 79-90).

I have the following observations

First, there is a typographical error on line 34. It should include a strike-out of “activity; and”. Compare prior S.B. No. 239 at line 29.

Second, the legislation defines “disruptive behavior” at lines 17-19. Schools are then invited to adopt a broader definition (“further define”) of “disruptive behavior”. This is dysfunctional. It makes little sense to adopt a statutory definition and then invite schools to adopt a hodgepodge of non-conforming, amplifying definitions. It is also inconsistent with the public policy embedded in the attached legislation (H.B. No. 42) adopted in 2011 which instructed the Department of Education to adopt “uniform definitions for student conduct” related to student discipline. Consider the following alternate remedial amendments to lines 35-36:

(2) ~~Further define and/or or~~ Provide interpretive guidance or examples of ‘disruptive behavior’ set forth in paragraph (a)(2) of this section.

OR

(2) ~~Further define and/or or~~ Provide an explanation or examples of ‘disruptive behavior’ set forth in paragraph (a)(2) of this section.

Third, unless repeal of current §702 is intended, the sponsors may wish to include a provision which explicitly recites that current §702 is redesignated as §703. The reference to §703 in line 29 suggests that redesignation is desired.

Fourth, although the legislation is ostensibly intended to collect data based on “the subgroups of students categorized as those with disabilities” [lines 23-24 and synopsis (Par. “(2)”], these subgroups are omitted from those subject to disaggregated data collection (lines 44-46). This is a major oversight. The term “disability classification” could be inserted in lines 45-46.

Fifth, the synopsis recites that schools are expected to “first collect and publicly report disaggregated student discipline data, and solicit feedback from students, staff, families, and community representatives.” In contrast, the bill omits the concept of soliciting input from students, staff, and community representatives (lines 47-56 and 79-90). Plans and strategies are ostensibly developed exclusively by public school personnel. The following amendments could be considered:

A. Amend line 49 as follows: “...submit a plan, developed with input from student, parent, and community stakeholders, identifying the strategies....”

B. Amend line 83 as follows: “(2) After soliciting input from student, parent, and community stakeholders, incorporate strategies to promote greater fairness and equity in discipline.”

OR

Amend line 83 as follows: “(2) After consultation with student, parent, and community stakeholders, incorporate strategies to promote greater fairness and equity in discipline.”

Sixth, since certain disability classifications (e.g. emotional disability; traumatic brain injury; other health impairment) are correlated with significantly higher suspension rates, using global data for all students with disabilities (lines 74-75) will likely “mask” disproportionate suspension. Using a global benchmark is equivalent to “lumping” all racial minorities into one group rather than breaking out data on subgroups with historically disproportionate suspension rates (e.g. Black; Hispanic). The bill could be improved by the following amendment to line 75: “...without disabilities, or the suspension gap between any subgroup of students with disabilities by classification and students without disabilities, exceeds any of the following:”

The SCPD may wish to share the above observations with policymakers with a courtesy copy to the ACLU and the Attorney General.

### 3. H.B. No. 162 (Financial Exploitation)

This legislation was introduced on May 9, 2017. As of May 30, it awaited action by the House Judiciary Committee.

As background, legislation (H.B. No. 417) was enacted in 2014 which amended the Adult Protective Services law. That bill authorized covered financial institutions to freeze transactions if they suspected financial exploitation, report to the State, and provide copies of records to the State and law enforcement agencies without a subpoena. Financial institutions implementing the law were accorded immunity. See codification at 31 Del.C. §3910. Although the original H.B. No. 417 covered “broker dealers”, “investment advisors”, and “federal covered advisors”, the bill was amended prior to enactment to delete coverage of these entities. In 2015, H.B. No. 17 was enacted which added these entities into the statutory scheme resulting in the current, broad definition of “financial institution” subject to the financial exploitation law [31 Del.C. §3902(12)].

H.B. No 162 ostensibly supplements the effects of the prior bills codified in 31 Del.C. Ch. 39. It adopts the same definition of protected consumers - elderly persons and vulnerable adults (lines 6-7). It adopts the same definition of “financial exploitation” (lines 8-20). However, it amends Delaware “securities law” (Title 6) by establishing similar financial exploitation protections covering broker-dealers and investment advisors in the statutory securities laws. Similar to the adult protective services model, H.B. No. 162 authorizes covered financial entities to delay suspicious transactions, notify State agencies, share records with State and law enforcement agencies, and benefit from immunity when implementing the law.

I have the following observations.

Since both the APS law and the securities law will cover some of the same entities, the standards must be consistent to avoid confusion and enhance compliance. Unfortunately, there are multiple instances of adoption of inconsistent standards. The following is a non-exhaustive set of examples.

First, lines 27-29 require “prompt” notification of APS and the Investment Protection Director (a deputy attorney general pursuant to 6 Del.C. §73-102). In contrast, the APS law does not require “prompt” notice to APS. Notice occurs upon completion of the institution’s investigation or 5 business days after identification of a suspicious transaction. See 31 Del.C. §3910( c).

Second, lines 57-61 authorize a freeze for 15 business subject to the Attorney General requesting an extension to 25 business days after initiation of the freeze. In contrast, the APS law allows the institution to continue to freeze a transaction for 10 business days after filing a report and another 30 business days at the request of the State. See 31 Del.C. §3110 ( c).

Third, lines 51-53 give the financial institution 7 business days after completion of its investigation to share its results with APS. In contrast, the APS law requires reporting upon completion of its investigation, not within 7 business days of completion of the investigation. See 31 Del.C. §3110( c).

Fourth, lines 68-71 authorize the financial institution to share records with APS and law enforcement. This may omit the Attorney General's Office. In contrast, the APS law explicitly authorizes the sharing of records with "the prosecuting attorney's office" as distinct from "law enforcement". See 31 Del.C. §3110(c).

The Council may wish to consider endorsement of the concept of the legislation subject to the sponsors' review of the above inconsistencies. A courtesy copy of comments could be shared with the Attorney General.

#### 4. S.B. No. 49 (Homeless Bill of Rights)

This legislation was introduced on March 28, 2017. As of May 30, it awaited action by the Senate Judicial & Community Affairs Committee. It is earmarked with a 2/3 vote requirement. The attached fiscal note is modest, aggregating \$26,000 in FY17, \$3,000 in FY18, and \$3,000 in FY19.

Predecessor legislation was introduced in 2014 (H.B. No. 378); 2015 (S.B. No. 134); and 2016 (SS No. 1 for S.B. No. 134. S.B. No. 49 closely resembles the 2016 legislation with a few modifications. Some of the modifications were ostensibly prompted by Council commentary on the 2016 bill.

As background, legislation creating a bill of rights for homeless individuals has been passed in a few states (e.g. Rhode Island; Connecticut; Illinois) and municipalities. See attached 2017 Wikipedia article. In 2013, the Delaware Homeless Planning Council issued a report which included a recommendation to promote adoption of a homeless bill of rights in Delaware (Executive Summary and excerpt attached). The report (p. 8) discusses the prevalence of persons with disabilities among the homeless population.

S.B. No. 49 is intended to prevent discrimination based on homelessness in a variety of contexts, including public places, applying for housing, seeking temporary shelter, and voting. Local governments would be barred from enacting ordinances or regulations inconsistent with listed rights (lines 59-60). An aggrieved person could file a complaint and seek remedies through the State Human Relations Commission. The Attorney General would also have the authority to seek enforcement through a civil action (lines 245-259). S.B. No. 49 is more restrained than the 2016 legislation in several respects, including omission of protections in employment; a limitation on the duty of providers to update facilities or provide new accommodations (lines 34-36); and a disclaimer that the provisions would limit nondiscriminatory enforcement of anti-loitering laws (lines 51-53).

I have the following observations.

First, there is a typographical error on line 100. The parentheses should be deleted. Compare the 2016 bill (S.S. No. 1 for S.B. No. 134) at line 97.

Second, the references to “§7803(a)” in lines 69, 72 and 96 should be simply to “§7803” to conform to lines 167 and 170 and clarify the availability of enforcement of §7803(b).

Third, in line 208, “are” should be substituted for “is”.

Fourth, lines 59-60 could be interpreted as limiting only prospectively enacted laws, ordinances, and regulations. Concomitantly, existing non-conforming laws, ordinances, and regulations would be “grandfathered”. The sponsors could consider amending lines 59-60 as follows: “No political subdivision of this State may enact or enforce any law, ordinance, or regulation contrary to subsection (a) of this section.”

Fifth, the 90-day statute of limitation (lines 140-141) to file a complaint with the State Human Relations Commission is relatively short. Contrast one (1) year statute of limitation for Fair Housing complaints filed with the Human Relations Commission [6 Del.C. §4610(a)].

The Council may wish to consider an endorsement of the legislation subject to amendments consistent with the above observations.

#### 5. H.B. No. 5 (Equal Protection)

This legislation was introduced on May 16, 2017 as a revised version of H.B. No. 2. As of May 30, it awaited action by the House Administration Committee.

As background, the 14<sup>th</sup> Amendment to the U.S. Constitution provides that no state may “deny any person within its jurisdiction the equal protection of the laws.” The federal “equal protection” clause has been invoked by the courts to invalidate discrimination against persons with disabilities. See, e.g., City of Cleburne v. Cleburne Living Center, 473 U.S. 432 (1985) [Supreme Court invalidated requirement of special use permit for group home housing individuals with intellectual disabilities as based on irrational prejudice and inconsistent with Equal Protection]. Many states include variations of the “equal protection” mandate in their respective state constitutions. For example, the New York State Constitution (§11) reflects the following standard: “No person shall be denied the equal protection of the laws of this state or any subdivision thereof.”

In 2016, former Senator Peterson discovered that the Delaware Constitution omits an equal protection clause. In response, she introduced legislation (S.B. No. 190) as the first leg of a Constitutional amendment to add an equal protection clause. S.B. No. 190 proposed to add the following provision to the Delaware Constitution:

§21. Equal protection

Section 21. Equal protection under the law shall not be denied or abridged because of race, sex, age, religion, creed, color, familial status, disability, sexual orientation, gender identity, or national origin.

For background on the 2016 bill, see the attached articles. The legislation was introduced late in the session and was ultimately laid on the table.

H.B. No. 5 proposes the adoption of a shorter version than the 2016 bill:

§21. Equal protection

Section 21. No person shall be denied equal rights under the law.

This version is ostensibly more analogous to the federal Equal Protection clause which does not explicitly list protected classes. It is conceptually analogous to statutes which foster fundamental fairness in application of laws. For example, the Delaware Bill of Rights for persons with intellectual disabilities (16 Del.C. Ch. 55) reflects the following “equal protection” sentiment without using that term:

§5501 Basic rights.

Persons diagnosed with intellectual disabilities or other specific developmental disabilities have the same basic rights as other citizens.

Consistent with the synopsis, the Delaware judiciary would be expected to establish jurisprudence concerning the interpretation of the clause. There appears to be considerable bipartisan support for H.B. No. 2 which lists 22 House and 10 Senate sponsors/co-sponsors. However, a 2/3 vote in successive General Assemblies would be required to amend the Delaware Constitution.

Given the potential benefit of the Constitutional amendment to protect the rights of individuals with disabilities, the SCPD may wish to consider endorsement.

6. H.B. No. 160 (End of Life Options)

This legislation was introduced on May 2, 2017. As of May 30, 2017, it awaited action by the House Health & Human Development Committee. A previous version of the legislation (H.B. No. 150) was introduced in 2015. The SCPD issued June 26, 2015 and June 6, 2016 comments generally opposing the prior bill and the concept of assisted suicide legislation.

Background on H.B. No. 160 is provided in the attached May 4, 2017 News Journal article, "Doctor-assisted suicide bill offered". The bill would authorize a competent individual with a terminal illness to obtain and self-administer a drug to end life. There are many safeguards, including waiting periods, review by both an attending and consulting physician, assessment by a psychiatrist or psychologist if either physician questions the patient's capacity/judgment, and attestation of 2 independent witnesses that the patient's written consent is voluntary and free of coercion.

There are currently six (6) states which have adopted similar legislation. See attached summary, "'Death with Dignity' Laws by State. Most of the laws adopt a variation of the model reflected in the Oregon law which was passed more than twenty (20) years ago. Legislation is pending in other states. See attached March 6, 2017 article, "Death with Dignity Wins and Loses in Several States".

Arguments in support of assisted suicide legislation are compiled at [www.deathwithdignity.org](http://www.deathwithdignity.org). Proponents posit that implementation in other states has been without major problems, it offers a humane option for patients in intractable pain, safeguards deter abuse, and polls demonstrate widespread support for the concept. There may be some recent support for the latter proposition. The attached May 21, 2017 USA Today article describes an end-of-life survey which found that only 23% of respondents characterized "living as long as possible" as extremely important while 42% opined that "being comfortable and without pain" was extremely important. The results of other polls are summarized in the attached January 18, 2017 document, "Polling on Voter Support for Medical Aid in Dying for Terminally Ill Adults".

Arguments against assisted suicide are compiled at [www.notdeadyet.org](http://www.notdeadyet.org) and <https://dredf.org/public-policy/assisted-suicide/>. See also the attached Delaware Developmental Disabilities Council position statement. Opponents posit that diagnoses of terminal illness can be wrong, the safeguards are hollow with no enforcement or investigation authority, vulnerable patients in poor health are subject to undue influence from caregivers or heirs, financial and emotional pressures may prompt individuals to choose death, and such legislation is a first step towards involuntary euthanasia of the elderly and persons with disabilities.

I have the following specific observations on H.B. No. 160.

1. Since a patient wishing to take advantage of the bill may have to pay for the services of an attending physician, a consulting physician, a counseling psychiatrist/psychologist, and the cost of both ancillary and "end of life" drugs, the legislation may only provide an option to the affluent.

2. The term "counseling" in lines 17-19 is a misnomer. Counseling implies that the mental health practitioner is providing guidance and advice. In contrast, the mental health practitioner is only conducting an assessment of function, not "counseling" the individual (lines 17-19 and 102-106).

3. The Delaware residency standard (lines 146-150) is not difficult to meet and may invite non-residents to seek qualification. The sponsors could consider more robust standards to deter “suicide tourism”. See attached article, “Canada legalizes physician-assisted suicide”. One option would be to require “domicile” rather than “residence”. See attached article discussing distinctions. Another option would be to require that the patient be a Delaware resident at the time the terminal condition was diagnosed. See analogous provision in Delaware’s cancer treatment program regulations, 16 DE Reg. 4203.4.1.3.

4. Although the most compelling rationale for this type of legislation is to obviate protracted pain and suffering, actual or predicted pain and suffering are not required to take advantage of the law. In contrast, comparable Canadian law requires an “irremedial” condition that causes “enduring and intolerable suffering”. Id. Assisted suicide legislation might garner more support if it only covered this narrower group.

5. There is no statutory definition of “disease” (line 41). The medical literature has various definitions of the term. Depending on which definition is chosen, it may or may not cover conditions such as traumatic brain injury. The following definition would be encompassing:

Disease is an abnormal process affecting the structure or function of a part, organ or system of the body. It is typically manifested by signs and symptoms, but the etiology may or may not be known. Disease is a response to a specific infective agent (a microorganism or a poison), to environmental factors (e.g. malnutrition, injury, industrial hazards), to congenital or hereditary defects, or to a combination of all these factors.

See <http://medical-dictionary.thefreedictionary.com/disease> and <https://en.wikipedia.org/wiki/Disease> for this and other definitions of “disease”.

6. The safeguards in lines 56-57 against witnesses lacking impartiality are limited to persons who may be entitled to a portion of the patient’s estate by “will” or “operation of law” (e.g. intestate entitlement). The safeguards could be enhanced by including beneficiaries of trusts, annuities, and life insurance. Cf. 16 Del.C. §2503(b) (barring trust beneficiary from witnessing advance health care directive).

7. The “witness” section (line 60) bars the “attending physician” from serving as a witness. The California law (§443.3) logically also bars the consulting physician and the mental health specialist (psychiatrist/psychologist) from serving as a witness.

8. The “witness” section (lines 50-60) would allow a minor to serve as a witness. Contrast the advance health care directive law [16 Del.C. §2503(b)] which requires the witnesses to be adults.

9. Delaware law requires a State Ombudsman to be a witness to an advance health care directive of a resident of a long-term care facility. See 16 Del.C. 2511(b). Other state assisted suicide initiatives contain similar safeguards. See Oregon law, 127.810 §2.02; pending Hawaii legislation, SB 1129/2017, §3; and pending Nevada legislation, S.B. No. 261, §12. This requirement has been omitted from H.B. No. 160. The Ombudsman could be required as a third witness for residents of long-term care facilities.

10. The legislation does not include any special provisions for pregnant patients seeking assisted suicide. The Delaware advance health care directive law (16 Del.C. §2503) contains the following provision:

(j) A life-sustaining procedure may not be withheld or withdrawn from a patient known to be pregnant, so long as it is probable that the fetus will develop to be viable outside the uterus with the continued application of a life-sustaining procedure.

11. The California law (§443.5) includes the safeguard of the attending physician interviewing the patient “outside the presence of any other persons, except for an interpreter”. This deters implicit coercion and pressure from third parties. H.B. No. 160 omits this safeguard.

12. There is some “tension” between lines 86 and 91. The former contemplates a 72-hour period prior to directly dispensing end-of-life drugs while the latter has no 72-hour period if dispensed by a pharmacist.

13. Lines 95-96 recite as follows:

(b) The attending physician may sign the qualified patient’s death certificate. The death certificate must list the underlying terminal illness as the cause of death.

Literally, this provision allows other physicians to sign the death certificate. Since the second sentence uses passive voice, it is somewhat unclear if the other physicians would be required to list the underlying terminal illness as the cause of death.

14. H.B. No. 162 contains no definition of “impaired judgment” (line 106). Pending Maine legislation (LD 347, §2908) includes the following definition:

E. “Impaired judgment” means the inability of a person to sufficiently understand or appreciate the relevant facts necessary to make an informed decision.

15. Lines 131-143, using passive voice, describes documentation to be filed in the patient’s medical record produced by the patient, the attending physician, the psychologist/psychiatrist, and the consulting physician. It’s not clear who is responsible for ensuring that all of the required documentation is actually filed in the record.

16. In line 143, it would be more inclusive to specify that the identity of both the end-of-life drug(s) and ancillary drugs (line 87) should be included in the medical record. For clarity, a reference to the ancillary drugs could also be included in the "request for medication" form (line 269).

17. Lines 170-180 could be interpreted to mean that a pre-existing life insurance policy which bars benefits for suicide would not be affected by H.B. No. 160. Lines 181-183 would apply to existing life insurance policies but query whether Delaware can affect out-of-state life insurance policies which typically recite that the laws of a specific state apply. Moreover, there may be financial consequences to assisted suicide as described in lines 256-258. The bill does not contemplate disclosure of such potentially significant negative consequences to the patient. This undermines "informed judgment". The bill (lines 66-71) exclusively limits "informed judgment" to medical considerations which is manifestly "underinclusive".

18. The bill does not require the patient to ingest the end-of-life drug in Delaware. The only guidance is encouragement to not take the drug in a public place (line 77). If a person travels to another state to ingest the end-of-life drug, query whether the laws of that state would apply to the death and its consequences.

19. The bill does not contain a definition of "public place" which could result in a patient dying in public view. The California law (§443.1) contains the following definition:

(n) "Public place" means any street, alley, park, public building, any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access.

Parenthetically, the Washington law (RCW 70.245.210) includes a financial disincentive for patients who take an end-of-life drug in a public place:

Any government entity that incurs costs resulting from a person terminating his or her life under this chapter in a public place has a claim against the estate of the person to recover such costs and reasonable attorneys' fees related to enforcing the claim.

20. The "request for medication" form (lines 259-282) does not include an authorization for the attending physician to contact any pharmacist to implement the request. Such an authorization is contained in the California law (§443.11) and the Washington law (§RCW70.245.220).

21. The pending Maine bill (LD 347, §12) includes a disclaimer that its provisions may not be construed to conflict with certain provisions of federal law. The sponsors may wish to assess whether a similar disclaimer should be included in H.B. No. 160.

22. Comparable legislation in other states include a criminal penalty for exerting undue influence or interference with rescission of an end-of-life authorization. See Oregon, 127.890, §4.02; Washington, RCW 70.245.200; and pending Hawaii bill, HI SB 1129/2017, §20. Such a protection is conspicuously absent from H.B. No. 160.

23. The California law (§443.2) includes a safeguard to explicitly disallow a surrogate requesting a prescription for an end-of-life drug:

(c) A request for a prescription for an aid-in-dying drug under this part shall be made solely and directly by the individual diagnosed with the terminal illness and shall not be made on behalf of the patient, including, but not limited to, through a power of attorney, an advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decisionmaker.

A similar provision could be added to H.B. No. 160 to clarify that guardians and other surrogates may not invoke the law and substitute decision-making on behalf of a patient with a terminal illness.

24. The California law (§443.5) requires the attending physician to counsel the patient on the importance of “maintaining the aid-in-dying drug in a safe and secure location until the time that the qualifying individual will ingest it”. This is an important consideration since it lessens the prospect for another person inadvertently taking the drug and dying. A comparable safeguard could be added to H.B. No. 160.

25. The California law (§443.11) addresses “native language” and “interpreter” issues since language could easily affect “informed judgment”. This feature is absent from H.B. No. 160.

26. The Washington law (RCW 70.245.140) addresses disposal of unused end-of-life drugs: “Any medication dispensed under this chapter that was not self-administered shall be disposed of by lawful means”. H.B. No. 160 does not address disposal of unused drugs.

The SCPD may wish to consider sharing its perspective on the legislation with policymakers while including the above observations.

Attachments

E: legis/2017/6/17bils  
F:pub/bjh/legis/2017p&l617bilspart1