
SENATE COMMITTEE ON HEALTH

Senator Dr. Richard Pan, Chair

BILL NO: SB 380
AUTHOR: Eggman
VERSION: February 10, 2021
HEARING DATE: March 24, 2021
CONSULTANT: Teri Boughton

SUBJECT: End of life

SUMMARY: Deletes the January 1, 2026 sunset date of the End of Life Option Act (EOLA). Permits an individual, if their attending physician has medically determined that they will, within reasonable medical judgment, die within 15 days after making the initial oral request, to qualify by reiterating the oral request to the attending physician at any time after making the initial oral request. Eliminates the final attestation form required to be filled out by the qualified individual within 48 hours prior to self-administering the aid-in-dying medication. Requires health care providers who elect not to participate in EOLA to provide information about EOLA and provide a referral to another health care provider who is participating in EOLA. Makes failure to provide EOLA information or referral to another health care provider or facility a failure to obtain informed consent for medical treatments and subject to liabilities and other actions.

Existing law:

- 1) Establishes EOLA, which authorizes a process for terminally ill adults living in California to obtain and self-administer drugs for medical aid in dying. Sunsets EOLA on January 1, 2026. [HSC §443-443.22]
- 2) Requires an individual seeking to obtain a prescription for an aid-in-dying drug to submit two oral requests, a minimum of 15 days apart, and a written request to his or her attending physician. Requires the attending physician to directly, and not through a designee, receive all three requests. [HSC §443.3]
- 3) Requires the written request to be on a prescribed form, signed and dated, by the individual seeking the aid-in-dying drug in the presence of two witnesses who attest that the individual is personally known to them, or has provided proof of identity, voluntarily signed the request in the witnesses presence, is believed to be of sound mind and not under duress, fraud, or undue influence, and not for whom either witness is the attending physician, consulting physician, or mental health specialist. [HSC §443.3]
- 4) Requires the attending physician to do the following before prescribing an aid-in-dying drug:
 - a) Make the initial determination that the requesting adult has the capacity to make medical decisions; if indications of mental disorder, requires referral for a mental health specialist assessment, and prohibits an aid-in-dying drug to be prescribed until the mental health specialist determines that the individual has the capacity to make medical decisions and is not suffering from impaired judgement due to a mental disorder;
 - b) Make the initial determination that the requesting adult has a terminal disease, has voluntarily made the request for an aid-in-dying drug pursuant to the law, is a qualified individual pursuant to the law, confirm that the individual is making an informed decision by discussing the following:

- i) His or her medical diagnosis;
 - ii) The potential risks associated with ingesting the requested aid-in-dying drug;
 - iii) The probable result of ingesting the aid-in-dying drug;
 - iv) The possibility the he or she may choose to obtain but not take the aid-in-dying drug; and,
 - v) The feasible alternatives or additional treatment options, including, but not limited to, comfort care, hospice care, palliative care, and pain control;
- c) Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions and has complied with EOLA;
- d) Confirm that the qualified individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, outside the presence of any other person, except for an interpreter, whether or not the qualified individual is feeling coerced or unduly influenced by another person; and,
- e) Counsel the qualified individual about the importance of:
- i) Having another person present when he or she ingests the aid-in-dying drug;
 - ii) Not ingesting it in a public place;
 - iii) Notifying next of kin of his or her request, but prohibits the denial of the request, if the qualified individual declines or is unable to notify next of kin;
 - iv) Participating in a hospice program;
 - v) Maintaining the aid-in-dying drug in a safe and secure location;
 - vi) Inform the individual that he or she may withdraw or rescind the request at any time and in any manner;
 - vii) Offer the individual an opportunity to withdraw or rescind the request before prescribing the aid-in-dying drug;
 - viii) Verify, immediately before writing the prescription that the qualified individual is making an informed decision;
 - ix) Confirm that all requirements are met and all appropriate steps are carried out in accordance with EOLA before writing a prescription;
 - x) Fulfill the required record documentation;
 - xi) Complete the attending physician checklist and compliance form, include it and the consulting physician compliance form in the individual's medical record, and submit both forms to the California Department of Public Health (CDPH); and,
 - xii) Give the qualified individual the final attestation form, with the instruction that the form be filled out and executed by the qualified individual within 48 hours prior to the qualified individual choosing to self-administer the aid-in-dying drug. [HSC §443.5]
- 5) Prohibits a health care provider or professional organization or association from subjecting an individual to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating in good faith compliance with EOLA or for refusing to participate in accordance with 7) and 8) below of existing law. [HSC §443.14]

- 6) Protects a health care provider from civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action sanction, or penalty or other liability for participating in EOLA, including, but not limited to, determining the diagnosis or prognosis of an individual, determining the capacity of an individual for purposes of qualifying for the EOLA, providing information to an individual regarding EOLA, and providing a referral to a physician who participates in the EOLA. [HSC §443.14]
- 7) Requires participation in activities authorized pursuant to EOLA to be voluntary. Permits a person or entity that elects, for reasons of conscience, morality, or ethics, not to engage in activities authorized pursuant to EOLA to not take any action in support of an individual's decision under EOLA. Prohibits a health care provider from being subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for refusing to participate in activities authorized under EOLA, including, but not limited to, refusing to inform a patient regarding his or her rights under EOLA, and not referring an individual to a physician who participates in activities authorized under EOLA. [HSC §443.14]
- 8) Permits, if a health care provider is unable or unwilling to carry out a qualified individual's request under EOLA, and, the qualified individual transfers care to a new health care provider, the individual to request a copy of his or her medical records pursuant to law. [HSC §443.14]
- 9) Protects a health care provider from the liabilities described in 7) above when refusing to participate in EOLA, including, but not limited to, refusing to inform a patient regarding his or her rights under EOLA, and not referring an individual to a physician who participates in EOLA. [HSC §443.14]
- 10) Permits a health care provider to prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under EOLA while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider. [HSC §443.15]
- 11) Requires a health care provider that elects to prohibit its employees, independent contractors, or other persons or entities, including health care providers, from participating in activities under EOLA, to first give notice of the policy prohibiting participation to the individual or entity, and prohibits, a health care provider that fails to provide notice to an individual or entity from being entitled to enforce such a policy against that individual or entity. [HSC §443.15]

This bill:

- 1) Deletes the January 1, 2026 sunset on EOLA.
- 2) Permits an aid-in-dying drug request to be received by more than one attending physician and requires an attending physician to ensure the date of a request is documented in an individual's medical record. Prohibits an oral request documented in an individual's medical record from being disregarded by an attending physician solely because it was received by a prior attending physician.

- 3) Permits an individual, notwithstanding 2) above, if the individual's attending physician has medically determined that the individual will, within reasonable medical judgment, die within 15 days after making the initial oral request, qualify by reiterating the oral request to the attending physician at any time after making the initial oral request. Requires an individual who makes two oral requests to also make a written request.
- 4) Requires a physician to transfer all relevant medical records including written documentation and the dates of the individual's oral and written requests seeking to obtain a prescription for an aid-in-dying drug if the individual decides to transfer care to another physician.
- 5) Deletes the requirement that the attending physician give the qualified individual the final attestation form and deletes the final attestation form from the EOLA.
- 6) Adds health care facilities to the protections from civil, criminal, administrative, and other liabilities that apply to a health care provider who participates in EOLA. Defines "health care facility" as any clinic, health dispensary, or licensed health facility, including a general hospital, medical clinic, nursing home or in-patient hospice facility. A health care facility does not include an individual who is a health care provider or provider of health care.
- 7) Deletes from the protections described in 5) of existing law, a health care provider or professional organization or association for refusing to participate in EOLA.
- 8) Revises the participation opt out authority described in 7) and 8) of existing law to indicate "participation" is not diagnosing whether a patient has a terminal disease, informing the patient of the medical prognosis, determining whether a patient has the capacity to make decisions, providing information to a patient about EOLA, or providing a patient, upon request, with a referral to another health care provider for the purposes of participating in the EOLA. *In other words, a health care provider cannot opt out from these activities and be protected from liabilities or other penalties, as specified.*
- 9) Permits a health care provider to be subject to liabilities listed in 9) of existing law, for refusing to inform a patient regarding his or her rights under EOLA, and not referring an individual to a physician who participates in EOLA.
- 10) Makes failure to provide information about medical aid in dying to an individual who requests it, or failure to refer upon the individual's request to another health care provider or health care facility that is willing to provide the information, a failure to obtain informed consent for subsequent medical treatments.
- 11) Prohibits a health care provider and a health care facility from engaging in false, misleading, or deceptive practices relating to a willingness to qualify an individual or provide a prescription to a qualified individual under EOLA. Makes intentionally misleading an individual as to the willingness of a provider or facility to participate under EOLA coercion or undue influence.

- 12) Revises the permission of a health care provider to prohibit its employees, contractors or others from participating in EOLA, to, instead, permitting only health care facilities to prohibit employees, contractors, or others from prescribing aid-in-dying medication to a qualified individual who intends to self-administer the medication while on premises of a facility under the management or control of the facility, or, while acting within the course and scope of employment or contract with the facility.
- 13) Requires a health care facility to first give notice upon employment or other affiliation and thereafter annual notice of the policy described in 12) immediately above.
- 14) Requires each health care facility to post on the facility's public website the facility's current policy governing medical aid in dying.
- 15) Prohibits a health care facility from engaging in false, misleading, or deceptive practices relating to its policy concerning end-of-life care services or engage in coercion or undue influence under EOLA. Defines "coercion or undue influence" as the willful attempt, whether by deception, intimidation, or any other means to do either of the following:
 - a) Cause an individual to request, obtain, or self-administer medication under EOLA with intent to cause the death of the individual, except for actions of a physician acting in good faith compliance; or,
 - b) Prevent a qualified individual from obtaining or self-administering medication.
- 16) Subjects to civil liability an individual who intentionally or knowingly coerces or exerts undue influence on an individual in order to obstruct a request under EOLA.
- 17) Indicates that nothing in this bill limits damages arising from negligent conduct or intentional misconduct including failure to obtain informed consent by any person, health care provider, or health care facility.
- 18) Prohibits, notwithstanding specified sections of law, qualified individuals from being discouraged from self-administering prescribed aid-in-dying medication in health care facilities.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

- 1) *Author's statement.* According to the author, EOLA will sunset on January 1, 2026. After the sunset date, terminally ill, capable adults who want the option of medical aid-in-dying will be denied access. Now is the time to remove the sunset, and address impediments to access while preserving essential safeguards. Currently, the law requires individuals and their healthcare team to comply with a lengthy and administratively burdensome multi-step process. While on paper it appears that a person can get through the process relatively quickly, in reality it takes a dying person several weeks to several months to get through the process, if they are able to complete it and obtain the prescription at all. The empirical and anecdotal data collected shows that the current process is unnecessarily cumbersome, with too many roadblocks for many dying patients to access the law. These burdens are heaviest for underserved communities in rural areas and individuals from diverse communities, consistent with the inequities experienced during the COVID-19 pandemic. The pandemic has placed a spotlight on the toll that lack of access to healthcare and administrative burdens

exact in minority communities. While healthcare disparities are not new, the coronavirus pandemic has amplified persistent, systemic healthcare inequality. This bill will remove barriers, especially for underserved ethnic, racially diverse and rural communities, ensuring that all eligible terminally ill individuals are in charge of their end of life care while retaining the right to remain autonomous and die with dignity.

- 2) *Annual report.* EOLA requires the California Department of Public Health (CDPH) to provide annual reports under strict privacy requirements. The 2019 report presents some of the data as reported to CDPH from the EOLA-mandated physician reporting forms received between January 1, 2019 and December 31, 2019, and reflects information on individuals who were prescribed aid-in-dying drugs and died in the calendar year of 2019, as well as the period commencing January 1, 2016 to December 31, 2019. For the year ending December 31, 2019, 618 individuals received prescriptions pursuant to EOLA. In 2019, 405 individuals died following their ingestion of the prescribed aid-in-dying drug(s), which includes 27 individuals who received prescriptions prior to 2019. Of the 405 individuals, 88.6% were 60 years of age or older, 89.9% had health insurance, and 85.4% were receiving hospice and/or palliative care. Between June 9, 2016 and December 31, 2019, prescriptions have been written for a total of 1,985 people; and 1,283 individuals (64.6%) have died from ingesting the medications. Of the 1,283 individuals who have died, 1,112, (86.7%) were receiving hospice and/or palliative care.
- 3) *Double referral.* This bill is double referred. *Should it pass out of this committee, it will be referred to the Senate Judiciary Committee.*
- 4) *Prior legislation.* ABx2-15 (Eggman, Chapter 1, Statutes of 2015-16 Second Extraordinary Session) permits a competent, qualified individual who is an adult with a terminal disease to receive a prescription for an aid-in-dying drug if certain conditions are met, such as two oral requests, a minimum of 15 days apart, and a written request signed by two witnesses, is provided to his or her attending physician, the attending physician refers the patient to a consulting physician to confirm diagnosis and capacity to make medical decisions, and the attending physician refers the patient to a mental health specialist, if indicated. Sunsets these provisions on January 1, 2026.

SB 128 (Wolk and Monning of 2015) would have permitted a qualified adult with capacity to make medical decisions, diagnosed with a terminal disease to receive a prescription for an aid in dying drug if certain conditions were met, such as two oral requests, a minimum of 15 days apart and a signed written request witnessed by two individuals provided to the attending physician, the attending physician refers the patient to an independent, consulting physician to confirm diagnosis and capacity of the patient to make medical decisions, and the attending physician referred the patient for a mental health specialist assessment if there were indications of a mental disorder. *SB 128 was never scheduled in the Assembly Health Committee.*

AB 2139 (Eggman, Chapter 568, Statutes of 2014) requires a health care provider, when making a diagnosis that a patient has a terminal illness, to notify the patient of his or her right to comprehensive information and counseling regarding legal end-of-life options. Extends the right to request information to a person authorized to make health care decisions for the patient and specifies that the information may be provided at the time of diagnosis or at a subsequent visit with the health care provider.

AB 2747 (Berg, Chapter 683, Statutes of 2008) facilitates end-of-life care communication between doctors and their patients by enacting the California Right to Know End-of-Life Act of 2008 to ensure that health care providers provide critically-needed information in carefully-circumscribed instances.

- 5) *Support.* Compassion & Choices Action Network, the sponsor of this bill, writes that this bill removes unnecessary regulatory roadblocks in the law, while maintaining the core eligibility requirements. According to the sponsor, a study by Kaiser Southern California demonstrates that a third of eligible patients die unable to make it through the waiting period. This bill removes unnecessary regulatory roadblocks, as Oregon has done, while keeping intact the same basic eligibility requirements and core safeguards that have always protected vulnerable patients. Compassion & Choices sees firsthand the need for greater transparency around the implementation of the California EOLA so that patients know whether or not providers and health systems are willing to support them in accessing the law; clarification and flexibility with the waiting period so that it does not become an unnecessary suffering period; and several small, but important changes to the law to improve access without compromising patient safety, such as authorizing licensed clinical social workers to participate and clarifying the medical aid in dying may be self-administered in a healthcare facility. The Dolores Huerta Foundation writes that this compassionate law will sunset on January 1, 2026 and terminally ill California adults who want the option of medical aid in dying will be denied access to it. Some provisions of the law intended as safeguards have actually become roadblocks, making it sometimes impossible for dying Californians to access the law. We must act now to permanently reauthorize EOLA and include improvements to the existing law to address the impediments to access, while we preserve its essential safeguards. Currently, this law requires individuals and their healthcare team to comply with a lengthy and administratively burdensome 13-step process. People who are dying do not have time to navigate the difficult process. The Chief Executive Officer of Hospice of Santa Cruz County writes, that while the number of patients choosing the EOLA at Hospice of Santa Cruz County remains small, I have witnessed the comfort and relief that patients receive from having this option. It is affirming to witness the dignity that patients feel by gaining some control at a time when they often feel like their bodies are failing them. We have also seen how comforted family members can be by knowing that their loved one died on their own terms. For a variety of reasons, too many suffering terminally ill Californians have been unable to access their end of life options.
- 6) *Opposition.* The League of United Latin American Citizens (LULAC) strongly believes that assisted suicide does not constitute health care and is a dangerous risk to Latino communities, who are struggling to attain any option of basic care. LULAC firmly believes that assisted suicide is not about choice when so many people of color lack access to sufficient medical care. Latinos face a myriad of health disparities due to inequities of our socio-economic systems and now amidst the Covid-19 pandemic are experiencing greater rates of infection and mortality due to lack of access to health care. Our Latino communities desperately need an option that ends suffering through actual medical care, not assistance with their suicides by medicine and the state, which is just an opportunity for commodity-based, profit-driven health systems to cop out of care by providing the ever-cheap “option to die.” This is the time for racial equity in access to medical care and options for healthy living, not broadening access to capacity to kill oneself. The Disability Rights Education and Defense Fund writes that the disability community is full of individuals who have been misdiagnosed as terminally ill, but gone on to live full lives after that initial scare. A bad day should not be a death sentence a few hours later. This bill removes other important

protections for patients: requiring more medical professionals, with more training, to judge a patient's prognosis and assess their decision-making capacity. This Act has extraordinarily little monitoring, data, and investigation of abuse—there's not even a phone number to call if concerned family members or friends fear their loved one is being coerced. It's almost as if the law is set up to avoid finding problems. The annual statistical reports are very minimal for such an important public policy. One example is that assisted suicide laws in Oregon and Washington State require that these states at least make public doctor-reported data on why their patients chose to hasten their death. Might it have been the economic pressures so rampant in our broken, profit-driven health care system? But in California, there is no requirement to report such data on patient reasons. And such important data is therefore missing from the California reports.

- 7) *Oppose unless amended.* The California Hospital Association (CHA) writes current language in this bill would severely limit or eliminate EOLAs protections for health care facilities and providers that choose not to participate in physician-assisted death. Consequently, CHA currently opposes this bill unless it is amended to correct these issues. This bill would effectively require health care facilities and providers to facilitate patients' participation EOLA despite their unwillingness — due to conscience, moral, ethical, or practical objections — to doing so. This bill would revise current law which broadly protects a person or entity from being required to participate under EOLA, to carve out specified activities from what constitutes such "participation," including providing information to a patient about EOLA and providing a referral to another health care provider for the purposes of participating in the activities authorized by EOLA. Further, this bill imposes an extraordinary penalty on any facility or provider that fails to provide such counseling and referral: all subsequent medical treatments provided by that entity or provider will be conclusively deemed to have been performed without informed consent — which constitutes medical malpractice and battery, with the attendant risk of claims for damages. This bill would require health care facilities to allow patients to take aid-in-dying medications in their facilities. A key provision added as a result of CHA's 2015 advocacy — allows a health care facility or provider to prohibit its employees, independent contractors, and others from participating in activities under EOLA while on premises owned or under the direct control of that provider, or while they are acting within the course and scope of their employment with that provider. This bill largely eviscerates this right. It would permit a facility to prohibit its employees, contractors, and others only from writing prescriptions for aid-in-dying medication if they knew the patient intended to self-administer the medication while on premises owned or controlled by the facility; the facility could not prohibit any other activities authorized by EOLA — including writing prescriptions and counseling patients regarding utilizing aid-in-dying medication.
- 8) *Concern and amendment request.* Critical to the California Medical Association's (CMA's) support of the original EOLA, is the absolute ability for physicians to choose whether or not to participate. This bill redefines 'participation,' including the requirement of informing and referring, which would severely threaten the autonomy of physicians, removing a true conscious objection and opt out. As physicians are already disallowed from using deceptive practices to dissuade patients from utilizing EOLA CMA is unclear why this modification is necessary, or in the best interest of patients or physicians. This bill would also allow counselors not previously permitted, to administer mental health evaluations of patients requesting aid in dying medication. While CMA sympathizes with the general shortage of mental health professionals, without evidence of an inadequate workforce to address these particular individuals, CMA sees no reason to expand the scope of these critical assessments

to lower credentialed professionals. CMA is committed to finding a solution that achieves both parties' objectives, while protecting the safety of the patient and sanctity of the physician-patient relationship.

- 9) *Policy comment.* There are provisions in this bill that prevent a provider from fully opting out of EOLA and require a provider to inform a person of their rights under EOLA and subject a provider to liability, sanctions or failure to provide informed consent if these requirements are not met, including requiring referral of the patient to another provider. Some of the penalties associated with these provisions may go too far. The bill does not indicate how much information a nonparticipating provider is required to provide and it is unclear if a discussion about palliative care before EOLA could potentially be viewed as obstructing a request for an aid-in-dying drug.

SUPPORT AND OPPOSITION:

Support: Compassion & Choices Action Network (sponsor)
 Access TLC Hospice
 American Nurses Association California
 Americans United for Separation of Church & State Orange County
 Compassion & Choices Latino Council
 Brownie Mary Democratic Club of San Francisco
 Dolores Huerta Foundation
 End of Life Choices California
 Good Grief Doula
 Hemlock Society of San Diego
 Hospice of Santa Cruz County
 Integrated MD Care
 Laguna Woods Democratic Club
 Long Beach Gray Panthers
 Mera Consulting
 Pilgrim United Church of Christ
 Sonoma County Democratic Party
 Voyages
 574 Individuals

Oppose: Alliance of Catholic Health Care, Inc.
 American Academy of Medical Ethics
 California Catholic Conference
 California Family Council
 California Hospital Association (unless amended)
 California League of United Latin American Citizens
 Disability Rights Education & Defense Fund
 Patients Rights Action Fund
 The Church of Jesus Christ of Latter-day Saints