

SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2021-2022 Regular Session

SB 380 (Eggman)
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JT

SUBJECT

End of life

DIGEST

This bill reduces barriers related to a terminally-ill patient's right to obtain an aid-in-dying prescription from their physician under in the End of Life Option Act (ABx2-15, Eggman, Ch. 1, Stats. 2016, 2nd Ex. Sess.) (Act), and deletes the Act's sunset date.

EXECUTIVE SUMMARY

Under narrow circumstances, the Act permits a doctor to prescribe aid-in-dying medication to a terminally-ill patient with capacity who repeatedly affirms, orally and in writing, their voluntary desire to exercise this right, which they must self-administer. Passed in 2015, the Act has been used by roughly 2,000 people to avoid unnecessary suffering by ending their lives on their own terms, swiftly, peacefully, and with dignity.

According to the author and sponsors, nearly 1,000 people who attempted to obtain a prescription have died before completing the approval process. Arguing that the existing process is excessively bureaucratic and cumbersome, the author has introduced this bill to make the process more accessible. The bill's principal changes:

- reduce the timeframe between the requisite two oral requests for an aid-in-dying prescription from 15 days to 48 hours;
- delete the requirements governing an attestation form the person must fill out 48 hours before ingesting the aid-in-dying medication;
- require a physician, if they choose not to participate in the Act, to inform an individual who makes a request for a prescription for aid-in-dying medication that they do not participate in the Act, document the individual's date of request and the physician's notice to the individual of their non-participation in the medical record, and transfer the individual's relevant medical records upon request;

- require each health care facility to post on the facility’s public website the facility’s current policy governing medical aid-in-dying;
- prohibit certain false, misleading, or deceptive practices relating to the Act;
- make additional changes to immunity and liability provisions; and
- delete the Act’s sunset date, thereby extending its operation indefinitely.

The bill is sponsored by the Compassion & Choices Action Network. It is supported and opposed by numerous organizations. Both sides include medical associations, religious groups, and other civic organizations. The bill passed out of the Senate Health Committee by a vote of 8-1. Clarifying amendments are proposed on page 13.

PROPOSED CHANGES TO THE LAW

Existing law:

- 1) Establishes the Act, which provides a process for terminally-ill adults living in California to obtain and self-administer aid-in-dying drugs. (Health & Saf. Code § 443 et seq.)¹
- 2) Defines the following:
 - a) “Aid-in-dying drug” means a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about their death due to a terminal disease. (§ 443(b).)
 - b) “Health care provider” means any licensed person under specified provisions, and any clinic, health dispensary, or health facility, as specified. (*Id.* at (h).)
 - c) “Qualified individual” means an adult who has the capacity to make medical decisions, is a resident of California, and has satisfied the requirements of the Act in order to obtain a prescription for a drug to end their life. (*Id.* at (o).)
 - d) “Terminal disease” means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months. (*Id.* at (q).)
- 3) 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, witnessed request to their attending physician. The attending physician must directly receive all three requests. (§ 443.3(a).) After the individual makes their written request on a final attestation form, requires that an additional 48 hours elapse before the individual is provided with the aid-in-dying drug. (§ 443.5(a)(12).)

¹ All further section references are to the Health and Safety Code unless otherwise specified.

- 4) Requires the attending physician, before prescribing the aid-in-dying drug to do the following:
 - a) Make an initial determination as to whether the adult has: the capacity to make medical decisions, a terminal disease, made the request voluntarily, and otherwise meets the requirements of the Act as a qualified individual.
 - b) Confirm the person is making an informed decision by discussing with them: their medical diagnosis and prognosis, the potential risks associated with ingesting the aid-in-dying drug, the probable result thereof, the possibility that a person may choose to obtain the aid-in-dying drug but not take it, and the feasible alternatives or additional treatment options.
 - 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 the provisions of the Act.
 - 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 of the presence of any other persons, except for an interpreter if required under the Act, whether or not the qualified individual is feeling coerced or unduly influenced by another person.
 - e) Counsel the qualified individual about the importance of: having another person present when they ingest the aid-in-dying drug, not ingesting the drug in a public place, notifying next of kin of their request for the drug, participating in a hospice program, and maintaining the drug in a safe and secure location until they ingest it.
 - f) Inform the individual of their right to withdraw or rescind the request at any time and in any manner.
 - g) Verify, immediately before writing the prescription for the drug, that the qualified individual is making an informed decision.
 - h) Confirm that all requirements of the Act are met and all appropriate steps are carried out in accordance with the Act before writing the prescription.
 - i) Fulfill specified record documentation requirements.
 - j) Complete a required checklist and compliance form and include them in the individual's medical record and submit both forms to the State Department of Public Health.
 - k) Give the qualified individual the final attestation form, with the instruction that the form be filled out and executed by the qualified individual 48 hours before the individual self-administers the drug. (§ 443.5(a).)

- 5) Establishes requirements for the form for a request for the drug and the final attestation form given to the qualified individual at the time the physician writes the prescription. (§ 443.11(a), (c).)

- 6) Provides broad immunity for entities that participate, or refuse to participate, in the Act. Specifically:
 - a) A person is not subject to civil or criminal liability solely because they were present when a qualified individual self-administers the drug. The person present may assist the qualified individual by preparing the drug but not in ingesting it. (§ 443.14(a).)
 - b) Prohibits a health care provider or a professional organization or association from subjecting an individual to discipline for participating in good faith compliance with the Act, or refusing to participate in activities authorized under the Act if they so elect for reasons of conscience, morality, or ethics. (*Id.* at (b), (e).)
 - c) A health care provider is not subject to liability for participating in the Act, as specified. (*Id.* at (c).)
 - d) If the health care provider, including a health care facility, is unable or unwilling to carry out a qualified individual's request, provides that the individual may request a copy of their medical records. (*Id.* at (e)(3).)
- 7) Authorizes 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 the Act while on premises owned or controlled by the provider or while acting within the scope of employment or contract with the provider. (§ 443.15(a).) Requires the provider to furnish notice of this policy, as specified. (*Id.* at (b).) Authorizes the provider to take action for violations of the policy. (*Id.* at (c).)
- 8) Punishes as a felony certain knowing misconduct that undermines a person's exercise of their rights under the Act. (§ 443.17(a), (b).) Provides that these provisions do not limit civil liability. (*Id.* at (e).)
- 9) Provides that the Act sunsets January 1, 2026.

This bill:

- 1) Reduces the timeframe between oral requests from 15 days to 48 hours; no longer requires a single physician to be the sole recipient of the requests; requires that a physician receiving a request ensure the date of the request is documented in the individual's medical record; prohibits the attending physician from disregarding an oral request documented in an individual's medical record solely because it was received by a prior attending physician or an attending physician who chose not to participate.
- 2) Requires a physician, upon request of an individual who decides to transfer care to another physician, to transfer all relevant medical records, including written

documentation including the dates of the individual's oral and written requests seeking to obtain a prescription for an aid-in-dying drug.

- 3) Deletes the requirements governing the attestation form.
- 4) Removes from the definition of "health care provider" a clinic, health dispensary, or health facility, and instead defines "health care facility" to include these terms. Distinguishes certain duties and obligations as they specifically apply to these entities.
- 5) Provides that a health care provider who objects for reasons of conscience, morality, or ethics to participating under the Act cannot be required to participate.
- 6) Limits the immunity provision for an entity that refuses to participate in the Act to a health care provider, thereby excluding a health care facility from these provisions.
- 7) Provides that if a health care provider is unable or unwilling to carry out an individual's request for a prescription for an aid-in-dying medication pursuant to the Act, the provider must, at a minimum, inform the individual that they do not participate in the Act, document the individual's date of request and provider's notice to the individual of their objection in the medical record, and transfer the individual's relevant medical records upon request.
- 8) Prohibits a health care provider or 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 the Act. Prohibits a health care facility from engaging in false, misleading, or deceptive practices relating to its policy concerning end-of-life services or engaging in coercion or undue influence.
- 9) Provides that a health care facility may prohibit its employees, independent contractors, or other persons or entities from prescribing aid-in-dying medication to a qualified individual who intends to self-administer the medication, narrowing this provision from existing law, which authorizes the prohibition of participation in activities under the Act.
- 10) Requires each health care facility to post on the facility's public website the facility's current policy governing medical aid-in-dying.
- 11) Provides that the Act's criminal provisions do not limit civil liability or damages arising from negligent conduct or intentional misconduct for actions authorized by the Act by any person, health care provider, or health care facility.
- 12) Eliminates the Act's sunset date, thereby extending it indefinitely.

COMMENTS

1. Author's statement

The author writes:

The End of Life Option Act 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, 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 COVID19 pandemic. The pandemic has placed a spotlight on the toll that lack of access to healthcare and administrative burdens exact in minority communities. While health care disparities are not new, the coronavirus pandemic has amplified persistent, systemic healthcare inequality. SB 380 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. The right to die

a. U.S. Constitutional cases

Generally, there is a constitutional right of individuals to refuse medical treatment. The U.S. Supreme Court has recognized that a competent adult has a constitutional right to withdraw or withhold life-sustaining treatment that may cause or hasten death. (*Cruzan v. Director, Missouri Dept. of Health* (1990) 497 U.S. 261.) The *Cruzan* Court also recognized that states have an important interest in protecting life and ensuring that a person desired the end of life treatment before it is suspended, and thus can require clear and convincing evidence that a person wanted treatment terminated before it is cut off. Further, the Court held that states can also prevent family members from terminating treatment for another as the right to do so belongs to the individual. (*Id.* at 281, 286.)²

² See Chemerinsky, *Constitutional Law Principles and Policies* (2011) 5th Edition, pp. 887-888.

In two cases, *Washington v. Glucksberg* (1997) 521 U.S. 702 and *Vacco v. Quill* (1997) 521 U.S. 793, the Supreme Court upheld facial challenges to state laws that prohibited the aiding of a suicide, drawing a distinction between refusing treatment, even where it might hasten death, and physician-assisted suicide. In those cases, the Court held that the state laws did not violate either a fundamental right under the due process clause (*Glucksberg*) or the equal protection clause (*Vacco*)—in other words, the Court found no constitutional right to physician-assisted suicide. At the same time, the decisions left open the possibility that legal protection could be afforded to such laws as a matter of state law or future Supreme Court rulings.³ To this end, Justice O’Connor, joined by Justices Ginsberg and Breyer, wrote that while there “is no generalized right to ‘commit suicide,’” the Court need not address the “narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her death.” (*Glucksberg*, 521 U.S. at 737 [J. O’Connor, concurring].)

Similarly, Justice Stevens, joined by Justices Souter, Ginsberg and Breyer, wrote in his separate concurrence to specify that there “is also room for further debate about the limits that the Constitution places on the power of the states to punish the practice.” (*Id.* at 739 [J. Stevens, concurring].) The Justices recognized that “[t]he *Cruzan* case demonstrated that some state intrusions on the right to decide how death will be encountered are also intolerable” and “[a]lthough there is no absolute right to physician-assisted suicide, *Cruzan* makes it clear that some individuals who no longer have the option of deciding whether to live or to die because they are already on the threshold of death have a constitutionally protected interest that may outweigh the State’s interest in preserving life at all costs. The liberty interest at stake in a case like this differs from, and is stronger than, both the common-law right to refuse medical treatment and the unbridled interest in deciding whether to live or die. It is an interest in deciding how, rather than whether, a critical threshold shall be crossed.” (*Id.* at 745.)

While it remains to be seen whether there is in fact a more limited, as opposed to absolute, constitutional right to die in some limited cases, the states have the ability to decide this issue pursuant to the political process and as a matter of a statutory right.

b. Statutory rights

Beginning with Oregon in 1997, a total of nine jurisdictions have adopted physician-assisted suicide laws. In 2015, California became the fifth state to do so with the passage of ABx2-15 (Eggman, Ch. 1, Stats. 2016, 2nd Ex. Sess.),⁴ which established the End of Life Option Act.

³ See Chemerinsky, *Constitutional Law Principles and Policies* (2011) 5th Edition, pp. 889-891.

⁴ In 2015, Governor Brown issued a proclamation convening a special session of the Legislature for certain specified purposes, including to “[i]mprove the efficiency and efficacy of the health care system, reduce the cost of providing health care services, and improve the health of Californians.” The bill was passed during that special session. A lawsuit contending that the Legislature acted outside of the scope of

The Act, which will sunset January 1, 2026, allows an individual who has complied with all of its requirements to obtain and to use an “aid-in-dying drug,” which is defined as “a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal disease.” (§ 443.1(b).) “Terminal disease” is “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.” (*Id.* at (q).) At that point, the individual may make a request to the attending physician for an aid-in-dying drug. (§§ 443.2 (a), 443.3(a).)

The attending physician must refer the individual to a consulting physician (§ 443.5(a)(3)), who must also diagnose the individual as having a terminal disease (§ 443.6(b)). If either the attending or the consulting physician finds indications that the individual has a mental disorder, they must refer the individual for a mental health specialist assessment. (§§ 443.5(a)(1)(A)(ii), 443.6(d).) Several additional steps must be taken to ensure that the person is making an informed decision that is not the result of coercion or undue influence or a mere whim: A terminally-ill patient of sound mind must submit to their attending physician two oral requests, made at least 15 days apart, in addition to a request written on statutory form that is signed and dated by the patient in the presence of two witnesses, who must attest that the patient is of sound mind and not under duress, fraud, or undue influence. (§ 443.3.) The attending physician may directly provide the aid-in-dying drug to the qualified patient or the physician may inform a pharmacist about the prescription to be provided to the person. (§ 443.5(b).) Finally, 48 hours before self-ingesting the aid-in-dying drug, the patient must complete a statutorily-prescribed attestation form restating their intent and that they are of sound mind. (§ 443(a)(12).)

If all the conditions of the Act are met, the attending physician may prescribe an aid-in-dying drug to the qualified individual. (§ 443.5(b).) The qualified individual may then self-administer the aid-in-dying drug. (§§ 443.1(b), 443.13(a)(2), 443.14(a).) The Act confers broad immunity on a physician who participates, or refuses to participate, in the process prescribed by the Act. (§§443.14(b), (c), (e).)

the Government’s proclamation is passing the Act was overruled on appeal because the physicians challenging the Act lacked standing. (*People ex rel. Becerra v. Superior Court* (2018) 29 Cal.App.5th 486; see *id.* at 539, [Slough, J. concurring and dissenting; arguing the court should have reached the merits and that the Act is constitutional]; modified by, rehearing denied by *Sang-Hoon Ahn v. Hestrin* (2020) Cal. App. Unpub. LEXIS 8581, 2020 WL 7585883 (Cal. App. 4th Dist., Dec. 22, 2020); review denied by *Sang-Hoon Ahn v. Hestrin*, (2021) Cal. LEXIS 1688 (Cal., Mar. 10, 2021).) The issue will likely continue to be litigated. The passage of this bill would not implicate the ordinary concerns attending legislation that affects pending litigation: the very issue in the litigation is whether the Act was duly enacted. In this regard, the bill would reaffirm what the Legislature and Governor have already made abundantly clear.

3. Seeks to reduce procedural barriers to obtaining aid-in-dying services

The author and sponsors argue that the existing bureaucratic, multi-step process in the Act hampers or prevents many terminally-ill individuals from exercising their right to obtain aid-in-dying medication. According to a report from the California Department of Public Health, between June 9, 2016 and December 31, 2019, prescriptions were written for a total of 1,985 people; 1,283 individuals (64.6 percent) have died from ingesting the medications.⁵ Of the individuals who died during that period, 1,112 (86.7 percent) were receiving hospice and/or palliative care.⁶ Extrapolating from the results of a study from Kaiser Permanente Southern California,⁷ the author and sponsors estimate that roughly 1,000 terminally-ill people who were otherwise eligible have sought and failed to obtain aid-in-dying services under the Act.

This bill makes several changes to reduce these procedural barriers. Specifically, the bill:

- reduces the timeframe between oral requests from 15 days to 48 hours;⁸
- no longer requires a single physician to be the sole recipient of the requests;
- requires that a physician receiving a request ensure the date of the request is documented in the individual's medical record;
- prohibits the attending physician from disregarding an oral request documented in an individual's medical record solely because it was received by a prior attending physician or an attending physician who chose not to participate;
- deletes the requirements governing the attestation form; and
- requires a physician, upon request of an individual who decides to transfer care to another physician, to transfer all relevant medical records, including written documentation with the dates of the individual's oral and written requests seeking to obtain a prescription for an aid-in-dying drug.

⁵ *California End of Life Option Act 2019 Data Report* (July, 2020) California Department of Public Health, p. 3 https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPHEndofLifeOptionActReport2019%20_Final%20ADA.pdf (as of Apr. 14, 2021).

⁶ *Id.*

⁷ Nguyen et al. *Characterizing Kaiser Permanente Southern California's Experience With the California End of Life Option Act in the First Year of Implementation*. *JAMA Internal Medicine*, H (2018) <https://www.deathwithdignity.org/wp-content/uploads/2018/01/Kaiser-Permanente-vs-CAEOLOA-JAMA-Internal-Medicine.pdf> (as of Apr. 14, 2021). The study found that of 379 patients who inquired about services under the Act, 176 completed their first oral request, 140 completed an examination with a consulting physician, 120 completed the second oral request, 108 were prescribed aid-in-dying medication, 92 had the drugs dispensed to them, and 68 ultimately ingested the medication. (*Id.* at pp. 3-4.) The study stated that "[m]any of the withdrawals at each step of the [Act's] process were owing to death or patients being too ill." (*Id.* at 4.) Through the course of that process, 125 were excluded because they died or were too ill to proceed, including 79 who reached this status between making an initial inquiry and making their first oral request. (*Id.* at 1.)

⁸ The prior version of the bill would have retained the 15-day period while providing for a waiver to reduce the period to 48 hours if the physician determines the person is likely to die within 15 days. This was similar to a recent change in Oregon that provides for a waiver of the 15-day period.

4. Seeks to prohibit obstruction of the Act without imposing an excessive burden on conscientious objectors

- a. *The introduced version of the bill required some affirmative steps to facilitate the provision of services under the Act*

Health care providers are free to abstain from providing services under the Act and are immune from liability and discipline for refusing to participate. (§ 443.14(e).) The bill seeks to remain consistent with these basic principles while doing more to prevent the obstruction of a person's ability to exercise their rights under the Act. This is a delicate balancing act: at some point, provisions intended to prevent obstruction might inadvertently force a person to take actions that violate their sincerely-held beliefs.

As introduced, the bill arguably did not strike the right balance. The introduced version of the bill would have required a physician who objects to the Act to carry out certain duties to affirmatively facilitate the ultimate provision of end-of-life services under the Act. Under existing law, a person or entity that elects for reasons of conscience, morality, or ethics, not to participate in activities authorized under the Act is not required to participate. (§ 443.14(e)(1).) The introduced version of the bill would have defined "participation" for these purposes to exclude: (1) diagnosing whether a patient has a terminal disease, informing the patient of the medical prognosis, or determining whether the patient has the capacity to make decisions; (2) providing information to a patient about the Act; and (3) providing a patient, upon request, with a referral to another health care provider for the purposes of participating in the activities authorized by the Act. The bill would have defined a failure to provide information or a referral under those provisions as a failure to obtain informed consent for subsequent treatments, and would have specified that a failure to obtain informed consent subjects the person, health care provider, or health care facility to civil liability.

By requiring physicians who sincerely believe the Act is immoral to choose between exposure to liability and affirmatively facilitating, to a limited extent, a person's exercise of their rights under the Act, including by conveying certain information, the prior version of the bill raised constitutional questions with respect to freedom of speech and the free exercise of religion.⁹ Although these provisions are no longer in the bill, those issues are generally addressed below.

⁹ Opposition testimony in the Senate Health Committee asserted that the referral requirement in the prior version of the bill violated Section 1553 of the Affordable Care Act, which prohibits discrimination against individuals or institutional health care entities that do not provide service that causes, or assists in causing, the death of any individual. While the sponsors disagree with this assertion, the point is moot as the provision is no longer in the bill.

b. The current version of the bill draws the line at non-obstruction

The Senate Health Committee recently amended the bill to instead draw the line at preventing those who do not wish to participate in the Act from obstructing the provision of care pursuant to the Act. As amended, the bill no longer narrows the definition of “participation” for purposes of the provision that provides that participation in activities authorized under the Act must be voluntary. The bill in print now provides:

- A health care provider who objects for reasons of conscience, morality, or ethics is not required to participate under the Act.
- If a health care provider is unable or unwilling to carry out an individual’s request for a prescription for an aid-in-dying medication pursuant to the Act, the provider must, at a minimum:
 - inform the individual that they do not participate in the Act;
 - document the individual’s date of request and provider’s notice to the individual of their objection in the medical record; and
 - transfer the individual’s relevant medical record upon request.¹⁰
- A health care provider or a health care facility is prohibited 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 the Act.
- Each health care facility must post on the facility’s public website the facility’s current policy governing medical aid-in-dying.
- A health care facility is prohibited from engaging in false, misleading, or deceptive practices relating to its policy concerning aid-in-dying services, or engaging in coercion or undue influence.
- A health care facility may prohibit its employees, independent contractors, or other persons or entities from prescribing aid-in-dying medication to a qualified individual who intends to self-administer the medication.¹¹

The sponsors argue that when these amendments were negotiated with the Senate Health Committee, with the input of the California Medical Association, the “mutual

¹⁰ Existing law expressly states that a person who is a conscientious objector is not required “to take any action in support of an individual’s decision” under the Act. (*Id.* at (e)(1).) Existing law expressly immunizes a health care provider who refuses to participate by “refusing to inform a patient regarding his or her rights under [the Act], and not referring an individual to a physician who participates in activities authorized under [the Act].” (*Id.* at (e)(2).) As conforming changes with the duties described above, the bill deletes these quoted provisions, but continues to provide that health care providers are free to abstain from providing services under the Act and are immune from liability and discipline for refusing to participate.

¹¹ There is a gap between what the health care facility may prohibit and what a non-participating physician is required to do under the bill. The non-participating physician must inform the person of their position on the Act, document the request, transfer medical records upon request, and be truthful. But the bill only authorizes a health care facility to prohibit prescriptions under the Act. Thus, a health care facility cannot prohibit, for instance, making a diagnosis or referral for purposes of the Act. This gap has drawn the opposition of California Hospitals Association.

goal was to strike an appropriate balance between ensuring that patients receive timely, accurate and complete information, while also respecting the conscience objections to medical aid-in-dying that some providers may have. The bill does not require physicians who object for reasons of conscience to qualify, confirm eligibility, write a prescription or make a referral to a physician who would participate under the act. SB 380 just makes sure that if a patient asks their physician about the End of Life Option Act that the physician provides the patient honest and timely information so that they can seek care elsewhere.”

c. *The bill likely does not violate the First Amendment*

i. Compelled speech

The First Amendment generally prohibits certain types of compelled speech. (*See Wooley v. Maynard* (1977) 430 U.S. 705 [government could not require person to display “live free or die” motto on their license plate].) However, free speech protections are diminished in the context of the regulation of professional conduct; for instance, liability is routinely imposed on doctors who give negligent medical advice or lawyers who disclose their clients’ confidences. (*See Pickup v. Brown* (9th Cir. 2014) 740 F.3d 1208, 1228.) With respect to compelled speech, the plurality in *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992) 505 U.S. 833 upheld a requirement that doctors disclose truthful, non-misleading information to patients about certain risks of abortion:

All that is left of petitioners’ argument is an asserted First Amendment right of a physician not to provide information about the risks of abortion, and childbirth, in a manner mandated by the State. To be sure, the physician’s First Amendment rights not to speak are implicated, but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State. We see no constitutional infirmity in the requirement that the physician provide the information mandated by the State here.

(*Id.* 884, citation omitted.) Neither the current nor the prior version of this bill contemplate anything beyond the disclosure of truthful information so that a patient can determine whether to seek a physician who participates in the Act.

ii. Free exercise of religion

The First Amendment also forbids laws prohibiting the free exercise of religion. For a person whose religious beliefs are inimical to the notion of a right to die, any participation in such a process risks inflicting psychological torment on that person by making them feel complicit with an act they find to be profoundly immoral. In view of such concerns, numerous laws, the Act included, allow medical professionals to opt out of providing certain forms of care or prescribing certain types of medications.

The right to exercise one's religion freely "does not relieve an individual of the obligation to comply with a valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes)." (*Emp't Div. v. Smith* (1990) 494 U.S. 872, 879 [internal quotation marks omitted].) A neutral law of general applicability need not be supported by a compelling government interest even when "the law has the incidental effect of burdening a particular religious practice." (*Church of Lukumi Babalu Aye, Inc. v. City of Hialeah* (1993) 508 U.S. 520, 531 [*Lukumi*].) Such laws need only survive rational basis review. (*Miller v. Reed* (9th Cir. 1999) 176 F.3d 1202, 1206.) For laws that are not neutral or not generally applicable, strict scrutiny applies. (See *Lukumi, supra*, 508 U.S. at 531-32 ["A law failing to satisfy these requirements must be justified by a compelling governmental interest and must be narrowly tailored to advance that interest"].)

"The Free Exercise Clause is not violated even if a particular group, motivated by religion, may be more likely to engage in the proscribed conduct. [Citations.]" (*Stormans, Inc. v. Wiesman* (9th Cir. 2015) 794 F.3d 1064, 1077.) However, as noted, the Act affirmatively protects those who refuse to participate by exempting them from the Act's requirements. The bill would not eliminate this conscience exemption; it simply contemplates a marginal narrowing of the exemption.

5. Amendments

The bill would remove from the definition of "health care provider" a clinic, health dispensary, or health facility, and instead define "health care facility" to include these entities. The bill distinguishes certain duties and obligations as they specifically apply to these entities. Under the bill, the Act's immunity provision for an entity that refuses to participate in the Act continues to be specific to a health care provider, thereby excluding a health care facility from these provisions. To make it clear that a health care facility continues to have the same protections, the author has agreed to the following amendment:

Amendment

In section 6 of the bill, amend section 443.14(e)(3) as follows:

(3) A health care provider or health care facility is not 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 this part.

Additionally, the bill provides that the Act's criminal provisions do not limit civil liability or damages arising from negligent conduct or intentional misconduct for actions authorized the Act by any person, health care provider, or health care facility. This is intended to ensure that a person who provides care under the Act is subject to

medical malpractice liability as they would be in any other context. In response to concerns over the wording of this provision, the author has agreed to the following amendment:

Amendment

In section 8 of the bill, amend section 443.17(e) as follows:

(e) This section does not limit civil liability or damages arising from negligent conduct or intentional misconduct ~~for~~ *in carrying out actions otherwise* authorized by this part by any person, health care provider, or health care facility.¹²

6. Support

The bill's sponsor, the Compassion & Choices Action Network, writes that "75% of Californians and the majority of every demographic and county in California approve of the California End of Life Option Act. For all of these reasons, it is essential that the sunset provision is removed and the California End of Life Option Act becomes permanent." They continue:

It is also necessary to improve the law, while maintaining the core eligibility requirements. Unfortunately, it has become clear that patient access across the state is a problem. A study by Kaiser Southern California demonstrates that a third of eligible patients die unable to make it through the waiting period. We applaud you for your efforts to remove unnecessary regulatory roadblocks, as Oregon has done, while keeping intact the same basic eligibility requirements and core safeguards that have always protected vulnerable patients.

Numerous organizations, including medical associations, religious groups, and other civil organizations support the bill. In a letter that echoes the letters from several other groups, the Monterey County Palliative Care Collaborative writes:

As physicians, social workers, nurses, nurse practitioners, and pharmacists, we believe our patients' experience at end-of-life should be compassionate and their wishes should be honored. Person-centered, dignified care means that together with their clinical team, patients who are faced with a life-limiting illness, should have the right to explore all treatment options, including aid-in-dying medication if certain conditions are met.

The California End-of-Life Option Act took effect in 2016 and since that time nearly 2,000 mentally capable, terminally ill Californians with six months or less

¹² The amendments may include the addition of co-authors as well as technical, nonsubstantive changes recommended by the Office of Legislative Counsel.

to live have exercised their legally available option to receive a prescription for medical aid-in-dying medication to peacefully end their unbearable suffering.

At the same time and for a variety of reasons, too many suffering terminally ill Californians have been unable to access their end of life options. The bureaucratic and burdensome 10+ step process has hampered or prevented many patients from accessing the law.

Shockingly, according to a study by Kaiser Permanente Southern California, one third of terminally ill adults who sought to access the End-of-Life Option Act died before completing the time-consuming process which includes a 15-day waiting period and can sometimes take months to complete.

In addition, the COVID-19 pandemic has exposed health disparities in access to care among different communities. The hurdles that make it difficult for dying people to use this compassionate law is magnified in communities of color, where patients often don't have access to the same resources and referral networks that can best inform them about their end of life options.

Over 850 individuals indicated their support for the bill. Several doctors described agonizing experiences in which patients were unable to complete the process to obtain aid-in-dying medication, leading to unnecessary suffering. One doctor recounts witnessing such patients who "died tragically, unable to ingest anything, in intractable vomiting and pain—a horrific death and nightmare to the family as well." Others write to express their gratitude for the fact that a loved one was able to end their suffering on their own terms. The Director of Hospice of Santa Cruz writes, "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."

7. Opposition

Several organizations oppose the bill for various reasons. Many concerns expressed in their letters are more germane to the prior version of the bill. Other concerns reflect on the Act itself, independent of the bill's changes. The Committee additionally received comments in opposition that are directly relevant to the current version of the bill.

Several faith-based organizations write in opposition based on a number of concerns primarily centered on the possibility that conscientious objectors are being forced to be complicit in carrying out acts they view as immoral. Alliance of Catholic Health Care argues that the bill limits the protections for the health facilities that choose not to participate in the Act, making it so that non-participation is, in effect, no longer voluntary. California Family Council similarly states that the author "is attempting to

remove many of the purported ‘safeguards’ in the Act. They argue that “[t]he proposed changes to this bill will only result in more people being manipulated into ending their lives when they could be offered better, live-affirming options.” The Church of Jesus Christ of Latter-day Saints writes that euthanasia, which they distinguish from removing artificial means of life support, “is a violation of the commandments of God.” They add: “We are particularly concerned, therefore, about the portions of the bill that shorten the time frame, that delete second-thought safeguards currently in the law, and that increase the potential liability to our church members who are health professionals and who wish to exercise a religious exemption to participating in an assisted suicide.”

The American College of Pediatricians argues that “SB 380 fails the terminally ill, undercuts the palliative care they need, corrupts medical ethics, neglects mental health, threatens the disabled and elderly, and worsens suicide rates.” The California Hospitals Association argues the bill “substantially limits a health care facility’s ability – whether due to conscience, moral, ethical, or practical objections to physician-assisted death – to have a policy prohibiting participation in the Act” and “removes current protections for health care facilities against liability or adverse action for refusing to participate in the Act.” They indicate they have been working closely and productively with the author’s office. Amendments described above should address the latter concern.

The Pacific Justice Institute argues that the bill “would remove existing safeguards and leave already vulnerable Californians more susceptible to undue influence during critical, life-and-death decisions.” The Capitol Resources Institute argues that “this bill seeks to eliminate the measures originally implemented to ensure physicians aren’t abusing patients and that patients are thinking carefully through their decision. The waiting period has been a crucial part of this decision, as many patients changed their minds during that period of time. If even one patient changes their mind in the waiting period described by current law, the waiting period has already proven to be a key component of the law.”

The League of United Latin American Citizens opposes the bill because they believe that medical aid-in-dying is unscrupulously deployed in a way that disproportionately harms the Latino community. They write 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. We firmly believe that AS 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.”¹³

¹³ The sponsors argue that there is no evidence to support these claims. They write:

Evidence and data demonstrates that the implementation of medical aid in dying contributes to improvements and access to other end-of-life care services. For example, a survey of physicians

SUPPORT

Compassion & Choices Action Network (sponsor)
Access TLC Hospice
American Nurses Association California
Americans United for Separation of Church & State, Orange County Chapter
Atheists United Los Angeles
Bloom in the Desert Ministries, United Church of Christ
Brownie Mary Democratic Club of San Francisco
California Council for the Advancement of Pharmacy
Compassion & Choices Latino Council
Democratic Women's Club of Santa Cruz
Dolores Huerta Foundation
End of Life Choices California
Good Grief Doula
Hemlock Society of San Diego
Hospice of Santa Cruz County
Humanist Association of Orange County
Integrated MD Care
Laguna Woods Democratic Club
Libertarian Party of California
Long Beach Gray Panthers
Mera Consulting
Monterey County Palliative Care Collaborative
Older Women's League San Francisco
Pilgrim United Church of Christ
Sonoma County Democratic Party
Southern California Secular Coalition
TheBrittanyFund.org
Voyages
Women For: Orange County
Over 850 individuals

following authorization of the Oregon Death With Dignity Act showed 30% of responding physicians had increased the number of referrals they provided for hospice care, and 76% made efforts to improve their knowledge of pain management.⁸ In addition, a 2015 Journal of Palliative Medicine study found that Oregon's medical aid-in-dying law may have contributed to more open conversations between doctors and patients about end-of-life care options, which led to the more appropriate hospice use and better palliative care training.

In fact, if anything, the additional regulatory roadblocks in this law could be having a disproportionate impact on Latinos and other underserved communities' ability to access the law. Only four percent of Californians who utilized the law were Hispanic, despite the fact that Hispanics represent more than 39 percent of the state's population. The amended bill is designed to help reduce these disparities in access so that all populations have equitable access to medical aid in dying.

OPPOSITION

Alliance of Catholic Health Care
American Academy of Medical Ethics
American College of Pediatricians
California Catholic Conference
California Family Council
California Foundation for Independent Living Centers
California Hospital Association
California League of United Latin American Citizens
California ProLife Council and Right to Life Federation
Capitol Resource Institute
Communities Actively Living Independent & Free
Disability Rights Education & Defense Fund
Fieldstead and Company
Pacific Justice Institute – Center for Public Policy
Patients Rights Action Fund
The Church of Jesus Christ of Latter-day Saints
The Salvador E. Alvarez Institute for Non-Violence
1 individual

RELATED LEGISLATION

Pending Legislation: SB 642 (Kamlager, 2021) would enact the Patient Medical Care Protection Act, which, among other things, aims to prevent undue interference in the practice of medicine due to improper motives, including discrimination, profit or cost control, business or competition, or any other nonmedical motives. SB 642 bill will be heard in the Senate Judiciary Committee on the same day as this one.

Prior Legislation: *See Comment 2.*

SB 128 (Wolk & Monning, 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.

PRIOR VOTES:

Senate Health Committee (Ayes 8, Noes 1)