

Date of Hearing: June 22, 2021

ASSEMBLY COMMITTEE ON HEALTH  
Jim Wood, Chair  
SB 380 (Eggman) – As Amended June 14, 2021

**SENATE VOTE:** 26-8

**SUBJECT:** End of life

**SUMMARY:** Deletes the January 1, 2026 sunset date on the End of Life Option Act (EOLA). Allows an individual to qualify for aid-in-dying medication by making two oral requests a minimum of 48 hours apart, rather than 15 days apart; requires that the date of all oral and written requests be documented in an individual's medical record and upon a transfer of care that record to be provided to the qualified individual; and, 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. Specifically, **this bill:**

- 1) Requires an individual seeking to obtain a prescription for an aid-in-dying drug to submit two oral requests, a minimum of 48 hours apart, and a written request to their attending physician. Requires an attending physician to receive a request and to ensure that 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 or an attending physician who chose not to participate.
- 2) Requires a physician, upon request, to transfer all relevant medical records including written documentation of the dates of an 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.
- 3) Deletes the requirement that a physician provide a qualified individual with a final attestation form and provide instructions that the form be filled out and executed by the individual within 48 hours prior to the individual choosing to self-administer the aid-in-dying drug.
- 4) Makes participation under EOLA voluntary, but does not limit the application of or excuse noncompliance with 5), 6), 7), and 9) below.
- 5) Requires a health care provider who objects for reasons of conscience, morality, or ethics to participating in EOLA, to, at a minimum, inform the individual that they do not participate in EOLA, 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.
- 6) Requires, if a health care provider is unable or unwilling to carry out a qualified individual's request and the individual transfers care to a new health care provider or health care facility, the individual's relevant medical record to be provided to the individual, and upon request, timely transferred with documentation of the date of the individual's request for a prescription for aid-in-dying drug in the medical record.

- 7) Prohibits a health care provider or a health care entity 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.
- 8) Authorizes a health care entity, as defined, to prohibit its employees, independent contractors, including health care providers, from prescribing aid-in-dying medication to a qualified individual who intends to self-administer the medication while on premises owned or under the management or direct control of that entity or while acting within the course and scope of any employment by, or contract with the entity.
- 9) Requires a health care facility to give notice of the prohibition pursuant to 7) above upon employment or other affiliation and annually thereafter. States that an entity that fails to provide notice is not entitled to enforce a prohibition policy. Makes posting the policy on the entity's public internet website sufficient for the annual notice requirement.

#### **EXISTING LAW:**

- 1) Enacts EOLA allowing an adult, qualified individual, diagnosed with a terminal disease, and with the capacity to make medical decisions, to receive a prescription for an aid-in-dying drug to end their life in a humane and dignified manner. Defines a qualified individual as an adult who has the capacity to make medical decisions, is a resident of California, and has satisfied all of the requirements of these provisions in order to obtain a prescription for a drug to end their life.
- 2) Defines various other terms for purposes of these provisions, including defining an adult as an individual 18 years of age or older, an aid-in-dying drug as a drug determined and prescribed by a physician for a qualified individual, and an attending physician as the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease. Defines terminal disease as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.
- 3) Requires an individual requesting an aid-in-dying drug to have done so voluntarily.
- 4) Allows a request for a prescription for an aid-in-dying drug to be made only by the individual diagnosed with the terminal disease, not by others on behalf of the individual, including prohibiting requests through a power of attorney, an advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decision maker.
- 5) Specifies that a person will not be qualified to obtain an aid-in-dying drug solely because of age or disability.
- 6) Requires an individual requesting a prescription for an aid-in-dying drug to submit two oral requests, a minimum of 15 days apart, and a written request, and for the attending physician to personally receive all three requests. Requires written requests to be signed and dated by the individual in the presence of two witnesses who must attest to the best of their knowledge and belief that the individual is personally known to them or has provided proof of identity, is of sound mind, and not under duress, fraud, or undue influence.

- 7) Prohibits the attending physician, consulting physician, or the mental health specialist of the requesting individual from being a witness on the written request. Allows only one of the witnesses to be related to the individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual's estate upon death, and only one of the witnesses to own, operate, or be employed at a health care facility where the individual is receiving medical treatment or resides.
- 8) Allows an individual at any time, to withdraw or rescind their request for an aid-in-dying drug, or decide not to ingest an aid-in-dying drug, without regard to their mental state.
- 9) Prohibits an attending physician from writing a prescription for an aid-in-dying drug without first personally offering the individual an opportunity to withdraw or rescind the request, and, requires the attending physician before prescribing to do all of the following:
  - a) Make an initial determination whether the requesting adult has the capacity to make medical decisions, and if there are indications of a mental disorder, to refer the individual for a mental health specialist assessment. If a mental health assessment referral is made, no aid-in-dying drugs will be prescribed until the mental health specialist determines that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder;
  - b) Determine whether the requesting adult has a terminal disease;
  - c) Determine whether the requesting adult has voluntarily made the request for an aid-in-dying drug and is a qualified individual;
  - d) Confirm that the individual is making an informed decision by discussing all of the following with them:
    - i) Their medical diagnosis and prognosis;
    - ii) The potential risks associated with ingesting the requested aid-in-dying drug;
    - iii) The possibility that they may choose to obtain the aid-in-dying drug but not take it; and,
    - iv) Feasible alternatives or additional treatment options including, but not limited to, comfort care, hospice care, palliative care, and pain control.
  - e) 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;
  - f) Confirm that the individual's request does not arise from coercion or undue influence by another person by privately discussing, unless an interpreter is needed, whether or not the individual is feeling coerced or unduly influenced by another person;
  - g) Counsel the individual about the importance of all of the following:
    - i) Having another person present when they ingest the aid-in-dying drug;

- ii) Not ingesting the aid-in-dying drug in a public place;
  - iii) Notifying the next of kin of their request for an aid-in-dying drug. An individual's inability or refusal to notify their next of kin does not constitute a reason to deny their request for an aid-in-dying drug;
  - iv) Participating in a hospice program; and,
  - v) Maintaining the aid-in-dying drug in a safe and secure location until they will ingest it.
  - h) Inform the individual that they may withdraw or rescind the request for an aid-in-dying drug at any time and in any manner, and offer the individual an opportunity to withdraw or rescind the request for an aid-in dying drug before prescribing the aid-in-dying drug;
  - i) Verify, immediately prior to writing the prescription for the aid-in-dying drug, that the individual is making an informed decision;
  - j) Confirm that all the requirements for requesting an aid-in-dying drug have been met;
  - k) Fulfill all medical record documentation requirements, including completing the EOLA Checklist and Compliance Form and placing it in the individual's medical record; and,
  - l) Provide the individual with a final attestation form and instruct them to fill it out and sign it 48 hours prior to ingesting the aid-in-dying drug. The form attests, among other things, that the individual has been fully informed of their diagnosis and prognosis, counseled regarding feasible alternatives, including hospice and palliative care, and that the individual understands they may choose not to ingest the drug and is under no obligation to ingest the drug. Requires the form to be delivered by the individual's health care provider, family member, or other representative to the attending physician to be included in the patient's medical record.
- 10) Once all of the requirements have been met, allows the attending physician to deliver the aid-in-dying drug in any of the following ways:
- a) Dispensing the aid-in-dying drug directly, including ancillary medication intended to minimize the qualified individual's discomfort, if the attending physician is authorized to dispense medicine under California law, has a current United States Drug Enforcement Administration certificate, and complies with any applicable administrative rule or regulation;
  - b) With the individual's written consent, contacting a pharmacist to inform them of the prescriptions, and delivering the written prescriptions personally, by mail, or electronically to the pharmacist, who may dispense the drug to the individual, the attending physician, or a person expressly designated by the individual and with the designation delivered to the pharmacist in writing or verbally; and,
  - c) Delivery of the dispensed drug to the qualified individual, the attending physician, or a person expressly designated by the individual may be made by personal delivery, or, with

a signature required on delivery, by the United Parcel Service, United States Postal Service, Federal Express, or by messenger service.

- 11) Prior to the individual obtaining an aid-in-dying prescription from the attending physician, requires the consulting physician to:
  - a) Examine the individual and their medical records;
  - b) Confirm in writing the attending physician's diagnosis and prognosis;
  - c) Determine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision;
  - d) Refer the individual for a mental health specialist assessment, if there are indications of a mental disorder; and,
  - e) Document all of the above in the individual's medical record.
- 12) Requires, if the attending or consulting physician refers the individual to a mental health specialist, the mental health specialist to:
  - a) Examine the qualified individual and their medical records;
  - b) Determine that the individual has the mental capacity to make medical decisions, act voluntarily, and make an informed decision;
  - c) Determine that the individual is not suffering from impaired judgment due to a mental disorder; and,
  - d) Document all of the above in the individual's medical record.
- 13) Requires all of the following to be documented in the individual's medical record:
  - a) All oral requests for aid-in-dying drugs;
  - b) All written requests for aid-in-dying drugs;
  - c) Both the attending physician's and consulting physician's diagnosis and prognosis, and the determination that a qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the attending or consulting physician has determined that the individual is not a qualified individual;
  - d) A report on the outcome and determinations made during a mental health specialist's assessment, if performed;
  - e) The attending physician's offer to the qualified individual to withdraw or rescind his or her request at the time of the individual's second oral request; and,
  - f) A note by the attending physician indicating that all requirements have been met and indicating the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed.

- 14) Requires the attending physician, within 30 calendar days of writing a prescription for an aid-in-dying drug, to submit a copy of the patient's written request, the attending physician compliance form, and the consulting physician compliance form to the Department of Public Health (DPH).
- 15) Requires the attending physician, within 30 calendar days following the qualified individual's death from ingesting the aid-in-dying drug, or any other cause, to submit the attending physician follow-up form to DPH.
- 16) Outlines the requirements of the witnessed form an individual must submit to request an aid-in-dying drug. Requires the language of the request to be written in the same translated language as any conversations, consultations, or interpreted conversations between a patient and his or her attending or consulting physicians. Prohibits an interpreter from being related to the individual requesting the aid-in-dying drug and requires interpreters to meet certain professional association standards.
- 17) Makes a provision in a contract, will, or other agreement executed on or after January 1, 2016, whether written or oral, to the extent the provision would affect whether a person may make, withdraw, or rescind a request for an aid-in-dying drug, invalid.
- 18) Prohibits the sale, procurement, or issuance of a life, health, or accident insurance or annuity policy; health care service plan contract; or, health benefit plan, or the rate charged for a policy or plan contract from being conditioned upon or affected by a person making, withdrawing, or rescinding a request for an aid-in-dying drug. Provides that an obligation owing under any contract executed on or after January 1, 2016, may not be conditioned or affected by a qualified individual making, withdrawing, or rescinding a request for an aid-in-dying drug.
- 19) Provides that death resulting from the self-administration of an aid-in-dying drug is not suicide, and health and insurance coverage will not be exempted on that basis.
- 20) Provides that a qualified individual's act of self-administering an aid-in-dying drug has no effect upon a life, health, or accident insurance or annuity policy other than that of a natural death from the underlying disease.
- 21) Prohibits an insurance carrier from providing any information in communications to an individual about the availability of an aid-in-dying drug unless requested by the individual or their attending physician at the behest of the individual. Clarifies that any communication must not include both a denial of treatment and information about the availability of aid-in-dying drug coverage.
- 22) Provides that a person will not be subject to civil or criminal liability solely because the person was present when the qualified individual self-administered the prescribed aid-in-dying drug, and that a person may, without civil or criminal liability assist the qualified individual by preparing the aid-in-dying drug, but not assist the individual in ingesting the aid-in-dying drug.
- 23) 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 these provisions, or for refusing to participate.

- 24) Prohibits a health care provider from being be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for participating in these provisions.
- 25) Specifies that the immunities and prohibitions on sanction of a health care provider are solely reserved for actions of a health care provider, and clarifies a health care provider may be sanctioned by their licensing board or agency for conduct and actions constituting unprofessional conduct, including failure to comply in good faith with EOLA.
- 26) Specifies that a request by a qualified individual to an attending physician to provide an aid-in-dying drug in good faith compliance does not constitute the sole basis for the appointment of a guardian or conservator, and actions taken in compliance with EOLA do not provide the basis for a claim of neglect or elder abuse.
- 27) Provides that participation in activities authorized by EOLA must be voluntary, and further clarifies that an individual is not subject to any type of sanction for refusing to inform a patient regarding his or her rights under these provisions and not referring an individual to a physician who does participate in activities authorized by EOLA.
- 28) Allows a health care provider, with advance notice, to prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in EOLA while on premises owned or under the management or control of the prohibiting health care provider.
- 29) Allows, if a health care provider has given notice, and an individual or entity violates the prohibition to participate in EOLA, the prohibiting provider to take action against an individual or entity, including, but not limited to, loss of privileges or membership, suspension, loss of employment, or termination of any lease or other contract between the prohibiting health care provider and the individual or entity that violates the policy.
- 30) Specifies that nothing in EOLA prevents a health care provider from providing an individual with services that do not constitute participation in EOLA, that a health care provider may not be sanctioned for making a determination that an individual has a terminal disease and informing them of their medical prognosis, or for providing information about EOLA to a patient upon the request of the individual.
- 31) Makes it a felony knowingly altering or forging a request for an aid-in-dying drug to end an individual's life without their authorization, or concealing or destroying a withdrawal or rescission of a request, or administering an aid-in-dying drug to an individual without their knowledge or consent.
- 32) Prohibits the attending physician, consulting physician, or mental health specialist from being related to the qualified individual by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the individual's estate upon death.

- 33) Makes it a felony to coerce or exert undue influence on an individual to request or ingest an aid-in-dying drug.
- 34) Specifies that the EOLA does not authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia.
- 35) Specifies that EOLA cannot be construed to limit civil liability.
- 36) Requires DPH to collect and review the information submitted by the attending physician on the patient's written request, the attending physician's compliance form, and the consulting physician's compliance form; requires the information to be confidential and collected in a manner that protects the privacy of the patient, the patient's family, and any medical provider or pharmacist involved with the patient under these provisions.
- 37) Requires DPH, on or before July 1, 2017, and each year thereafter, based on the information collected on the attending physician follow-up form in the previous year, and DPH's access to vital statistics, to compile a report which includes, but is not limited to all of the following:
- a) The number of people for whom an aid-in-dying prescription was written;
  - b) The number of known individuals who died each year for whom aid-in-dying prescriptions were written, and the cause of death of those individuals;
  - c) For the period commencing January 1, 2016, to and including the previous year, cumulatively, the total number of aid-in-dying prescriptions written, the number of people who died due to use of aid-in-dying drugs, and the number of those people who died who were enrolled in hospice or other palliative care programs at the time of death;
  - d) The number of known deaths in California from using aid-in-dying drugs per 10,000 deaths in California;
  - e) The number of physicians who wrote prescriptions for aid-in-dying drugs;
  - f) Of the people who died due to using an aid-in-dying drug, demographic percentages organized by the following characteristics:
    - i) Age at death;
    - ii) Education level;
    - iii) Race;
    - iv) Sex;
    - v) Type of insurance, including whether or not they had insurance; and,
    - vi) Underlying illness.
- 38) Requires DPH to post the report on its Internet website.



- 39) Requires DPH to make the following forms available on its internet web site: the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician follow-up form.
- 40) Specifies that these provisions remain in effect only until January 1, 2026, and as of that date are repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date.

**FISCAL EFFECT:** According to the Senate Appropriations Committee, DPH reports the need for one new permanent position and a one-time IT cost for a total initial cost of \$139,216 General Fund and \$133,000 annually thereafter.

**COMMENTS:**

- 1) **PURPOSE OF THIS BILL.** According to the author, the 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. The author states that 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 COVID19 pandemic. The author states that 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. The author concludes that 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) **BACKGROUND.** On October 5, 2015, California became the fifth state in the nation to authorize medical aid-in-dying. AB X2 15 (Eggman), Chapter 1, Statutes of 2015-16 Second Extraordinary Session, EOLA, permits terminally ill adult patients with capacity to make medical decisions to be prescribed an aid-in-dying medication to peacefully end their suffering, if certain conditions are met. EOLA became effective on June 9, 2016 and will sunset January 1, 2026.

EOLA was modeled after Oregon's first-in-the nation statute and modified to meet the unique needs of California and its residents. To date, eight other jurisdictions have authorized medical aid-in-dying statutes: Washington, Vermont, Colorado, the District of Columbia, Hawaii, New Jersey, Maine, and Montana.

- a) **DPH EOLA report.** EOLA requires physicians to submit specified forms and information to DPH, and DPH to compile an annual report. The most recent EOLA data report for 2019, was published in July of 2020. This report presents data as reported to

DPH 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 cumulative counts for the period commencing January 1, 2016. The information collected has been aggregated to protect the privacy of the individuals.

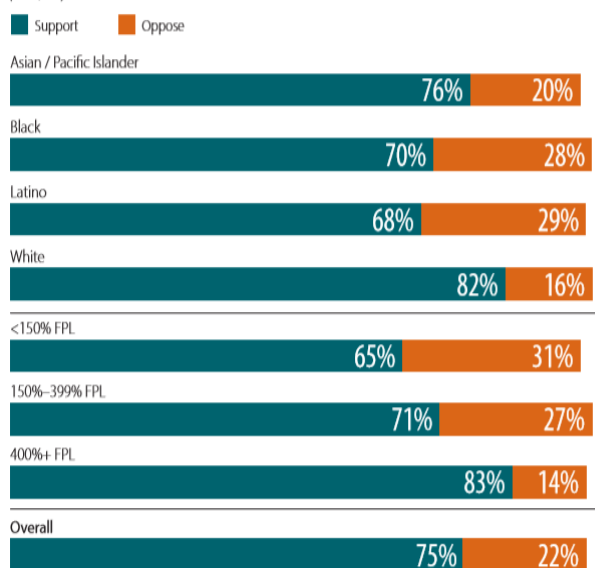
For the year ending December 31, 2019, 618 individuals received prescriptions under EOLA. In 2019, 405 individuals died following their ingestion of the prescribed aid-in-dying drug(s), which includes 27 individuals who received prescriptions prior to 2019. Of the 405 individuals, 88.6% were 60 years of age or older, 89.9% had health insurance and 85.4% were receiving hospice and/or palliative care, 11.4% were under 60 years of age, and 14.1% were 90 years of age and older. The median age was 76 years. The decedents were 87.2% white, and 55.3% were male. In addition, 84.0% informed their family of their decision to participate in EOLA.

Since the law came into effect June 9, 2016 through December 31, 2019, prescriptions have been written for a total of 1,985 people and 1,283 individuals, or 64.6%, have died from ingesting the medications. Of the 1,283 individuals who have died under EOLA, 1,112, or 86.7%, were receiving hospice and/or palliative care.

**b) California Health Care Foundation Report (CHCF).** According to a 2019 CHCF Report, “Help Wanted: Californians’ Views and Experiences of Serious Illness and End-of-Life Care,” three in four Californians surveyed support the EOLA.

### Views of the End of Life Option Act, by Race/Ethnicity and Income Level, California, 2019

In June 2016, the End of Life Option Act became law in California. This state law gives some terminally ill adults the option to take life-ending medication prescribed by a doctor. Do you support or oppose people having this option? Base: all respondents (n = 2,588)



Notes: In 2019, the federal poverty level (FPL) was \$12,490 for a single person and \$25,750 for a household of four. Nonresponders not shown. Segments may not total 100% due to nonresponse rounding.

Source: *Californians’ Attitudes Toward and Experiences with Serious Illness and End-of-Life Care*, statewide survey of 2,588 adult Californians, PerryUndem, 2019.

In February of 2012 CHCF published a survey, “Final Chapter: Californians’ Attitudes and Experiences with Death and Dying.” The survey found that most Californians would prefer a natural death if they became severely ill, rather than have all possible care provided; that they want to die at home rather than in a hospital or nursing home, and want to talk with their doctor about their wishes for end-of-life care. However, what individuals want isn’t what happens in practice, as the survey numbers illustrate:

- i) Seventy percent of Californians would prefer to die at home; however of deaths in 2009, 32% occurred at home, 42% in a hospital, and 18% in a nursing home;
  - ii) Almost 80% say they definitely or probably would like to talk with a doctor about end of life wishes, but only 7% have had a doctor speak with them about it; and,
  - iii) The survey also found that what matters most at the end of life varies by race and ethnicity, for example, Latinos rate living as long as possible more highly than do other groups. African Americans and Latinos are much more likely to place importance on being at peace spiritually. Asians and white/non-Latinos place the least importance on living as long as possible. Sixty percent of all respondents say it is extremely important that their family not be burdened by decisions regarding their care.
- c) **Barriers to accessing EOLA.** As noted above, EOLA was modeled on the original Oregon statute. In 2019, Oregon updated their law because too many people were dying during the waiting period. Oregon authorized a waiver of the waiting period when the attending physician has medically determined that the qualified individual will, within reasonable medical judgement, die within 15 days after making the initial verbal request for aid-in-dying medication. Recent data shows that a significant number of patients (20%), who otherwise would have died during the waiting period, were able to access their medical aid in dying law after that change. Recently, New Mexico passed End of Life legislation that included a 48 hour period, which this bill codifies.

A study by Kaiser Permanente Southern California published in the *Journal of American Medicine (JAM)*, “Characterizing Kaiser Permanente Southern California’s Experience With the California End of Life Option Act in the First Year of Implementation,” shows that one-third of terminally ill adults who requested to use EOLA died before completing the process which includes a 15-day waiting period and often takes weeks or months to finish.

Additionally, another *JAM* report from 2019, “Hospital Responses to the End of Life Option Act: Implementation of Aid in Dying in California,” as of approximately 18 months after implementation of the EOLA, most hospitals in California had an ELOA policy, the majority of which prohibited physicians, from participating while under the organization’s purview. Of the 315 hospitals surveyed, the report’s authors obtained responses for 270 (86%). Nonresponding hospitals were more likely to be rural and for-profit, and less likely to be part of a hospital system. The responding 270 hospitals were covered by 89 unique policies. Fifty-three EOLA policies (among 229 hospitals) applied to all health system inpatient and outpatient facilities. In contrast, 36 policies applied to 41 hospitals, but offered no guidance for outpatient locations.

Of the 270 hospitals, 235 (87%) had a formal policy for the EOLA. Overall, 106 (39%) hospitals permitted physicians to write ELOA prescriptions: 97 had a formal EOLA policy and nine did not. These hospitals accounted for 42% (1,289,236) of hospital discharges in 2016. Of the 164 (61%) hospitals forbidding physicians to write prescriptions under the EOLA, 138 hospitals had formal policies explicitly prohibiting EOLA prescribing, and an additional 26 hospitals had no written policy. Hospitals opting out of the EOLA accounted for 48% (1,501,452) of hospital discharges. The report also noted that hospitals and health systems that allowed the EOLA were more likely to offer palliative and bereavement services than those hospitals prohibiting aid in dying. This suggests that where the ELOA is permitted, it is not as a replacement for, but a complement to, existing end-of-life services.

According to information provided by the author and sponsors, another barrier to access is that certain healthcare facilities under the existing provisions of the EOLA, can forgo participation in medical aid in dying and have no obligation to tell their patients about their policy. This bill maintains that no health care provider who objects for reasons of conscience, morality or ethics is required to participate in EOLA. However, the bill clarifies that if a health care provider is unable or unwilling to carry out an individual's request for a prescription for medical aid-in-dying medication, at a minimum, a health care provider must inform the individuals that they do not participate in EOLA, document the patient's date of request and provider's notice to the patient of their objection in the medical record and transfer their medical record upon request.

- 3) **SUPPORT.** The Compassion and Choices Action Network (CCAN) is the sponsor of this bill and states that since EOLA went into effect in 2016, data collected by DPH shows that the law works as intended for those who can access it. Keeping in line with more than 60 combined years of data from all of the states that have similar medical aid in dying laws, there has not been a single incident of coercion or abuse. The law has directly benefited those who have used the law and indirectly benefited all terminally ill residents. Evidence clearly suggests that the passage of medical aid in dying has resulted in: improved conversations between physicians and patients; better palliative care training; and improved enrollment in hospice care. CCAN notes that 75% of Californians and the majority of every demographic and county in California approve of EOLA, and for all of these reasons, it is essential that the sunset provision is removed and the California End of Life Option Act becomes permanent. CCAN also points to a study by Kaiser Southern California found that a third of eligible patients die unable to make it through the waiting period. Oregon amended their law to allow the prescribing physician the ability to waive the 15 day waiting period if, within the physician's best judgement, the terminally ill patient is unlikely to survive it. Oregon's data show that a significant number of patients (20%), who otherwise would have died during the waiting period, were able to access their medical aid in dying law thanks to that amendment. CCAN concludes that this bill similarly seeks to address the burden of the waiting period by shortening it to 48 hours, a provision that the New Mexico legislature just approved in March with their newly enacted medical aid in dying law.

The American Nurses Association/California (ANA/C) states that since the enactment of EOLA, nearly 2,000 mentally capable, terminally ill Californians with life expectancy of less than six months exercised their legally available option to receive a prescription for medical aid-in-dying to peacefully end their suffering. ANAC/C notes that the COVID19 pandemic exposed massive health disparities and barriers to care for people in underrepresented or

lower socio-economic communities. These hurdles make it quite difficult for dying people to use EOLA, especially if they do not have access to resources or referral networks that would help them access information relevant to their end of life options.

- 4) **OPPOSITION.** Disability Rights California (DRC) is opposed to this bill and states that it removes critical protections for consumers and as a result great risks remain for people with disabilities:

**15 day “cooling off” period removed:** A Lancet study found that “a patient’s will to live can fluctuate 30% in a 12-hour period and between 60-70% over 30 days.” Many people requesting assisted suicide have changed their minds—some living decades beyond their prognosis, having achieved a cure for the supposedly “terminal” illness.

**Final attestation requirement removed,** wherein the patient affirms that they are voluntarily taking the lethal drugs at the time of ingestion. This removal puts patient autonomy at risk, opening the door to abuse by greedy heirs or abusive caregivers. No reporting, no 3rd party witnesses at time of death make it so no one would ever know if the person changed their mind or if there was coercion.

DRC states that assisted suicide is not about choice when people with disabilities lack access to sufficient medical care. The COVID-19 Pandemic revealed long standing disparities in our health care delivery system as we witnessed disproportionate rates of infection and mortality in our aging and disability community as well as our Black and Latino communities. Now more than ever we should be focused on addressing inequities in our health care delivery system, not expanding access to assisted suicide. Finally, in California, patients’ reasons for resorting to assisted suicide are not reported to the public. It is premature and dangerous to make EOLA permanent in the absence of data that would help us better understand the impact of assisted suicide on Californians. DRC concludes that a bad day should not result in a death sentence.

The California Catholic Conference (CCC) is opposed to this bill and states that the prime reason for individuals in a terminal state to choose to take their own lives is a fear of becoming a financial or emotional burden to their families. The legislature passed EOLA during a special summer session of the legislature convened to deal only with a shortfall in Medi-Cal funding. The legislature then chose to fund the cost of those life ending drugs in Medi-Cal. How does this “benefit” funded by Medi-Cal address the concern of those who are terminal, struggling, low-income and on Medi-Cal and feel they are a burden? Due to our California COVID-19 experience we have all come to understand the stark reality of health care inequity in the Black and Latino communities. CCC states that the debate on this bill can be viewed as subtly encouraging terminally ill Medi-Cal patients to more easily choose the less expensive option of assisted suicide when faced with the reality that equitable quality care, especially hospice and palliative care, is not always available to them.

## 5) PREVIOUS LEGISLATION.

- a) AB X2 15 enacts EOLA allowing an adult diagnosed with a terminal disease, and with the capacity to make medical decisions, to receive a prescription for an aid-in-dying drug to end his or her life in a humane and dignified manner.

- b) SB 128 (Wolk and Monning) was substantially similar to AB X2 15. SB 128 was not heard in the Assembly Health Committee.
  - c) 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.
  - d) SB 1004 (Ed Hernandez), Chapter 574, Statutes of 2014, requires the Department of Health Care Services (DHCS) to assist Medi-Cal managed care plans in delivering palliative care services, and requires DHCS to consult with stakeholders and directs DHCS to ensure the delivery of palliative care services in a manner that is cost-neutral to the General Fund, to the extent practicable.
  - e) 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.
  - f) AB 3000 (Wolk), Chapter 266, Statutes of 2008, creates the Physician Orders for Life Saving Treatment (POLST) in California, which is a standardized form to reflect a broader vision of resuscitative or life-sustaining requests and to encourage the use of POLST orders to better handle resuscitative or life sustaining treatment consistent with a patient's wishes.
  - g) AB 374 (Berg) of 2007 would have enacted the California Compassionate Choices Act, which would have authorized competent adults who have been determined by two physicians to be suffering from a terminal disease to make a request for medication to hasten the end of their lives in a humane manner. AB 374 was moved to the inactive file on the Assembly Floor without a vote recorded.
  - h) AB 651 (Berg), of 2006, would have established a procedure for a competent adult person who is terminally ill and expected to die within six months to obtain from his or her physician a prescription for medication that he or she may self-administer in order to end his or her life. AB 651 failed passage in the Senate Judiciary Committee.
  - i) AB 654 (Berg), of 2005, would have enacted the California Compassionate Choices Act, which would authorize competent adults who have been determined by two physicians to be suffering from a terminal disease to make a request for medication to hasten the end of their lives in a humane and dignified manner. AB 654 was moved to the inactive file on the Assembly Floor without a vote recorded.
- 6) **DOUBLE REFERRAL.** This bill is double referred; upon passage in this Committee, this bill will be referred to the Assembly Judiciary Committee.

**REGISTERED SUPPORT / OPPOSITION:**

**Support**

Compassion & Choices Action Network (sponsor)  
 Access TLC Hospice  
 American Nurses Association/California  
 Americans United for Separation of Church and State Orange County  
 Atheists United Los Angeles  
 Be Present Care  
 Bloom in the Desert Ministries, United Church of Christ  
 Brownie Mary Democratic Club of San Francisco  
 California Council for the Advancement of Pharmacy  
 City of Santa Cruz  
 Compassion and Choices Latino Leadership Council  
 County of Santa Cruz Board of Supervisors  
 Democratic Women's Club of Santa Cruz County  
 Dolores Huerta Foundation  
 End of Life Choices, California  
 Full Circle of Living and Dying  
 Good Grief Doula  
 Hemlock Society of San Diego  
 Hospice of Santa Cruz  
 Humanist Association of Orange County  
 Integrated MD Care  
 Integrus Health Group  
 LA Patient Advocates  
 Laguna Woods Democratic Club  
 Libertarian Party of California  
 Long Beach Gray Panthers  
 Mera Consulting  
 Monterey County Palliative Care Collaborative  
 National Association of Social Workers, California Chapter  
 Older Women's League San Francisco  
 Pilgrim United Church of Christ  
 Riverside Temple Beth El  
 San Luis Obispo County Democratic Party  
 Sonoma County Democratic Party  
 Southern California Secular Coalition  
 The Brittany Fund  
 Voyages  
 Women For: Orange County  
 Women's International League for Peace and Freedom  
 1426 individuals

**Opposition**

City of San Jose Councilmember for District 3 Raul Peralez  
 Santa Clara County Supervisor Susan Ellenberg, District 4

Alliance of Catholic Health Care  
California Catholic Conference  
California Family Council  
California Foundation for Independent Living Centers  
California Right to Life Committee, Inc.  
Capitol Resource Institute  
Disability Rights California  
Euthanasia Prevention Coalition USA  
Fieldstead and Company, Inc.  
Green Party of Santa Clara County CA  
League of United Latin American Citizens (LULAC)  
Pacific Justice Institute  
Patients Rights Action Fund  
The Church of Jesus Christ of Latter-Day Saints  
The Salvador E. Alvarez Institute for Non-Violence  
Six individuals

**Analysis Prepared by:** Lara Flynn / HEALTH / (916) 319-2097