

Date of Hearing: July 6, 2021

ASSEMBLY COMMITTEE ON JUDICIARY

Mark Stone, Chair

SB 380 (Eggman) – As Amended June 14, 2021

**SENATE VOTE:** 26-8

**SUBJECT:** END OF LIFE

**KEY ISSUE:** SHOULD PROCEDURAL BARRIERS RELATED TO A TERMINALLY ILL PATIENT'S RIGHT TO OBTAIN AN AID-IN DYING PRESCRIPTION FROM THEIR PHYSICIAN AS PROVIDED IN CALIFORNIA'S END OF LIFE OPTIONS ACT BE REDUCED BY, AMONG OTHER THINGS, SHORTENING THE WAITING PERIOD BETWEEN REQUESTS TO A PHYSICIAN FROM 15 DAYS TO 48 HOURS?

**SYNOPSIS**

*This bill is intended to reduce barriers related to a terminally ill patient's right to obtain an aid-in-dying prescription from their physician under the End of Life Option Act (Act), including by removing the requirement that a patient wait 15 days between requests for assistance, and delete the Act's sunset date. According to the author, sponsor, and supporters, in nearly five years of practice, the protections in the Act have proven successful in that no reported instances of abuse or coercion have been reported to the California Department of Public Health. The proponents argue, however, that some requirements of current law have created barriers to some eligible and interested patients who wished to utilize the Act, but were unable to do so before their deaths. The Act, enacted by ABX2 15 (Eggman, Chap. 1, Stats. 2016, 2nd Ex. Sess.), took effect on June 9, 2016. According to data collected by the California Department of Public Health, as of December 31, 2019, nearly 2,000 terminally ill individuals with six months or less to live have received a prescription pursuant to the Act. However, it also appears that many eligible patients appear to have been unable to access the law. A study by Kaiser Permanente Southern California shows that one-third of terminally ill adults who request to use the End of Life Option Act die before completing the time-consuming process set forth in current law, including a 15-day waiting period, which often takes weeks or even months to complete.*

*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. It is clear that states have the ability to legislate in this area as long as they do not abridge the constitutionally protected interests recognized by the U.S. Supreme Court. Notwithstanding the clear legal authority of a state to set parameters in this area of the law, the topic of a person choosing to hasten their death with prescribed medication is fraught with powerful emotional, moral, ethical, and religious issues. While the bill makes a number of changes to current law, the most controversial are as follows: (1) The reduction in waiting period from 15 days to 48 hours; (2) removal of final attestation requirement; and (3) removal of the sunset provision on the Act. The bill also has several provisions dealing with immunity from civil and criminal liability--the main reason why the Committee has jurisdiction over the bill, which are discussed in the analysis.*

*The bill is supported by a large number of religious, political, hospice and elder organizations. It is opposed by a large number of religious organizations, disability rights advocacy groups, political organizations, and right to life groups.*

**SUMMARY:** Reduces barriers related to a terminally ill patient's right to obtain an aid-in-dying prescription from their physician under the End of Life Option Act (Act) and deletes the Act's sunset date. Specifically, **this bill:**

- 1) Reduces the minimum timeframe between oral requests for an aid-in-dying prescription 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; and 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 entity" to include these terms. Distinguishes certain duties and obligations as they specifically apply to these entities.
- 5) Defines "Health care entity" to mean any clinic, health dispensary, or health facility licensed pursuant to Division 2, (commencing with Health & Safety Code Section 1200), including a general hospital, medical clinic, nursing home or hospice facility; clarifies that a health care entity does not include either a "health care provider," or a "public place."
- 6) Provides that a health care entity (as well as a health care provider, who is already covered by existing law) 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 the Act.
- 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 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 the Act. Prohibits a health care entity 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 entity 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 under certain circumstances (narrowing this provision from existing law, which authorizes the prohibition of participation in activities under the Act).
- 10) Requires that a health care entity must provide notice of the prohibition described in 9) upon employment or other affiliation and thereafter on an annual basis; clarifies that if the notice is not provided, the entity may not enforce the prohibition; and allows the public website posting described in 11) to satisfy the annual notice requirement.
- 11) Requires each health care entity to post on the entity's public website the entity's current policy governing medical aid-in-dying.
- 12) 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 entity.
- 13) Eliminates the Act's sunset date, thereby extending it indefinitely.

#### **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 & Safety Code Section 443 *et seq.* All further statutory references are to this code, unless otherwise specified.)
- 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. (Section 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. (Section 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. (Section 443.5 (a)(12).)

- 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. (Section 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. (Section 443.11 (a), (c).)
- 6) Immunizes entities that participate, or refuse to participate, in the Act in the following ways:

- 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. (Section 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 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. (Section 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. (Section 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.

**FISCAL EFFECT:** As currently in print this bill is keyed fiscal.

**COMMENTS:** This bill is intended to reduce barriers related to a terminally ill patient's right to obtain an aid-in-dying prescription from their physician under the End of Life Option Act (Act), including by removing the requirement that a patient wait 15 days between requests for assistance, and delete the Act's sunset date. According to the author, sponsor, and supporters, in nearly five years of practice, the protections in the Act have proven successful in that no reported instances of abuse or coercion have been reported to the California Department of Public Health. The proponents argue, however, that some requirements of current law have created barriers to some eligible and interested patients who wished to utilize the Act, but were unable to do so before their deaths.

According to the author:

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.

**Background.** The Act, enacted by ABX2 15 (Eggman, Chap. 1, Stats. 2016, 2nd Ex. Sess.), took effect on June 9, 2016. According to data collected by the California Department of Public Health, as of December 31, 2019, nearly 2,000 terminally ill individuals with six months or less to live have received a prescription pursuant to the Act. However, it also appears that many eligible patients appear to have been unable to access the law. A study by Kaiser Permanente Southern California shows that one-third of terminally ill adults who request to use the End of Life Option Act die before completing the time-consuming process set forth in current law, including a 15-day waiting period, which often takes weeks or even months to complete. Therefore, it can be estimated that nearly 1,000 individuals statewide have died before obtaining a prescription (approximately 275 people on an annual basis) between June of 2016 and the end of 2019.

California modeled the Act after Oregon's medical aid-in-dying law, which has been in effect for more than 20 years. In 2019, Oregon updated their law to take into account that many people were dying during the waiting period. Oregon authorized a waiver of the waiting period when the attending physician has determined that the qualified individual will, based upon reasonable medical judgement, die within 15 days of making an initial verbal request for aid-in-dying medication. Recent data from Oregon shows that a significant number of patients (20%), who otherwise would have died during the waiting period, were able to access the state's medical aid-in-dying law as a result of the 2019 revision. (Oregon Health Authority, "Oregon Death with Dignity Act, 2020 Data Summary" (Feb. 2021), available at <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf>.) Recently, New Mexico passed End of Life legislation that includes a 48-hour waiting period.

**Data Regarding California's Implementation of the Act.** According to the California Department of Public Health, which provides annual reports about the Act, since the law went into effect on June 9, 2016 and through December 31, 2019, prescriptions have been written for a total of 1,985 people under the Act and 1,283 individuals, or 64.6 percent of those who obtained a prescription for aid-in-dying medication died as a result of ingesting the medications. (CDPH, "California End of Life Option Act, 2019 Data Report (July 2020), p. 3, available at [https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPHEndofLifeOptionActReport2019%20\\_Final%20ADA.pdf](https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPHEndofLifeOptionActReport2019%20_Final%20ADA.pdf).) Of the 1,283 individuals who ingested the prescribed aid-in-dying medication and died, 1,112 (or 86.7 percent) were receiving hospice and/or palliative care. (*Ibid.*) Of the 405 individuals who died during 2019, 67.9 percent were identified as having malignant neoplasms (cancer); and neurological diseases such as

Amyotrophic Lateral Sclerosis and Parkinson's Disease accounted for the second largest underlying illness grouping, totaling 10.1 percent. (*Id.* at p. 5.) More than 88 percent were 60 years of age or older; 89.9 percent had health insurance; and 85.4 percent were receiving hospice and/or palliative care when they died. (*Id.* at p. 3.)

***The Right to Die – Constitutional Jurisprudence.*** 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 stopped. Further, the Court held that states can prevent family members from terminating treatment for another as the right belongs to the individual. (*Id.* at 281, 286.)

In two cases, *Washington v. Glucksberg* (1997) 521 U.S. 702 and *Vacco v. Quill* (1997) 521 U.S. 793, the U.S. 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. 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.)

It is clear that states have the ability to legislate in this area as long as they do not abridge the constitutionally protected interests recognized by the U.S. Supreme Court.

***The Bill's Three Most Controversial Provisions.*** Notwithstanding the clear legal authority of a state to set parameters in this area of the law, the topic of a person choosing to hasten their death with prescribed medication is fraught with powerful emotional, moral, ethical, and religious issues. While the bill makes a number of changes to current law, the most controversial are as follows: (1) The reduction in waiting period from 15 days to 48 hours; (2) removal of final

attestation requirement; and (3) removal of the sunset provision on the Act. The concerns of the opposition about these issues are discussed below.

***Immunity for Health Care Prescribers and Entities.*** The bill has several provisions dealing with immunity from civil and criminal liability--the main reason why the Committee has jurisdiction over the bill. First, while existing law provides that a health care provider 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 the Act*. This bill extends that same immunity to a health care entity.

Second, the bill extends the existing law, under which a health care provider shall not 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 the Act to a health care entity.

Finally, the bill clarifies that it does not limit the civil liability or damages for which a person, health care provider, or health care entity is responsible that arise from negligent conduct or intentional misconduct in carrying out actions otherwise authorized by the Act. This is consistent with other laws and also with the standard of care for health care providers and entities.

***ARGUMENTS IN SUPPORT:*** Compassion & Choices explains that existing law should be changed for several reasons:

- 1) greater transparency around the implementation of the California End of Life Option Act so that patients can make timely and informed decisions about their end-of-life care, while respecting the desire of providers to be able to opt out of participation;
- 2) the waiting period to be shortened so that it does not become an unnecessary suffering period; and
- 3) several small, but important changes to the law to improve access without compromising patient safety, such as clarifying the medical aid in dying may be self-administered in a healthcare facility.

Hospice of Santa Cruz County supports the bill because of the dignity and control that it provides to terminally ill patients: "While the number of patients choosing the EOLOA at Hospice of Santa Cruz County remains small, I have witnessed the comfort and relief that patients receive from having this option. It is affirming to witness the dignity that patients feel by gaining some control at a time when they often feel like their bodies are failing them. We have also seen how comforted family members can be by knowing that their loved one died on their own terms."

***ARGUMENTS IN OPPOSITION:*** Disability Rights California focuses on two issues in its letter of opposition. First, it objects to the removal of the 15-day waiting period to obtain a prescription on the basis that, "Many people requesting assisted suicide have changed their minds--some living decades beyond their prognosis, having achieved a cure for the supposedly "terminal" illness." Second, they object to the elimination of the final attestation, in which the patient affirms that they are voluntarily taking the lethal drugs at the time of ingestion. According to Disability Rights California, "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.” They also add that, “It is premature and dangerous to make the End of Life Act permanent in the absence of data that would help us better understand the impact of assisted suicide on Californians.”

Similarly, The Alliance of Catholic Health Care, which represents California’s Catholic-affiliated health systems and hospitals, writes that the significant changes to the law proposed by the bill are premature and unwise. “Less than five years after the implementation of the EOLOA, SB 380 would weaken or remove the very “safeguards” included to secure the support for the original measure.” The Alliance urges the Legislature to adopt more oversight of the state regulator, require more data to be collected and disclosed to the public. “And finally, the author and supporters assert that the current process is unnecessarily cumbersome and burdensome for underserved communities in rural areas and individuals from diverse communities. . . . Rather than provide easier access to the EOLOA, we would argue that access to the very services that would alleviate the need for this Act elude many communities of color.”

## **REGISTERED SUPPORT / OPPOSITION:**

### **Support**

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 Association for Nurse Practitioners  
 California Commission on Aging  
 California Council for The Advancement of Pharmacy  
 City of Santa Cruz  
 City of Watsonville  
 Compassion & Choices  
 Compassion & Choices Action Network  
 Compassion and Choices Latino Leadership Council  
 Democratic Party of Santa Cruz County  
 Democratic Women of Santa Barbara County  
 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  
 LA Patient Advocates  
 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  
San Luis Obispo County Democratic Party  
Sonoma County Democratic Party  
Southern California Secular Coalition  
Temple Beth El, Aptos, CA  
The Brittany Fund  
Voyages  
Women For: Orange County  
Women's International League of Peace and Freedom, East Bay

**Opposition**

Alliance of Catholic Health Care, INC.  
American Academy of Medical Ethics  
American College of Pediatricians  
California Catholic Conference  
California Family Council  
California Foundation for Independent Living Centers  
California League of United Latin American Citizens  
California Lulac  
California ProLife Council and Right to Life Federation  
California Right to Life Committee, INC.  
Capitol Resource Institute  
Communities Actively Living Independent & Free  
Disability Rights California  
Disability Rights Education & Defense Fund (DREDF)  
Fieldstead and Company, INC.  
Green Party of Santa Clara County CA  
League of United Latin American Citizens (LULAC)  
Office of Councilmember Raul Perez  
Pacific Justice Institute  
Patients Rights Action Fund  
Real Impact.  
Right to Life League of Southern California  
Santa Clara County Supervisor Susan Ellenberg, District 4  
The Church of Jesus Christ of Latter-day Saints  
The Salvador E. Alvarez Institute for Non-violence  
Washington Civil & Disability Advocate

**Analysis Prepared by:** Alison Merrilees / JUD. / (916) 319-2334