FACTSHEET 32: California End of Life Options Act

The California Senate Bill 128-End of Life Option Act 2015-2016 is an addition to the Health Safety Code signed in October 2015 and came into effect on June 9, 2016. Modelled on the Oregon legislation of 1994, the California legislation sets out conditions under which terminally ill adults who are California residents and who have been assessed as having less than six months to live, may request their attending physician to prescribe a life-ending drug. This drug must be self-administered, although the attending physician and others may be present without penalty. The full Bill may be accessed at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml? bill_id=2015

Provisions include that a patient must:

- be at least 18 years of age and a resident of California
- have a terminal disease, which cannot be cured or reversed and is expected to result in death within six months
- have the capacity to make medical decisions
- have no mental disorder which impairs their judgement, and
- the ability to take the drug themselves at a time they wish.

Requests for aid in dying cannot be made in advance care directives or by others on behalf of the patient, even with evidence that this is what the patient wanted.

The End of Life Options Act contains a checklist of procedures for health professionals to follow. A patient must

- request their attending physician to determine that he or she has a terminal disease, which cannot be cured or reversed and is expected to result in death within six months, and that the patient has the capacity to make medical decisions
- make two oral requests and one written request to the doctor for a prescription, and the two requests must be made at least 15 days apart.
- to ensure the request is voluntary, make the written request on a special form, witnessed by two people, and discussed by the patient and doctor alone (except where an interpreter is required),
- consult a second doctor who can confirm the patient's diagnosis, prognosis, and capacity to make medical decisions. If either doctor

thinks the patient may have a psychiatric disorder the patient must be referred to a specialist.
- demonstrate informed consent by discussing all of the following with the attending physician: the effects, efficacy and time course of the drug; realistic alternatives to taking the drug, such as palliative care or pain control; withdrawal of the request for the drug, and the freedom to decide against taking it once prescribed; the circumstances in which the patient will take the drug, eg who else will be present, and who will notify next of kin.
- sign a form immediately before taking the drug confirming it is being taken voluntarily.

Actively ending another person's life (euthanasia) remains illegal, but protections for the patient and physician include

- voluntary participation by doctors and institutions
- the attending doctor cannot be related to the patient or benfit from their estate
- witnesses to the patient's signature on the request form must testify that the patient signed voluntarily and had the capacity to sign. The doctor cannot be a witness, and at least one of the witnesses cannot be related to the patient or benefit from their estate, nor be an employee of the institution caring for the patient
- restrictions being placed on insurance and other financial institutions to prevent patients feeling financial pressure to end their lives
- the death certificate listing the underlying disease as the cause of death; not classfied as suicide.

The First Six Months

Data for the first six months of operation of the End of Life Options Act was released in July 2017. The data reveals

1. 111 terminally ill people used drugs prescribed under the provisions of the End of Life Options Act to end their life.
2. 250 people started the request process with 191 people receiving prescription, written by 173 different doctors
3. 65 people had cancer
4. 20 people had neuromuscular disorders
5. 12 people were non-white – 90% were white, 58% were tertiary educated seniors, 1% were uninsured
6. 45% were male

This data is similar to the data from two decades of operation of the Oregon Death with Dignity Act.