SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2025-2026 Regular Session

SB 403 (Blakespear)
Version: March 24, 2025
Hearing Date: April 29, 2025
Fiscal: Yes
Urgency: No
AWM

SUBJECT

End of Life Option Act: sunset

DIGEST

This bill repeals the January 1, 2031, sunset date for the End of Life Option Act (EOLOA), thereby making it permanent; the author also agreed to amend the bill to require the California Department of Public Health (CDPH) to meet with stakeholders about including additional information in its annual EOLOA report in time to include such information in its 2026 report.

EXECUTIVE SUMMARY

EOLOA has two primary goals: providing terminally ill adults the option to end their lives, while also providing sufficient safeguards to protect patients from coercion and ensure that everyone's participation—patients and physicians—is voluntary. To that end, EOLOA allows an individual who has complied with all of its requirements to obtain and to use an "aid-in-dying drug," which must be prescribed by a physician and self-administered by the terminally ill person. 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 48 hours 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.

EOLOA was enacted in 2015 with a ten-year sunset. (*See* ABx2-15 (Eggman, Ch. 1, Stats. 2015, 2nd Ex. Sess.).) The Legislature extended the sunset until January 1, 2031, and made other changes to the EOLOA process in 2021. (*See* SB 380 (Eggman, Ch. 542, Stats. 2021).) This bill eliminates the EOLOA sunset entirely. Additionally, the author committed to amend the bill in the Senate Health Committee to require the CDPH to meet with stakeholders no later than April 1, 2026, for the purpose of determining what

additional data should be included in the CDPH's annual EOLOA public report. These amendments will be crossed by this Committee.

This bill is sponsored by the Compassion & Choices and is supported by A Better Exit, AgeSong Marin, American Nurses Association California, Death With Dignity, End of Life Choices, Full Circle Living and Dying, Long Beach Gray Panthers, and 34 individuals. This bill is opposed by the Alliance of Catholic Health Care, the California Foundation for Independent Living Centers, the California League of United Latin American Citizens, La Luz Project, The Church of Jesus Christ of Latter-Day Saints, The Salvador E. Alvarez Institute for Non-Violence, and two individuals. The Senate Health Committee passed this bill with a vote of 9-2.

PROPOSED CHANGES TO THE LAW

Existing law:

1) Establishes EOLOA, which provides a procedure by which a person with a terminal illness may obtain and self-administer aid-in-dying drugs. (Health & Saf. Code, div. 1, pt. 1.85, §§ 443 et seq.)

2) Defines the following relevant terms:
    a) "Adult" is an individual 18 years of age or older.
    b) "Aid-in-dying drug" is 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.
    c) "Attending physician" is the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease.
    d) "Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers, consistent with the definition of "capacity" in section 4609 of the Probate Code.
    e) "Consulting physician" is a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's terminal disease.
    f) "Department" is the CDPH.
    g) "Health care provider" or "provider of health care" is any person licensed or certified pursuant to specified provisions of the Business and Professions Code and the Health and Safety Code.

h) "Informed decision" is a decision by an individual with a terminal disease to request and obtain a prescription for a drug that the individual may self-administer to end the individual's life, that is based on an understanding and acknowledgement of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:
   i. The individual's medical diagnosis and prognosis.
   ii. The potential risks associated with taking the drug to be prescribed.
   iii. The probable result of taking the drug to be prescribed.
   iv. The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it.
   v. The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

i) "Medically confirmed" means the medical diagnosis and prognosis of the attending physician has been confirmed by a consulting physician who has examined the individual and the individual's relevant medical records.

j) "Mental health specialist assessment" is one or more consultations between an individual and a mental health specialist for the purpose of determining that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

k) "Qualified individual" is an adult who has the capacity to make medical decisions, is a resident of California, and has satisfied the requirements set forth below in order to obtain a prescription for a drug to end their life.

l) "Self-administer" is a qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about their own death.

m) "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. (Health & Saf. Code, § 443.1.)

3) Permits an individual who is an adult with the capacity to make medical decisions and with a terminal disease to make a request to receive a prescription for an aid-in-dying drug if all of the following conditions are satisfied:
   a) The individual's attending physician has diagnosed the individual with a terminal disease.
   b) The individual has voluntarily expressed the wish to receive a prescription for an aid-in-dying drug.
   c) The individual is a resident of California and can establish residency through specified means.
   d) The individual documents their request pursuant to 5).
   e) The individual has the physical and mental ability to administer the aid-in-dying drug. (Health & Saf. Code, § 443.2(a).)

4) Provides that an individual shall not be a "qualified individual" solely because of age or disability, and that a request for a prescription for an aid-in-dying drug must be made by the individual diagnosed with the terminal disease themselves, not by anyone acting on their behalf (including through a power of attorney, an advance health care directive, a conservator, or any other legally recognized health care decisionmaker). (Health & Saf. Code, § 443.2(b), (c).)

5) Provides a procedure by which an individual seeking to obtain a prescription for an aid-in-dying drug may make the request, including making two oral requests, a minimum of 48 hours apart, and a written request, in a form prescribed by statute, witnessed by at least two other persons to their attending physician; the requests must be documented in the individual's medical record. The request may be withdrawn at any time, or the person may decline to ingest the aid-in-dying drug, without regard to their mental state. (Health & Saf. Code, §§ 443.3, 443.4, 443.11.)

6) Requires an attending physician, before prescribing an aid-in-dying drug, to take specified steps, including making an initial determination about the requester's capacity to make medical decisions (and referring them to a mental health specialist for an evaluation if necessary), confirming that the individual is making an informed decision and not the result of coercion or undue influence of another, and referring the individual to a consulting physician for medical confirmation of the diagnosis and prognosis.
    a) If the attending physician determines that all of the necessary conditions are satisfied, they may deliver the aid-in-dying drug in specified ways, including dispensing the drug directly.
    b) An attending physician, consulting physician, or mental health specialist may not 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. (Health & Saf. Code, §§ 443.5, 443.17(d).)

7) Requires specified information to be documented in an individual's medical record, including all oral and written requests for aid-in-dying drugs, the diagnoses and prognoses set forth by the attending and consulting physician, the determination as to the individual's capacity, and a note indicating that all of the requirements to carry out a request for aid-in-dying drug have been satisfied, including a notation of the aid-in-dying drug prescribed. (Health & Saf. Code, § 443.8.)

8) Requires the attending physician, immediately before writing a prescription for an aid-in-dying drug, to verify that the individual is making an informed decision. (Health & Saf. Code, § 443.10.)

9) Limits the civil or criminal liability of, and professional consequences for, persons involved in an individual's prescription for, and administration of, an aid-in-dying drug, as follows:

a) A person shall not be subject to civil or criminal liability solely because the person was present when the qualified individual self-administers the prescribed aid-in-dying drug.
b) A person who is present may, without civil or criminal liability, assist the qualified individual by preparing the aid-in-dying drug so long as the person does not assist the qualified person in ingesting the aid-in-dying drug.
c) A health care provider, health care entity, or professional organization or association shall not subject 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 EOLOA or for refusing to participate, as provided in 10).
d) A health care provider or a health care entity shall not be subject to civil, criminal, administrative, disciplinary, employment, professional discipline, contract liability, or medical staff action, sanction, or penalty or other liability for participating in EOLOA.
e) A request by a qualified individual to an attending physician to provide an aid-in-dying drug in good faith compliance with the provisions of EOLOA shall not provide the sole basis for the appointment of a guardian or conservator.
f) Actions taken in compliance with EOLOA shall not constitute or provide the basis for any claim of neglect or elder abuse for any purpose of law, unless a health care entity has prohibited its employees, independent contractors, or other persons or entities from participating in EOLOA and the person acts in contravention of that prohibition.
g) A health care provider may not be sanctioned for making an initial determination pursuant to the standard of care that an individual has a terminal disease and informing them of the prognosis, providing information about EOLOA to a patient at their request, or providing an individual, upon request, with a referral to another physician.
h) Actions taken in accordance with EOLOA shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse under the law. (Health. & Saf. Code, §§ 443.14(a)-(d), 443.15, 443.16(a), 433.18.)

10) Provides that a professional's participation in EOLOA is voluntary and provides that a person who elects not to participate for reasons of conscience, morality, or ethics shall not be required to participate or be subject to any civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for refusing to participate. (Health & Saf. Code, § 443.14(e).)

11) Provides that the immunities and prohibitions on sanctions of a health care provider are solely reserved for actions of a health care provider taken pursuant to EOLOA, and that, notwithstanding any contrary provision in EOLOA, health care providers may be sanctioned by their licensing board or agency for conduct and actions

constituting unprofessional conduct, including failure to comply in good faith with EOLOA. (Health & Saf. Code, § 443.16(c).)

12) Establishes civil and criminal liability for specified acts in violation of EOLOA:
    a) Knowingly altering or forging a request for an aid-in-dying drug to end an individual's life without their authorization or knowingly concealing or destroying a withdrawal or rescission of a request for an aid-in-dying drug is punishable as a felony if the act is done with the intent or effect of causing the individual's death.
    b) Knowingly coercing or exerting undue influence on an individual to request or ingest an aid-in-dying drug for the purpose of ending their life or to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without their knowledge or consent, is punishable as a felony.
    c) The above provisions do not limit civil liability or damages arising from negligent conduct or intentional misconduct in carrying out actions otherwise authorized by EOLOA by any person, health care provider, or health care entity.
    d) The penalties above do not preclude criminal penalties applicable under any law for conduct inconsistent with EOLOA, and nothing in EOLOA may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia. (Health & Saf. Code, §§ 443.17(a)-c), (e),

13) Requires the CDPH to collect and publish specified information regarding the number of persons for whom aid-in-dying prescriptions were written and the number of persons known to have used their prescriptions, in a manner that protects patient confidentiality. (Health & Saf. Code, § 443.19.)

14) Provides that EOLOA shall remain in effect only until January 1, 2031, and as of that date is repealed. (Health & Saf. Code, § 443.215.)

This bill, as the author agreed to amend it in the Senate Health Committee:

1) Repeals the January 1, 2031, EOLOA sunset date, thereby making the EOLOA permanent.

2) Requires the CDPH, by April 1, 2026, to meet with relevant stakeholders for the purpose of seeking input on the inclusion of additional information already available to the CDPH in its annual report on the EOLOA.

3) Requires the CDPH to include in its annual report, commencing with the report due on or before July 1, 2026, any additional data the CDPH elects to include based on the input in 2).

COMMENTS

1. Author's comment

According to the author:

> In 2015, the Legislature Passed the End of Life Option Act to give mentally capable, terminally ill Californians the right to request aid-in-dying drugs from their doctor. This allows the person to have an end-of-life experience aligned with their beliefs and values. Since the law went into effect on June 9, 2016, a total of 4,287 people have died following ingestion of aid-in-dying medication.
>
> The law is set to sunset on January 1, 2031 and is the only medical-aid-in-dying (MAiD) law in the country that contains a sunset date. The looming sunset can cause undue stress and fear in people diagnosed with a disease that will—in several years—be the cause of their death.
> Nine years of data show the law is working as intended and MAiD is being safely practiced in California. There have been no reported problems or abuses. SB 403 removes the sunset, making the law permanent. Patients, advocates, medical providers, and faith leaders who rely on it will no longer need to worry about access to MAiD being removed.

2. This bill removes the sunset on the End of Life Act and, as the author has agreed to amend it, requires the CDPH to modify its annual report, as specified

EOLOA is currently set to sunset on January 1, 2031.[1] This bill removes the sunset provision, making EOLOA permanent. Information about the legality of "right to die" laws, the EOLOA process, prior legal challenges to EOLOA, and the statistics of EOLOA users is set forth in the Comments below.

Additionally, the author agreed to take amendments in the Senate Health Committee that require the CDPH to meet with stakeholders for the purpose of seeking input on the inclusion of additional information already available to the CDPH in its annual public report on the EOLOA. The CDPH must meet with stakeholders by April 1, 2026, for purposes of including the additional information in the report due on or before July 1, 2026. These amendments will be crossed by this Committee.

3. The right to die

The United States Supreme Court has long recognized that a competent adult has the right to refuse medical treatment, even if doing so will cause them to die.[2] This right stems from the principle of informed consent, the logical corollary of which is that the

[1] Health & Saf. Code, § 443.215.
[2] *See Cruzan v. Director, Missouri Dept. of Health* (1990) 497 U.S. 261.

patient generally possesses the right not to consent, i.e., to refuse treatment.[3] That right is exclusive to the patient—a third party may not refuse treatment on the patient's behalf—and a state's interest in protecting its residents may set a high bar for proving that a patient who is incapacitated or incompetent would have chosen to cease treatment.[4]

The Supreme Court has also held that there is no constitutional right to physician-assisted dying.[5] The Court did, however, leave open the possibility that states could pass laws permitting physician-assisted dying.[6] Such laws would not be constitutionally mandated, but simply a matter of state policy. And since 1997, eleven jurisdictions—ten states[7] and the District of Columbia—have done just that.[8] California adopted its aid-in-dying law in 2015.[9]

4. The EOLOA process

EOLOA was drafted, and amended in 2021,[10] with two goals in mind: providing terminally ill adults the option to end their lives, while also providing sufficient safeguards to protect patients from coercion and ensure that everyone's participation—patients and physicians—is voluntary. To that end, EOLOA 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."[11] A "[t]erminal disease" is "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months."[12] At that point, the individual may make a request to the attending physician for an aid-in-dying drug.[13] The request must be made by the individual themselves, not through a power of attorney, advance health care directive, or other legal representative.[14]

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[3] *Id.* at p. 270.
[4] *Id.* at p. 280.
[5] *Washington v. Glucksberg* (1997) 521 U.S. 702, 735; *Vacco v. Quill* (1997) 521 U.S. 793, 799.
[6] *Glucksberg*, *supra*, 521 U.S. at pp. 718-719.
[7] Oregon, Washington, Montana, Vermont, California, Colorado, Hawai'i, New Jersey, Maine, and New Mexico.
[8] *See* Compassion & Choices, States Where Medical Aid in Dying is Authorized (2024), https://www.compassionandchoices.org/resource/states-or-territories-where-medical-aid-in-dying-is-authorized. All links in this analysis are current as of April 24, 2025. All of the aid in dying measures were passed through legislation except in Montana, where the state's Supreme Court held that the state's Rights of the Terminally Ill Act extended to physicians providing assistance to patients who otherwise qualified under the law. (*See Baxter v. Montana* (Mont. 2009) 224 P.3d 1211, 1217-1218.
[9] ABx2-15 (Eggman, Ch. 1, Stats. 2015, 2nd Ex. Sess.).
[10] SB 380 (Eggman, Ch. 542, Stats. 2021).
[11] Health & Saf. Code, § 443.1(b).
[12] *Id.*, § 443.1(r).
[13] *Id.*, §§ 443.2(a), 443.3(a).
[14] *Id.*, § 443.2(c).

The attending physician must discuss the patient's options and the consequences of ingesting the requested end-of-life drug and refer the individual to a consulting physician,[15] who must also diagnose the individual as having a terminal disease.[16] 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.[17] 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 48 hours 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.[18]

If all of the conditions are met, the attending physician must verify again that the individual is making an informed decision, and then may prescribe an aid-in-dying drug to the qualified individual.[19] 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.[20] The qualified individual may then self-administer the aid-in-dying drug.[21] A qualified individual may also opt out of the EOLOA process "at any point—after requesting or receiving the prescription, after the drugs are in their hand, after the feeding tube has been installed, after saying goodbye."[22]

EOLOA confers broad civil and criminal immunity, and immunity from licensure or other professional consequences, on a physician or other authorized health care provider who participates in the EOLOA process.[23] The bill also grants absolute immunity on any person who was present when a qualified individual self-administers a prescribed aid-in-dying drug, provided that the person does not assist the qualified person in ingesting the aid-in-dying drug.[24] EOLOA also makes participation voluntary: any person or entity that elects, for reasons of conscience, morality, or ethics, not to participate in the EOLOA process cannot be required to participate and is immune from civil, criminal liability, and from professional or licensure consequences, for their refusal.[25]

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[15] *Id.*, § 443.5(a).
[16] *Id.*, § 443.6.
[17] *Id.*, §§ 443.5(a)(1)(A)(ii), 443.6(d).
[18] *Id.*, § 443.3.
[19] *Id.*, §§ 443.5(b), 443.10.
[20] *Ibid.*
[21] *Id.*, §§ 443.1(b), (q), 443.14(a).
[22] *Shavelson v. Bonta* (N.D.Cal. 2022) 608 F.Supp.3d 919, 928; Health & Saf. Code, § 443.4(a).
[23] *Id.*, § 443.14.
[24] *Id.*, § 443.14(a).
[25] *Id.*, § 443.14(e). SB 380 (Eggman, Ch. 542, Stats. 2021) modified EOLA to provide additional protections for persons and entities who refused to participate in the EOLA process.

5. Legal challenges to EOLOA

EOLOA has been challenged as overly broad. In *Christian Medical and Dental Association v. Bonta*, a coalition of medical professionals sought to enjoin the enforcement of EOLOA on the ground that it required them to participate in assisted suicide in a way that violated their religious beliefs and, by extension, the Free Exercise Clause of the First Amendment.[26] The federal district court ruled that EOLOA's provisions protecting individuals and entities that do not wish to participate in the EOLOA process meant that the plaintiffs were unlikely to succeed on their Free Exercise claim and denied the request for injunction.[27]

EOLOA has also been challenged as overly narrow. In *Shavelson v. Bonta*, a plaintiff with amyotrophic lateral sclerosis argued that EOLOA violates the Americans with Disabilities Act (ADA)[28] because the nature of her illness meant that, by the time she qualified for aid-in-dying medication, she would likely lack the strength and coordination to self-administer the medication as required by EOLOA.[29] She and several physicians who wished to help terminally ill patients who could not self-administer aid-in-dying drugs sought a declaration that prohibiting physicians from doing so violates the ADA and an injunction prohibiting criminal prosecution of physicians who help otherwise-eligible patients ingest aid-in-dying medication.[30] The federal district court denied the requests, ruling that the requested accommodations would "fundamentally alter" EOLOA's legislatively crafted "sharp boundary" that "allow[s] a person to take their own life with aid-in-dying medication, but forbidding the taking of anyone else's."[31]

6. EOLOA in practice

According to the CDPH, in 2023, physicians wrote 1,281 prescriptions for aid-in-dying drugs, and 884 individuals died following the ingestion of aid-in-dying drugs.[32] This is a slight decrease from 2022, but still far higher than the numbers in 2021 and prior.[33]

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[26] *Christian Medical and Dental Association v. Bonta* (C.D.Cal. 2022) 625 F.Supp.3d 1018, 1025-1026; *see* U.S. Const., 1st amend.
[27] *Id.* at pp. 1032-1035.
[28] 42 U.S.C. §§ 12111 et seq.
[29] *Shavelson*, *supra*, 608 F.Supp.3d at p. 925.
[30] *Ibid.*
[31] *Id.* at p. 927. More recently, a federal district court dismissed with prejudice a complaint alleging, among other things, that EOLA provides inadequate safeguards to ensure that a requesting patient's decision is voluntary. (*United Spinal Assoc. v. State of California* (C.D.Cal. Mar. 27, 2024) Order Granting Defendants' Motions to Dismiss and Denying Motion to Intervene, Case No. 2:23-cv-03107-FLA-GJS, Dkt. No. 73, pp. 12-13.) The court held that the complaint failed to establish that EOLA's safeguards to avoid a patient involuntarily ingesting aid-in-dying medication. (*Id.* at p. 13.)
[32] CDPH, California End of Life Option Act, 2022 Data Report (Jul. 2024) p. 3, *available at* https://www.cdph.ca.gov/Programs/CHSI/pages/end-of-life-option-act-.aspx.
[33] *Id.* at p. 4. In 2021, doctors wrote 861 prescriptions, and 523 deaths were reported; in 2020, doctors wrote 779 prescriptions, and 497 deaths were reported. (*Ibid.*)

The post-2021 spike coincides with the implementation of legislation reducing the time between prescription requests from 15 days to 48 hours.[34]

Of the 884 individuals who died through the EOLOA process in 2023, 63.8 percent had cancer, 12.1 percent had cardiovascular disease, 8.8 had neurological disease, and 8 percent had non-cancer respiratory diseases; a handful of other conditions made up the remaining terminal illnesses.[35] Demographically, 85.4 percent of the decedents were white and 50.1 were male; 7.2 percent were under 60 years of age, 76.6 percent were between 60 and 89 years of age, and 16.2 percent were 90 years of age or older.[36]

7. Arguments in support

According to the bill's sponsor, Compassion & Choices:

> Since the California End of Life Option Act went into effect in 2016, data collected by the California Department of Public Health (CDPH) shows that the law works as intended for those who can access it. This aligns with nearly 30 years of national data on the effectiveness and safety of medical aid-in-dying laws. Since the EOLOA went into effect in 2016, more than 4,000 people have used the law to end their lives peacefully and on their own terms. In 2023, according to the CDPH annual report, over 1,200 Californians received a prescription, and 835 ultimately chose to use it. The majority were enrolled in hospice or palliative care and were 60 years or older. As you know, the law includes numerous safeguards, including a multi-step request process, confirmation of eligibility, and the opportunity for the patient to rescind their request if they change their mind.
>
> The law has not only benefited those who have utilized medical aid in dying—it has improved end-of-life care for all terminally ill Californians. 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.
>
> Yet, California is the only state in the nation with a medical aid-in-dying law that includes a sunset clause. If not removed, this provision will repeal the EOLOA on January 1, 2031 — leaving patients, providers, and families in fear and uncertainty about the future of end-of-life care in our state. For all of these reasons, it is essential that the sunset provision is removed and the California End of Life Option Act becomes permanent.

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[34] *See* SB 380 (Eggman, Ch. 542, Stats. 2021).
[35] CDPH, California End of Life Option Act, 2022 Data Report, *supra*, at pp. 7-8.
[36] *Id.* at p. 7.

8. Arguments in opposition

According to the Alliance of Catholic Health Care:

> In the nine years since the implementation of the EOLOA, not only has there been no substantive review on the compliance of current law, there has not been full transparency on the data that is collected, but is not reported.
>
> We urge that before the sunset is removed, the Legislature and the California Department of Public Health (CDPH) provide a comprehensive review of current law, including an evaluation on the compliance with the current law. CDPH has testified at informational hearings of the Select Committee on End of Life Health that the forms physicians are required to complete by law are not all compliant, but they have not presented an analysis that outlines how many forms are out of compliance and what element(s) on the form are not complete. While the Department states that it has no enforcement authority to ensure compliance, we believe that the Legislature should require CDPH to collect and report that information to enable the Legislature to fulfill its oversight obligation of this law. It would be irresponsible to remove the sunset when we have no way to know if there is compliance with the current law. And given the lack of full data reporting and transparency, the Legislature has been denied the ability to provide needed oversight…
>
> It would seem good public policy to have a comprehensive review regarding the collection, dissemination and retention of data related to such critical health care data before the sunset is removed. The latter was implied as part of the many assurances by the authors and sponsors of the original EOLOA legislation.

SUPPORT

Compassion & Choices (sponsor)
A Better Exit
AgeSong Marin
American Nurses Association California
Death With Dignity
End of Life Choices
Full Circle Living and Dying
Long Beach Gray Panthers
34 individuals

OPPOSITION

Alliance of Catholic Health Care
California Foundation for Independent Living Centers
California League of United Latin American Citizens

La Luz Project
The Church of Jesus Christ of Latter-Day Saints
The Salvador E. Alvarez Institute for Non-Violence
Two individuals

RELATED LEGISLATION

Pending legislation: None known.

Prior legislation:

SB 1196 (Blakespear, 2024) would have modified the EOLOA by extending the option to take aid-in-dying drugs to persons with a "grievous and irremediable medical condition," as defined, and by permitting aid-in-dying drugs to be administered intravenously through a pathway placed by a health care provider, provided that the person taking the drugs introduces the drug into their vein; and repealed the EOLOA sunset date. SB 1196 died in the Senate Health Committee.

SB 380 (Eggman, Ch. 542, Stats. 2021) extended the January 1, 2026, sunset date of EOLOA to January 1, 2031; permitted an individual to make a second oral request a minimum of 48 hours from the first request for medical aid in dying; eliminated 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; and required health care providers who elect not to participate in EOLOA to inform a patient and transfer records to another health care provider.

SB 1338 (Morrell, 2018) would have expanded the CHPH's EOLOA reporting obligations to require the CDPH to disclose additional information regarding the physicians who wrote aid-in-dying-drug prescriptions and the patients who received aid-in-dying drug prescriptions. SB 1338 died in the Senate Health Committee.

ABx2-15 (Eggman, Ch. 1, Stats. 2015, 2nd Ex. Sess.) established the EOLOA, with a sunset date of January 1, 2026.

PRIOR VOTES:

Senate Health Committee (Ayes 9, Noes 2)

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