



Effective Date 05/2016  
Approved Date 04/2022  
Revised Date 04/2022  
Next Review 04/2025

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Applicability Ronald Reagan,  
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Reference Tags Lippincott

## California End of Life Option Act, HS 1490

### PURPOSE

To describe the process used by UCLA Health to implement the California End of Life Option Act (hereafter the "Act") and to provide guidelines for responding to patient requests for an aid-in dying medication.

### SCOPE

This Health System Policy applies to the Ronald Reagan UCLA Medical Center, the Santa Monica UCLA Medical Center & Orthopaedic Hospital, the Resnick Neuropsychiatric Hospital (RNPH) at UCLA, and the Clinic Outpatient Areas Licensed and Non-licensed

#### I. PRINCIPLES

- A. UCLA Health permits its physicians (assisted by other qualified staff) to accede to requests to prescribe aid-in-dying medication, provided adherence to all the conditions required by law and this policy. This does not imply promotion of the practice, but recognizes patients' legitimate interest in appropriate access to services permitted by law.
- B. Recognizing the long ethical tradition of physicians and other health care professionals not assisting a patient to actively end their life, the law makes participation in aid-in-dying entirely voluntary. UCLA Health respects the voluntary nature of participation and the right of healthcare professionals not to participate on grounds of conscience, morality and ethics. Respect for this right acknowledges the disagreement among health care professionals about the ethicality of aid-in-dying.
- C. Patients requesting aid-in-dying have a right to be treated with the greatest of respect and compassion by their Attending physician and other health care providers regardless of whether those professionals have chosen to participate in aid-in-dying.
- D. The stated purpose of aid-in-dying is to respect and enhance the personal autonomy of terminally ill patients by enabling them to control, if they wish, the time and manner of their death. Therefore, it is important that a request for aid-in-dying is an authentic expression of a patient's autonomy.
- E. All forms of undue influence, intentional or otherwise, must be meticulously avoided in the approach to aid-in-dying requests.

- F. Patient education is essential for informed decision making about end of life care. All reasonable treatment options should be presented to patients regarding their terminal diagnosis, which may include curative, palliative and hospice options. Physicians must avoid pressure or unintended promotion of aid-in-dying and avoid engendering or aggravating concerns that a patient poses a burden on others.
- G. UCLA patients have a right to have their pain and other distressing symptoms expertly managed. UCLA Health is deeply committed to the provision of excellent palliative care at the end of life.

## II. DEFINITIONS

### **As described in the Act**

**Aid-in-dying drug** - 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.

**Attending physician** - The physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease.

**California resident** – A person able to establish residency through at least one of the following:

- A. Possession of a California Driver license or other identification issued by the State of California
- B. Registration to vote in California
- C. Evidence that the patient owns or leases property in California
- D. Filing of a California tax return for the most recent tax year

**Capacity to make medical decisions** - In the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, 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.

**Consulting physician** - 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.

**Informed decision** - 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 acknowledgment of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:

- A. The individual's medical diagnosis and prognosis.
- B. The potential risks associated with taking the drug to be prescribed.
- C. The probable result of taking the drug to be prescribed.
- D. The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it.

The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

**Medically confirmed** - 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.

**Mental health specialist** - A psychiatrist or a licensed psychologist.

**Qualified Individual** - 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 his or her life.

**Self-administer** - A qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about his or her own death.

Terminal disease - An incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

**Not described in the Act**

Disability - An umbrella term for impairments, activity limitations and participation restrictions. The interaction between individuals with a health condition (e.g., cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g., negative attitudes, inaccessible transportation and public buildings, and limited social supports).

**A. DISTINCTIONS**

- A. It is important to clearly distinguish prescribing an aid-in-dying drug from the provision of end of life Palliative care and other common end of life practices (e.g., withholding or withdrawing life-sustaining treatment).
  1. Palliative care. Aid-in-dying involves a physician prescribing a lethal dose of medication that a terminally ill patient requested for the purposes of ending his own life, if he or she so chooses. The goal of palliative care at the end of life, on the other hand, is to help terminally ill patients live with their terminal illness until their natural death while enhancing their quality of life by preventing and relieving suffering. It is never the goal of palliative care to intentionally cause or otherwise hasten a patient's death. An intervention does not cease to be palliative, however, because it may foreseeably hasten a patient's death provided the intended goal of the intervention is symptom relief and not the hastening of death and the dosage of medication administered is carefully titrated to achieve that effect alone.
  2. Withholding and withdrawing life sustaining treatment. Physician prescribed aid-in-dying also is distinguished from the common practice of withholding or withdrawing life-sustaining treatments from terminally ill patients either at their own request or because its provision is no longer medically appropriate (HS1319). The intention motivating withholding and withdrawing life-sustaining treatment in these circumstances is to limit unwanted, non-beneficial or harmful treatment thus allowing for a natural death. The cause of the patient's death is their underlying terminal illness or its complications. In physician-prescribed aid-in-dying, the cause of death is lethal medication prescribed by a physician and self-ingested by the patient.
- B. It is of the utmost importance to distinguish aid-in-dying from euthanasia or mercy killing. Whereas aid-in-dying involves the self-administration by the patient of a lethal medication previously prescribed by a physician, euthanasia or mercy killing involves the active administration by a physician or other health care professional of a lethal medication intending to bring about the patient's death. Nothing in the Act or this policy should be interpreted to permit euthanasia or mercy killing, which is strictly prohibited and unlawful.

**B. POLICY**

- A. The Act allows adult (18 years or older) terminally ill patients with capacity to make health care decisions to request a lethal dose of a medication from an Attending physician. These terminally ill patients must be California residents who will, within reasonable medical judgment, die within 6 months. Patients requesting an aid-in-dying medication must satisfy all requirements of the Act in order to obtain the prescription.
- B. UCLA physicians may participate in the Act if they so choose and other UCLA providers/ employees may participate in relevant supporting roles if they so choose including performing the duties of the Attending and Consulting physician and Mental health specialist, prescribing and dispensing aid-in-dying medication, being present when the patient self-administers the medication, and providing patient or provider support.

- C. Participation in activities authorized under the Act is completely voluntary. If a health care provider is unable or unwilling to participate, the provider shall, at a minimum, inform the individual that they do not participate in the End of Life Option Act, document the individual's date of request and provider's notice to the individual of their objection in the medical record, and transfer the individual's relevant medical record upon request. A physician must not abandon a patient because of a request for aid-in-dying.
- D. Patients with terminal illness who request aid-in-dying because of suffering contributed to by lack of access to medical care or environmental factors must have those factors explored and options offered to provide access to treatment or support before aid-in-dying medication is prescribed.
- E. Participation of UCLA clinicians with a UCLA patient requesting aid-in-dying under the Act will be guided by a structure that includes an Attending physician, a specially-trained Clinical consultant (social worker or psychologist), a qualified Consulting physician, a specially-trained pharmacist and, when warranted, a Mental health specialist. Multiple physicians share clinical responsibility for a terminally ill patient. The Attending physician who prescribes the aid-in-dying drug will follow the patient in continuity, but may not be the only physician with ongoing responsibility for treatment of the patient's terminal condition.
- F. Participating Attending physicians, Consulting physicians, and Mental health specialists must not be related to a patient to whom they are providing services related to the Act by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the individual's estate upon death.
- G. A physician should not encourage use of an aid-in-dying drug.
- H. Supplying and permitting self-administration of aid-in-dying medication is not permitted in the hospital or in an inpatient hospice bed.
- I. UCLA clinicians will provide appropriate continuity of care to patients whether aid-in-dying medication is provided or not.
- J. UCLA will perform quality evaluations to ensure that the Procedure is followed as required by the Act and this policy.
- K. UCLA will post this policy governing medical aid-in-dying on its public internet website.

### C. PROCEDURE

Materials for the End of Life Option Act can be found at: <https://mednet.uclahealth.org/end-of-life-option-act-resources-and-materials/>

#### A. Eligible patients for the California End of Life Option Act

A UCLA adult patient who has capacity to make health care decisions and who has a terminal illness may make a request to receive a prescription for an aid-in-dying drug if all of the following conditions are met:

1. The patient's Attending physician has diagnosed the patient with a terminal illness;
2. The patient has voluntarily made three requests for an aid-in-dying drug (two oral and one written);
3. The patient has the physical and mental capacity to self-administer the aid-in-dying drugs;
4. The patient is a California resident; and
5. The patient must not be considered a "qualified individual" under the Act solely because of age or disability.

#### B. Request of an aid-in-dying drug and Attending physician response

Requests for an aid-in-dying drug must come directly and solely from the patient who will self-administer the drug. Such requests cannot be made by a patient's surrogate or by the patient's

health care provider. If a request is made by someone other than the patient, the physician must explain that s/he cannot act on requests other than those made by a patient. To make a request for a prescription for an aid-in-dying drug, the patient must directly submit his or her request to the attending physician:

1. Two oral requests that are made a minimum of 48 hours apart. The Attending physician must document these requests in the medical record under the Goals of Care tab.
2. One written request, appropriately witnessed, using the form required by the State of California "Request for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner" (<https://www.mbc.ca.gov/Download/Forms/aid-in-dying-request.pdf>).
3. The request must be made directly to the Attending physician. It may not be made through a designee such as an assistant or resident. Residents, fellows, physician assistants and nurse practitioners must notify the attending physician about any patient requests under the Act.
4. If an Attending physician receives a request from a patient who wishes to receive an aid-in-dying medication under the Act, the physician should explore the reasons for the request including inadequately controlled symptoms or other areas of distress including inadequate support. The physician should offer appropriate referrals (e.g., hospice, pain management, Palliative care).
5. If the patient's needs cannot be met in another way and the Attending physician believes that the patient is making a qualified request for an aid-in-dying medication under the Act, the physician must contact or make a referral to the designated Clinical consultant.
6. The Attending physician should summarize each discussion about aid-in-dying with the patient in a Goals of Care note.
7. The duration of the process to carry out the steps to receive aid-in-dying medication should reflect a balance between the weight of the decision and practical factors, as well as the interest a patient may have in completing the process expediently due to intense suffering or the risk of losing capacity to make medical decisions or ingest medication.

**C. Engaging the Designated Clinical Consultant**

The designated Clinical consultant will be a UCLA social worker or psychologist specially trained to perform a psychosocial and vulnerability assessment on the patient and also coordinate response to the Act for the Attending physician and the patient, including following all steps in the Procedure, guiding completion of administrative records and filing of reports with the California Department of Public Health. The Clinical consultant will do the following:

1. Assist the Attending physician with the requirements of the Act
2. Meet with the patient to provide support and assess for unmet needs, vulnerability and mental impairment and inform the Attending physician of the findings of the assessment
3. Suggest potential designated Consultant physicians to the Attending physician
4. Identify additional resources or suggest or refer to other consultants, including but not limited to a Mental health specialist, pastoral care, ethics and nursing that might be helpful to the patient
5. At the direction of the Attending physician, arrange for the patient to meet with a Consultant physician and other consultants
6. Facilitate that documentation is being completed and collected according to the Act,

although ultimately the physician is responsible for making certain all forms have been completed before prescribing the aid-in-dying medication

7. Convene a meeting including the Attending physician, Consultant physician and others if there are disagreements that require additional attention
8. Facilitate appropriate documentation submitted to CDPH
9. Document interactions with the patient in a Goals of Care note

**D. Responsibilities of the Attending Physician**

The responsibilities of an Attending physician cannot be delegated. Before prescribing the aid-in-dying drug, the Attending physician must do all of the following:

1. First the Attending physician should discuss the following with the patient as part of the informed consent discussion:
  - a. The meaning behind the request
  - b. Loss of control, abandonment, financial hardship, burden to others, and personal or moral beliefs
  - c. What constitutes unacceptable suffering in the patient's view?
  - d. Pain, other physical symptoms, psychological distress and existential crisis  
The physician must offer to treat symptoms for which there are treatment options available, refer to a Palliative Care specialist if expert consultation is needed and consider referral to hospice.  
The physician must document this discussion in a Goals of Care note.
2. Make the initial determination about whether the patient is qualified under the Act as described in section V.A above, including determination that:
  - a. The patient has capacity to make health care decisions
  - b. The patient has a terminal illness, medically confirmed by a Consulting physician
  - c. The patient has made a voluntary request for an aid-in-dying drug, including completion of witness attestations that the patient is of sound mind and not under fraud, duress or undue influence
  - d. The patient has met the residency requirements of the Act
3. Confirm that the patient is making an informed decision, defined as 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 acknowledgment of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:
  - a. The individual's medical diagnosis and prognosis
  - b. The potential risks associated with taking the drug to be prescribed
  - c. The probable result of taking the drug to be prescribed
  - d. The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it
  - e. The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control
4. If there are indications of a mental disorder, the physician shall refer the individual

- for a mental health specialist assessment (see Section V.F).
5. Refer the patient to a physician that the Attending physician has confidence can carry out the tasks (see section V.E) required of the Consulting physician.
  6. Confirm that the patient's request does not arise from coercion or undue influence. The physician must do this by discussing with the patient, outside the presence of any other person (except for an interpreter as described in section V.J below) whether or not the patient is feeling coerced or unduly influenced by another person.
  7. Counsel the patient about the importance of:
    - a. Depositing the prescription at the pharmacy to retrieve the medication when it will be used. After receipt, maintaining the aid-in-dying drug in a safe and secure location until the patient takes it
    - b. Having another person present when he or she ingests the aid-in-dying drug.
    - c. Not ingesting the aid-in-dying drug in a public place. "Public place" means any street, alley, park, public building, or any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access. "Public place" does not include a health care entity.
    - d. Notifying the next of kin of his or her request for an aid-in-dying drug. A patient who declines or is unable to notify next of kin must not have his or her request denied for that reason, but this should be strongly encouraged unless there is a compelling reason not to disclose.
    - e. Considering participating in a hospice program when useful for the patient.
  8. When appropriate, the Attending physician should complete a POLST with the patient. If not applicable at the time that the aid-in-dying medication is prescribed, the Attending physician should inform the patient that a POLST should be completed indicating "DNR" before the patient ingests the aid-in-dying drug.
  9. Inform the patient that he or she may withdraw or rescind the request for an aid-in-dying drug at any time and in any manner. The patient has the right to change his or her mind without regard to his or her mental state. Therefore, if a patient makes a request for an aid-in-dying drug while having capacity to make health care decisions, then loses his or her capacity, the patient can still decide not to take the aid-in-dying drug.
  10. Offer the patient an opportunity to withdraw or rescind the request for an aid-in-dying drug before prescribing the drug.
  11. Verify, for a second time, immediately before writing the prescription for an aid-in-dying drug, that the patient is making an informed decision.
  12. Confirm that all requirements are met and all appropriate steps are carried out in accordance with the law (as outlined in this policy) before writing a prescription for an aid-in-dying drug.
  13. Fulfill all the documentation requirements (see V.H below)
  14. Complete the "Attending Physician Checklist & Compliance form" ([https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/EOL%20Attending%20Physician%20Checklist%20and%20compliance%20form-ADA%20FINAL%20\(3\).pdf](https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/EOL%20Attending%20Physician%20Checklist%20and%20compliance%20form-ADA%20FINAL%20(3).pdf)) and place it and the completed "Consulting Physician Compliance Form" (<https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/>

[EOL%20CONSULTING%20PHYSICIAN%20COMPLIANCE%20FORM%20\(fillable\).pdf](#) in the patient's medical record.

15. Complete the Attending Physician Follow-up Form ([https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/EOL%20Attending%20Physician%20follow-up%20form%20\(fillable\).pdf](https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/EOL%20Attending%20Physician%20follow-up%20form%20(fillable).pdf)).
16. Ensure that within 30 days of writing the aid-in-dying prescription the following forms are assembled in the Goals of Care note section of the chart for the Clinical Consultant to submit to CDPH: Patient's written request, Attending physician checklist and compliance form, and the Consulting physician compliance form.
17. Ensure that within 30 days of the patient's death the Attending physician followup form is in the Goals of Care note section of the chart for the Clinical Consultant to submit to CDPH.

**E. Responsibilities of the Consulting Physician**

A physician who chooses to act as a Consulting physician must understand the requirements of the Act and must be independent from the Attending physician prescribing the aid-in-dying drug. This Consulting physician may provide continuity care to the patient. The Consulting physician must do all the following:

1. Examine the patient and his or her relevant medical records.
2. Confirm in writing the Attending physician's diagnosis and prognosis.
3. Determine that the individual has the capacity to make medical decisions, is acting voluntarily and has made an informed decision.
4. If there are indications of a mental disorder, the physician shall refer the individual for a mental health specialist assessment (see Section V.F).
5. Fulfill the documentation requirements (see section V.H below) including completing a Goals of Care note.
6. Complete the State of California form "End of Life Option Act Consulting Physician Compliance form" ([https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/EOL%20CONSULTING%20PHYSICIAN%20COMPLIANCE%20FORM%20\(fillable\).pdf](https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/EOL%20CONSULTING%20PHYSICIAN%20COMPLIANCE%20FORM%20(fillable).pdf)) and ensure that it is in the Goals of Care note section of the chart for the Clinical Consultant to submit to CDPH.

**F. Responsibility of Mental Health Specialist**

A psychiatrist or psychologist who chooses to act as a mental health specialist must conduct one or more consultations with the patient and do all of the following if the patient has been referred to the mental health specialist:

1. Examine the qualified patient and his or her relevant medical records.
2. Determine that the patient has the mental capacity to make medical decisions, act voluntarily, and make an informed decision.
3. Determine that the patient is not suffering from impaired judgment due to a mental disorder. Patients with depression are not automatically excluded and it must be determined that a mental illness is interfering with decision making capacity.
4. Document in the patient's medical record a report of the outcome and determinations made during the mental health specialist's assessment including a Goals of Care note.

**G. Addressing conflicts that arise in evaluation concerning the Act**

Concerns or conflicts identified by the Attending physician, the Consulting physician, the

Mental health specialist, the Clinical consultant, another consulting clinician or clinician or staff caring for the patient should be addressed among the clinicians and if unresolved should be addressed as follows:

1. If there are concerns among any clinician regarding the capacity of the patient to make an informed decision regarding aid-in-dying, a mental health consultation is required.
2. If there is disagreement between the Attending and Consulting physicians regarding the terminal prognosis, a meeting should be convened including the Attending physician, the Consulting physician, the Clinical consultant and other consulting clinicians that includes experts in the patient's condition and palliative care to assemble the best evidence to inform the decision of whether the patient qualifies for the Act.
3. If there is concern regarding the voluntariness of the request, these should be investigated with the utmost seriousness and consultation with Legal, Risk Management and law enforcement should be considered. Ethics Committee involvement should be requested. Aid-in-dying medication must not be prescribed in the presence of concerns about the voluntary nature of the request.
4. If there is disagreement regarding whether the patient's needs can be met in another way, a meeting should be convened including the Attending physician, the Consulting physician, the Clinical consultant, other consulting clinicians and additional consultants to clarify the interventions that might benefit the patient and identify whether they should be presented to the patient before or in lieu of aid-in-dying medication. Ethics Committee involvement should be requested.

#### **H. Documentation requirements**

All of the following must be documented in the patient's medical record. Written notes should be placed in Goals of Care.

1. All oral requests for aid-in-dying drugs from qualified individuals, even if the Attending physician chooses not to participate.
2. All written requests for aid-in-dying drugs
3. The Attending physician's diagnosis and prognosis, and the determination that the qualified patient has the capacity to make healthcare decisions, is acting voluntarily, and has made an informed decision, or that the Attending physician has determined that the individual is not a qualified patient.
4. The Consulting physician's diagnosis and prognosis and verification that the qualified patient has the capacity to make healthcare decisions, is acting voluntarily and has made an informed decision, or that the Consulting physician has determined that the individual is not a qualified patient.
5. A report of the outcome and determination made during a mental health specialist's assessment, if performed.
6. The Attending physician's offer to the qualified patient to withdraw or rescind his or her request at the time of second oral request
7. A note by the Attending physician indicating that all requirements of the Act have been met and indicating the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed.

#### **I. Death Certificate**

Actions taken under the Act shall not, for any purpose, constitute suicide, assisted suicide, homicide, or elder abuse. Thus, physicians should not list suicide or "pursuant to the End of Life Option Act" as the cause of death. Physicians should list the underlying terminal illness as

the cause of death.

**J. Use of an Interpreter**

An interpreter can participate in discussions regarding the Act and in completion of patient forms. The Request for an Aid-in-Dying Drug to end My Life in a Humane and Dignified Manner may be completed with the assistance of an interpreter two ways:

1. The written request form signed by the patient may be written in the same language as any conversations, consultations or interpreted conversations or consultations between a patient and his or her attending or consulting physician
2. The written request form signed by the patient may be prepared in English even when the conversations or consultations were conducted in a language other than English if the Interpreter completes the interpreter attestation (<https://www.mbc.ca.gov/Download/Forms/aid-in-dying-request-interpreter-declaration.pdf>).

The interpreter must not be related to the patient by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the patient's estate upon death. The interpreter must meet the standards promulgated by the California Healthcare Interpreting Association or the National Council on Interpreting in Health Care or other standards deemed acceptable by CDPH.

**K. Prescribing or Delivering the Aid-in-Dying Drug**

After the Attending physician has fulfilled his or her responsibilities under the Act, the Attending physician may prescribe the aid-in-dying drug by following these steps:

1. The patient will sign the End of Life Option Act Prescription Consent form (Appendix A) that attests to the following:
  - a. Consent to transmit the prescription for the aid-in-dying medication to the pharmacy. It is strongly recommended that the prescription be left at the pharmacy until patient is ready to use the medication.
  - b. Store the medication in a secure location
  - c. Self-administer the aid-in-dying medication as directed without assistance, in a private place with another individual present
  - d. Dispose of unused medication at the appropriate location
2. The aid-in-dying drug may not be dispensed directly by the physician.
3. With the patient's written consent, the electronic prescription will be sent to the RR-UCLA B-floor pharmacy. The designated pharmacist may dispense the drug to the patient, the attending physician, or a person expressly designated by the patient. This designation may be delivered to the pharmacist electronically, in writing or verbally.
4. Delivery of the dispensed drug to the patient, the attending physician, or a person expressly designated by the patient may be made by personal delivery, or with a signature required on delivery by messenger service.
5. If the patient does not intend to ingest the medication immediately, the prescription may be left at the pharmacy to be dispensed at the appropriate time. Prescriptions expire after six months and would need to be rewritten by the Attending physician, if appropriate. If two prescriptions expire (it has been a year since the patient first received a prescription for the aid-in-dying drug), the Attending physician must write a Goals of Care note documenting that the patient continues to qualify for the Act before writing a second refill. The patient will review and sign a new End of Life Option Act Prescription Consent form that is uploaded into the chart. If the patient received a mental health consult before the initial aid-in-dying prescription, the

Attending should consider whether this should be repeated.

6. The pharmacist will counsel the patient or the patient's designated person on the optimal procedures for administration of the drug and provide a written handout with instructions.
  7. Physicians should counsel patients how to dispose of left over aid-in-dying drugs.
- L. Prescribing, supplying and allowing self-administration of aid-in-dying medication is not allowed in the inpatient setting**
1. Prescribing, supplying and self-administration of an aid-in-dying medication is not allowed in the hospital or in an inpatient hospice bed.
  2. Discussions and form completion to initiate the aid-in-dying process may be started in the inpatient setting.
- M. CDPH Reporting Requirements**
- Within 30 calendar days of writing a prescription for an aid-in-dying drug, the Clinical consultant will submit the following to CDPH (<https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx>; California Department of Public Health Public Health Vital Statistics Branch Attention: End of Life Option Act, MS 5205, P.O. Box 997377, Sacramento, CA 95899-7377; forms can also be faxed to (916) 636-6045):
1. A copy of the qualifying patient's written request: "Request for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner"
  2. The "End of Life Option Act Attending Physician Checklist & Compliance Form"
  3. The "End of Life Option Act Consulting Physician Compliance form"
  4. Within 30 calendar days following the qualified patient's death from ingesting the aid-in-dying drug, or any other cause, the Attending physician must submit to CDPH the "End of Life Option Act Attending Physician Follow-Up Form"
- N. Monitoring the California End of Live Option Act**
- The handling of cases in which UCLA patients are evaluated for prescription of an aid-in-dying medication and a report on the number of cases, adherence with Procedures and outcomes will be provided to the MSEC on an annual basis.

## FORMS IN THE APPENDIX

- A. End of Life Option Act – Prescription Consent form (Form 16495)

## REFERENCES

California Health and Safety Code section 443 et. Seq. (End of Life Option Act)

California Probate Code section 4609 California Probate Code Sections 4600, et. seq. (Health Care Decisions Law)

Patient Self-Determination Act; 42 CFR (489.100 and 489.102)

UCLA Hospital System – HS 1423 Physician Order for Life sustaining Treatment (POLST) Policy

UCLA Hospital System – HS 1346 Obtaining and Documenting Consent

UCLA Hospital System – HS 1347 Who May Give an Informed Consent

TJC Standard RI.01.05.01

# CONTACT

UCLA End of Life Option Act Workgroup

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## Attachments

[A: Request for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner](#)

## Approval Signatures

Step Description	Approver	Date
Administration Approval- President and CEO, UCLA Health	Johnese Spisso: Ceo Med Ctr [JB]	04/2022
Ronald Reagan Medical Staff Executive Committee- Chief of Staff	Lynnell Mccullough: Hs Clin Prof-Hcomp [JB]	04/2022
Santa Monica Medical Staff Executive Committee- Chief of Staff	Roger Lee: Hs Clin Prof-Hcomp [JB]	04/2022
Resnick Neuropsychiatric Medical Staff Executive Committee- Chief of Staff	Aaron Kaufman: Hs Assoc Clin Prof-Hcomp [JB]	04/2022
Hospital System Policy Committee Chair	Jeffrey Bergen: Regl And Cmplnc Hc Mgr 2 [KK]	04/2022
Policy Owner	Neil Wenger: Prof-Hcomp	03/2022