

THE CALIFORNIA END OF LIFE OPTION ACT (PATIENT'S REQUEST FOR AID-IN-DYING DRUG)

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 significant 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:

1. Possession of a California Driver license or other identification issued by the State of California
2. Registration to vote in California
3. Evidence that the patient owns or leases property in California
4. 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:

1. The individual's medical diagnosis and prognosis.
2. The potential risks associated with taking the drug to be prescribed.
3. The probable result of taking the drug to be prescribed.
4. The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it.

5. 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).

III. 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.

IV. 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. A physician, staff or employee who elects not to engage in activities authorized by the Act may, but is not required to, take any action in support of a patient's request for a prescription for an aid-in-dying medication, including, but not limited to, acknowledging a patient's option to request an aid-in-dying drug or referral to another provider who participates in such activities. 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.

V. 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 15 days 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” (attached as Appendix A).
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.

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. 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.
 - 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. Inform Risk Management that such a request has been made.
 - 15. Complete the "Attending Physician Checklist & Compliance form" (Attached as Appendix C) and place it and the completed "Consulting Physician Compliance Form" (Attached as Appendix D) in the patient's medical record and arrange for its submittal to CDPH by the Office of Regulatory Affairs.
 - 16. Give the "Final Attestation for an Aid-in-Dying Drug to End my Life in a Humane and Dignified Manner" (Appendix B) to the requesting patient and instruct the patient that within 48 hours prior to self-administration the aid-in-dying drug, the patient must complete the

form. If the attending physician receives this document, he or she is required to put it in the patient's medical record.

17. Complete the Attending Physician Follow-up Form and submit it to CDPH (Attached as Appendix E) through the Office of Regulatory Affairs.

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" (attached as Appendix D).

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
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 (Appendix A) may be completed with the assistance of an interpreter two ways:

1. The written request form signed by the patient (Appendix A) 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 (Appendix A) 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 in Appendix A.

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 that attests to the following:
 - a. Consent to transmit the prescription for the aid-in-dying medication to the pharmacy
 - b. Store the medication in a secure location

- c. Complete the Final Attestation for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner (Appendix B) before self-administering the aid-in-dying medication
 - d. Self-administer the aid-in-dying medication as directed without assistance, in a private place with another individual present
 - e. 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 or written prescription will be sent to the RR-UCLA B-floor pharmacy. It is not permissible to give the patient a written prescription to take to a 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 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 UPS, US Postal Service, Federal Express or by messenger service.
 - 5. 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.
 - 6. 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.
- 3. Implementation of aid-in-dying in the inpatient setting will be re-evaluated 18 months after this policy is established.

M. CDPH Reporting Requirements

Within 30 calendar days of writing a prescription for an aid-in-dying drug the Attending physician must submit the following to CDPH (California Department of Public Health Public Health Policy and Research Branch Attention: End of Life Option Act, MS 5205, P.O. Box 997377, Sacramento, CA 95899-7377; forms can also be faxed to (916) 440-5209) through the Office of Regulatory Affairs:

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: Appendix A
2. The "End of Life Option Act Attending Physician Checklist & Compliance Form" Appendix C
3. The "End of Life Option Act Consulting Physician Compliance form". Appendix D
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" Appendix E.

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 will be evaluated by the Quality Assessment program and a report on the number of cases, adherence with Procedures and outcomes will be provided to the MSEC on a quarterly basis.

FORMS IN THE APPENDIX

- A. Request for an Aid-in-Dying Drug to end My Life in a Humane and Dignified Manner.
- B. Final Attestation for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner.
- C. End-Of-Life Option Act Attending Physician Checklist and Compliance Form
- D. End-Of-Life Option Act Consulting Physician Compliance Form
- E. End-Of-Life Option Act Attending Physician Follow-Up Form
- F. 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 4609California 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

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REVISION HISTORY

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Appendix A

(See Cal. Health & Safety Code § 443.11(a)-(b): Form for Written Request for an Aid-in-Dying Drug & Interpreter's Declaration, If Applicable)

REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I,, am an adult of sound mind and a resident of the State of California.

I am suffering from, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

INITIAL ONE:

..... I have informed one or more members of my family of my decision and taken their opinions into consideration.

..... I have decided not to inform my family of my decision.

..... I have no family to inform of my decision.

I understand that I have the right to withdraw or rescind this request at any time.

I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this request voluntarily, without reservation, and without being coerced.

Signed:.....

Dated:.....

DECLARATION OF WITNESSES

We declare that the person signing this request:

- (a) is personally known to us or has provided proof of identity;
- (b) voluntarily signed this request in our presence;
- (c) is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and
- (d) is not an individual for whom either of us is the attending physician, consulting physician, or mental health specialist.

.....Witness 1/Date

.....Witness 2/Date

NOTE: Only one of the two witnesses may be a relative (by blood, marriage, registered domestic partnership, or adoption) of the person signing this request or be entitled to a portion of the person's estate upon death. Only one of the two witnesses may own, operate, or be employed at a health care facility where the person is a patient or resident.

Appendix A (Cont'd)

I, (INSERT NAME OF INTERPRETER), am fluent in English and (INSERT TARGET LANGUAGE).

On (insert date) at approximately (insert time), I read the "Request for an Aid-In-Dying Drug to End My Life" to (insert name of individual/patient) in (insert target language).

Mr./Ms. (insert name of patient/qualified individual) affirmed to me that he/she understood the content of this form and affirmed his/her desire to sign this form under his/her own power and volition and that the request to sign the form followed consultations with an attending and consulting physician.

I declare that I am fluent in English and (insert target language) and further declare under penalty of perjury that the foregoing is true and correct.

Executed at (insert city, county, and state) on this (insert day of month) of (insert month), (insert year).

X_____ Interpreter signature

X_____ Interpreter printed name

X_____ Interpreter address

Appendix B

(See Cal. Health & Safety Code § 443.11(c): Form for Final Attestation for an Aid-in-Dying Drug)

FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I,, am an adult of sound mind and a resident of the State of California.

I am suffering from, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.

INITIAL ONE:

..... I have informed one or more members of my family of my decision and taken their opinions into consideration.

..... I have decided not to inform my family of my decision.

..... I have no family to inform of my decision.

My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified manner. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

Signed:.....

Dated:.....

Time:.....

Appendix C

(See Cal. Health & Safety Code § 443.22: Attending Physician Checklist & Compliance Form. The following form is required unless and until updated by the Medical Board of California. The California Department of Public Health must publish updated forms on its website upon completion.)

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

| | | |
|----------|--|---------------|
| A | PATIENT INFORMATION | |
| | PATIENT'S NAME (LAST, FIRST, M.I.) | DATE OF BIRTH |
| | PATIENT RESIDENTIAL ADDRESS (STREET, CITY, ZIP CODE) | |

| | | |
|----------|--|-----------------------------------|
| B | ATTENDING PHYSICIAN INFORMATION | |
| | PHYSICIAN'S NAME (LAST, FIRST, M.I.) | TELEPHONE NUMBER () - |
| | MAILING ADDRESS (STREET, CITY, ZIP CODE) | |
| | PHYSICIAN'S LICENSE NUMBER | |

| | | |
|----------|--|-----------------------------------|
| C | CONSULTING PHYSICIAN INFORMATION | |
| | PHYSICIAN'S NAME (LAST, FIRST, M.I.) | TELEPHONE NUMBER () - |
| | MAILING ADDRESS (STREET, CITY, ZIP CODE) | |
| | PHYSICIAN'S LICENSE NUMBER | |

| | |
|----------|---|
| D | ELIGIBILITY DETERMINATION |
| | <p>1. TERMINAL DISEASE</p> <hr/> <p>2. CHECK BOXES FOR COMPLIANCE:</p> <p><input type="checkbox"/> 1. Determination that the patient has a terminal disease.</p> <p><input type="checkbox"/> 2. Determination that patient is a resident of California.</p> <p><input type="checkbox"/> 3. Determination that patient has the capacity to make medical decisions**</p> <p><input type="checkbox"/> 4. Determination that patient is acting voluntarily.</p> <p><input type="checkbox"/> 5. Determination of capacity by mental health specialist, if necessary.</p> <p><input type="checkbox"/> 6. Determination that patient has made his/her decision after being fully informed of:</p> <p style="margin-left: 20px;"><input type="checkbox"/> a) His or her medical diagnosis; and</p> <p style="margin-left: 20px;"><input type="checkbox"/> b) His or her prognosis; and</p> <p style="margin-left: 20px;"><input type="checkbox"/> c) The potential risks associated with ingesting the requested aid-in-dying drug;</p> <p style="margin-left: 20px;"><input type="checkbox"/> d) The probable result of ingesting the aid-in-dying drug;</p> <p style="margin-left: 20px;"><input type="checkbox"/> e) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it</p> |

Appendix C (Cont'd)

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

| E ADDITIONAL COMPLIANCE REQUIREMENTS | |
|--------------------------------------|--|
| <input type="checkbox"/> | 1. Counseled patient about the importance of all of the following: |
| <input type="checkbox"/> | a) Maintaining the aid-in-dying drug in a safe and secure location until the time the qualified individual will ingest it; |
| <input type="checkbox"/> | b) Having another person present when he or she ingests the aid-in-dying drug; |
| <input type="checkbox"/> | c) Not ingesting the aid-in-dying drug in a public place; |
| <input type="checkbox"/> | d) Notifying the next of kin of his or her request for an aid-in-dying drug. (an individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason); and |
| <input type="checkbox"/> | e) Participating in a hospice program or palliative care program. |
| <input type="checkbox"/> | 2. Informed patient of right to rescind request (1 st time) |
| <input type="checkbox"/> | 3. Discussed the feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control. |
| <input type="checkbox"/> | 4. Met with patient one-on-one, except in the presence of an interpreter, to confirm the request is not coming from coercion |
| <input type="checkbox"/> | 5. First oral request for aid-in-dying: _____ / _____ / _____ Attending physician initials: _____ |
| <input type="checkbox"/> | 6. Second oral request for aid-in-dying: _____ / _____ / _____ Attending physician initials: _____ |
| <input type="checkbox"/> | 7. Written request submitted: _____ / _____ / _____ Attending physician initials: _____ |
| <input type="checkbox"/> | 8. Offered patient right to rescind (2 nd time) |

| F PATIENT'S MENTAL STATUS | |
|---|--|
| Check one of the following (required): | |
| <input type="checkbox"/> | I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder. |
| <input type="checkbox"/> | I have referred the patient to the mental health specialist**** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder. |
| <input type="checkbox"/> | If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder |
| Mental health specialist's information, if applicable: | |
| MENTAL HEALTH SPECIALIST NAME | |
| MENTAL HEALTH SPECIALIST TITLE & LICENSE NUMBER | |
| MENTAL HEALTH SPECIALIST ADDRESS (STREET, CITY, ZIP CODE) | |

Appendix C (Cont'd)

ATTENDING PHYSICIAN CHECKLIST &
COMPLIANCE FORM

| | | |
|----------|---|---------------------------|
| G | MEDICATION PRESCRIBED | |
| | PHARMACIST NAME | TELEPHONE NUMBER () - |
| | <p>1. Aid-in-dying medication prescribed:</p> <p><input type="checkbox"/> a. Name: _____</p> <p><input type="checkbox"/> b. Dosage: _____</p> <p>2. Antiemetic medication prescribed:</p> <p><input type="checkbox"/> a. Name: _____</p> <p><input type="checkbox"/> b. Dosage: _____</p> <p>3. Method prescription was delivered:</p> <p><input type="checkbox"/> a. In person</p> <p><input type="checkbox"/> b. By mail</p> <p><input type="checkbox"/> c. Electronically</p> <p>4. Date medication was prescribed: ____/____/____</p> | |

| | | | |
|--|----------|-----------------------|------|
| | X | PHYSICIAN'S SIGNATURE | DATE |
| | | NAME (PLEASE PRINT) | |

*** "Capacity to make medical decisions" means that, 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

***** "Mental Health Specialist" means a psychiatrist or a licensed psychologist.

Appendix D

(Sec Cal. Health & Safety Code § 443.22: Consulting Physician Compliance Form. The following form is required unless and until updated by the Medical Board of California. The California Department of Public Health must publish updated forms on its website upon completion.)

CONSULTING PHYSICIAN COMPLIANCE FORM

| | | |
|--|-----------------------------------|-----------------------------------|
| A PATIENT INFORMATION | | |
| PATIENT'S NAME (LAST, FIRST, M.I.) | DATE OF BIRTH | |
| B ATTENDING PHYSICIAN | | |
| ATTENDING PHYSICIAN'S NAME (LAST, FIRST, M.I.) | TELEPHONE NUMBER () - | |
| C CONSULTING PHYSICIAN'S REPORT | | |
| 1. TERMINAL DISEASE | DATE OF EXAMINATION(S) | |
| 2. Check boxes for compliance. <i>(Both the attending and consulting physicians must make these determinations.)</i> <input type="checkbox"/> 1. Determination that the patient has a terminal disease. <input type="checkbox"/> 2. Determination that patient has the mental capacity to make medical decisions.** <input type="checkbox"/> 3. Determination that patient is acting voluntarily. <input type="checkbox"/> 4. Determination that patient has made his/her decision after being fully informed of: <input type="checkbox"/> a) His or her medical diagnosis; and <input type="checkbox"/> b) His or her prognosis; and <input type="checkbox"/> c) The potential risks associated with taking the drug to be prescribed; and <input type="checkbox"/> d) The potential result of taking the drug to be prescribed; and <input type="checkbox"/> e) The feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control. | | |
| D PATIENT'S MENTAL STATUS | | |
| Check one of the following (required): <input type="checkbox"/> I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder. <input type="checkbox"/> I have referred the patient to the mental health specialist**** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder. <input type="checkbox"/> If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder | | |
| MENTAL HEALTH SPECIALIST'S NAME | TELEPHONE NUMBER () - | DATE |
| E CONSULTANT'S INFORMATION | | |
| X | PHYSICIAN'S SIGNATURE | |
| | DATE | |
| | NAME (PLEASE PRINT) | |
| | MAILING ADDRESS | |
| CITY, STATE AND ZIP CODE | | TELEPHONE NUMBER () - |

** "Capacity to make medical decisions" means that, 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

**** "Mental Health Specialist" means a psychiatrist or a licensed psychologist.

Appendix E

(See Cal. Health & Safety Code § 443.22: Attending Physician Follow-up Form. The following form is required unless and until updated by the Medical Board of California. The California Department of Public Health must publish updated forms on its website upon completion.)

ATTENDING PHYSICIAN FOLLOW-UP FORM

| |
|---|
| <p>The End of Life Option Act requires physicians who write a prescription for an aid-in-dying drug to complete this follow-up form within 30 calendar days of a patient's death, whether from ingestion of the aid-in-dying drug obtained under the Act or from any other cause.</p> <p>For the State Department of Public Health to accept this form, it must be signed by the attending physician, whether or not he or she was present at the patient's time of death.</p> <p>This form should be mailed or sent electronically to the State Department of Public Health. All information is kept strictly confidential.</p> <p>Date: ____/____/____</p> <p>Patient name: _____</p> <p>Attending physician name: _____</p> <p>Did the patient die from ingesting the aid-in-dying drug, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink?</p> <p><input type="checkbox"/> Aid-in-dying drug (lethal dose) → Please sign below and go to page 2. Attending physician signature: _____</p> <p><input type="checkbox"/> Underlying illness → There is no need to complete the rest of the form. Please sign below. Attending physician signature: _____</p> <p><input type="checkbox"/> Other → There is no need to complete the rest of the form. Please specify the circumstances surrounding the patient's death and sign. Please specify: _____ _____</p> <p>Attending physician signature: _____</p> <p>PART A and PART B should only be completed if the patient died from ingesting the lethal dose of the aid-in-dying drug.</p> <p>Please read carefully the following to determine which situation applies. Check the box that indicates the scenario and complete the remainder of the form accordingly.</p> <p><input type="checkbox"/> The attending physician was present at the <u>time of death</u>. → The attending physician must complete this form in its entirety and sign Part A and Part B.</p> <p><input type="checkbox"/> The attending physician was not present at the <u>time of death</u>, but another licensed health care provider was present. → The licensed health care provider must complete and sign Part A of this form. The attending physician must complete and sign Part B of the form.</p> <p><input type="checkbox"/> Neither the attending physician nor another licensed health care provider was present at the <u>time of death</u>. → Part A may be left blank. The attending physician must complete and sign Part B of the form.</p> |
|---|

Appendix E (Cont'd)

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART A: To be completed and signed by the attending physician or another licensed health care provider present at death:

1. Was the attending physician at the patient's bedside when the patient took the aid-in-dying drug?

☐ Yes

☐ No

If no: Was another physician or trained health care provider present when the patient ingested the aid-in-dying drug?

☐ Yes, another physician

☐ Yes, a trained health-care provider/volunteer

☐ No

☐ Unknown

2. Was the attending physician at the patient's bedside at the time of death?

☐ Yes

☐ No

If no: Was another physician or a licensed health care provider present at the patient's time of death?

☐ Yes, another physician or licensed health care provider

☐ No

☐ Unknown

3. On what day did the patient consume the lethal dose of the aid-in-dying?

____/____/____ (month/day/year) ☐ Unknown

4. On what day did the patient die after consuming the lethal dose of the aid-in-dying drug?

____/____/____ (month/day/year) ☐ Unknown

5. Where did the patient ingest the lethal dose of the aid-in-dying drug?

☐ Private home

☐ Assisted-living residence

☐ Nursing home

☐ Acute care hospital in-patient

☐ In-patient hospice resident

☐ Other (specify) _____

☐ Unknown

6. What was the time between the ingestion of the lethal dose of aid-in-dying drug and unconsciousness?

Minutes _____ and/or Hours _____ ☐ Unknown

7. What was the time between lethal medication ingestion and death?

Minutes _____ and/or Hours _____ ☐ Unknown

Appendix E (Cont'd)

ATTENDING PHYSICIAN FOLLOW-UP FORM

8. Were there any complications that occurred after the patient took the lethal dose of the aid-in-dying drug?

- ☐ Yes- vomiting, emesis
☐ Yes-regained consciousness
☐ No Complications
☐ Other- Please describe: _____
☐ Unknown

9. Was the Emergency Medical System activated for any reason after ingesting the lethal dose of the aid-in-dying drug?

- ☐ Yes- Please describe: _____
☐ No
☐ Unknown

10. At the time of ingesting the lethal dose of the aid-in-dying drug, was the patient receiving hospice care?

- ☐ Yes
☐ No, refused care
☐ No, other (specify) _____

Signature of attending physician present at time of death: _____

Name of Licensed Health Care Provider present at time of death if not attending physician: _____

Signature of Licensed Health Care Provider: _____

Appendix E (Cont'd)

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART B: To be completed and signed by the attending physician

12. On what date was the prescription written for the aid-in-dying drug? ____/____/____

13. When the patient initially requested a prescription for the aid-in-dying drug, was the patient receiving hospice care?

- ☐ Yes
☐ No, refused care
☐ No, other (specify) _____

14. What type of health-care coverage did the patient have for their underlying illness? (Check all that apply.)

- ☐ Medicare
☐ Medi-cal
☐ Covered California
☐ V.A.
☐ Private Insurance
☐ No insurance
☐ Had insurance, don't know type

15. Possible concerns that may have contributed to the patient's decision to request a prescription for aid-in-dying drug
Please check "yes," "no," or "Don't know," depending on whether or not you believe that concern contributed to their request (Please check as many boxes as you think may apply)

A concern about...

- His or her terminal condition representing a steady loss of autonomy
☐ Yes
☐ No
☐ Don't Know
- The decreasing ability to participate in activities that made life enjoyable
☐ Yes
☐ No
☐ Don't Know
- The loss of control of bodily functions
☐ Yes
☐ No
☐ Don't Know
- Persistent and uncontrollable pain and suffering
☐ Yes
☐ No
☐ Don't Know
- A loss of Dignity
☐ Yes
☐ No
☐ Don't Know
- Other concerns (specify): _____

Signature of attending physician: _____

**END OF LIFE OPTION ACT
PRESCRIPTION CONSENT FORM**

MRN:

Patient Name:

I _____ have requested an aid-in-dying medication from my
Attending Physician, Dr. _____, and we have completed the following
steps (*check each step completed*):

- ☐ Confirmed I am an adult California resident 18 years or older
- ☐ Confirmed I have a terminal illness (incurable, irreversible disease that, within reasonable medical judgment, will result in death within 6 months)
- ☐ Confirmed I have the capacity to make the decision to request an aid-in-dying drug
- ☐ Confirmed I have the physical capacity to self-administer and self-ingest the aid-in-dying drug
- ☐ Explored my reasons for requesting the aid-in-dying drug
- ☐ I have made 3 requests for an aid-in-dying drug, two oral and one in writing and I completed the "Request for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner"
- ☐ I have seen a Patient advocate and a Consulting physician who further considered my request
- ☐ I am aware of alternative treatment options including, but not limited to, comfort care, hospice care, palliative care, and pain control
- ☐ My physician met with me alone to confirm that I am making this decision voluntarily
- ☐ My physician made it clear that I can withdraw my request for the aid-in-dying drug

I understand that the aid-in-dying drug will almost certainly result in my death within minutes after I self-ingest it. But I also understand that there is a very small chance that I will not die. In order to receive the aid-in-dying drug, I agree to the following (*check each item*):

- ☐ I should very strongly consider notifying next of kin if I have not already done so
- ☐ I should consider participation in a hospice program if I am not enrolled
- ☐ I must maintain the aid-in-dying drug in a safe and secure location until used
- ☐ I must have another person present when I ingest the aid-in-dying drug
- ☐ I must not ingest the aid-in-dying drug in a public place
- ☐ I must self-administer the aid-in-dying medication as directed without assistance
- ☐ I will complete the **Final Attestation for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner** within 2 days before self-administering the drug, and return the form to my physician
- ☐ Unused aid-in-dying drug will be disposed of at the appropriate site.
- ☐ I may rescind the request at any time including not picking up the drug from the pharmacy.

MRN:

Patient Name:

**END OF LIFE OPTION ACT
PRESCRIPTION CONSENT FORM**

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner. I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

The medication will be picked up from the pharmacy by ☐ Me / ☐ the following person expressly designated to pick up the medication:

(Printed Name of Person)

Signature of Patient _____ Date _____ Time _____

Printed Name of Patient _____

Signature of Attending Physician _____ Date _____ Time _____

Printed Name of Physician _____