Is This The End of the End of Life Option Act?

The Suspension's Impact on Senior Care Providers

by Pamela S. Kaufmann

A New Development on the Subject (Update as of June 15th)
Click Here to Read »

A flurry of rulings during the last two weeks of May has generated enormous confusion regarding the status of California's two-year-old End of Life Option Act ("EOLOA"), the law that allows a terminally ill adult with a six-month prognosis to obtain aid-in-dying drugs from a physician, subject to numerous safeguards.

It started on May 15, when Judge Daniel Ottolia of the Riverside County Superior Court ruled in Ahn v. Hestrin that the EOLOA was procedurally invalid because it exceeded the scope of health care issues being considered at the legislative session in which it was passed. The State Attorney General (AG), Xavier Becerra, was given five days to file an emergency appeal, which he did on May 21. That appeal was rejected. Two days later, the Fourth District Court of Appeal denied a separate motion by the AG to suspend the ruling (and allow the EOLOA to stand) pending final resolution of this matter in the courts. At the same time, it ordered the plaintiffs to show cause why the court should not overturn the ruling in 25 days. Judge Ottolia finalized his ruling on May 25, and on May 30, he rejected a motion brought by Compassion & Choices on behalf of two terminally ill patients and a physician to reverse his ruling. He did, however, set a hearing for June 29 to consider the motion to vacate filed by the AG.

The outcome of these dizzying events (five hearings in 15 days) is that the EOLOA is, for now, suspended.

What does this mean for senior care residents who wish to exercise their rights under the EOLOA? What does it mean for senior care providers whose policies allow them to "participate" under the EOLOA? And what are the risks of "bending the rules" while the courts grapple with these difficult issues?

Let's start with the consequences. They are dire. Before passage of the EOLOA, taking drugs to end one's life prematurely was deemed suicide – and assisting a person in this process could be deemed homicide. Add to this several potential civil consequences, including invalidation of life insurance and other

insurance policies, and de-licensure of physicians and other health care providers who helped their patients obtain the drugs. The suspension of the EOLOA resurrects these consequences, at least until the courts decide that the EOLOA can stand (for now). Even if one believes that the courts will ultimately uphold the EOLOA or that state agencies will not prosecute or penalize participants, participating under the EOLOA at this uncertain time is risky. And it could be some time before the issues in Ahn v. Hestrin, which includes both procedural and substantive challenges to the EOLOA, are fully resolved.

To protect themselves, senior care providers should immediately address the following questions:

1. Do you "participate" under the EOLOA? In other words, do you act as the primary or consulting physician who vets the patient (and in the case of the primary care physician, prescribes the aid-in-dying drugs) or the mental health professional who may be brought in to confirm that the patient does not suffer from a mental health issue that impairs his judgment? Alternatively, do you attend the patient's ingestion of aid-in-dying drugs, deliver or dispense the drugs, or deliver the prescription for them? All of these acts of "participation" could, at least until the courts sort out Ahn v. Hestrin, be prosecuted as criminal acts.

The vast majority of providers I have counseled since the law was signed in October 2015 have opted not to participate. They have been religious and secular, conservative and liberal, single-site and multi-site. Most have been senior care and housing providers offering residential care, assisted living, skilled nursing, or continuing care. However, a handful of clients have carved out exceptions, such as allowing a chaplain to attend a resident's ingestion of aid-in-dying drugs. These providers should strongly consider discontinuing such practices until the suspension of the EOLOA is lifted.

2. Do you have residents who may opt to exercise their rights under the EOLOA at your community? If a care provider is a physician, hospice agency, or even a hospital, the patient has a reasonable option of ingesting the aid-in-dying drugs at home. However, for residents of senior care communities, the community is their home. In addition, residential care facilities for the elderly (aka assisted living facilities) are required by California law to protect the rights of their residents to store and ingest aid-in-dying drugs in their residential units.

Even if they do not "participate" under the EOLOA, these providers generally have EOLOA policies in place that encourage residents to inform them of their plans under the EOLOA to enable the provider to care plan to help assure the resident's comfort, privacy and dignity. Until the suspension of the EOLOA is lifted, it may be advisable to discontinue discussions with residents regarding their end-of-life plans – or at least to apprise them of the law's suspension and encourage them to talk with their families and physicians. While you are not personally responsible for imparting this information to residents, you also do not want to mislead them about the law's status or be accused of causing them to lose life or health insurance benefits. If a resident is midway through the process (e.g., he has been vetted by both physicians and has received the aid-in-dying drugs), this precaution is particularly critical.

3. Do you train your staff, contractors, and volunteers regarding your EOLOA policy? If you provide your EOLOA policy to staff, contractors, and/or volunteers, or if you train them regarding your policy, you may need to modify your approach. Until the courts lift the suspension of the EOLOA, you may wish to stop circulating the policy and suspend related training sessions. At a minimum, I would suggest inserting a brief warning about the suspended status in all documents that might refer to your EOLOA practices, such as your EOLOA policy, personnel policy, staff acknowledgment forms, and even your resident agreement and resident handbook.

What is next?

With luck, we will have a clearer sense of the future of the EOLOA by the end of June. Until then, it is critical that providers protect themselves and their employees by taking the precautions described above.

For more information, please contact:

Pamela S. Kaufmann, Partner
415-995-5043
pkaufmann@hansonbridgett.com