

**Case No. E070545**

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA  
FOURTH APPELLATE DISTRICT, DIVISION TWO

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**ATTORNEY GENERAL OF THE STATE OF CALIFORNIA,**

**XAVIER BECERRA, et al.,**

*Defendants/Intervenors and Petitioners,*

**v.**

**SUPERIOR COURT OF CALIFORNIA, COUNTY OF RIVERSIDE,**

*Respondent,*

**DR. SANG-HOON AHN, et al.,**

*Plaintiffs and Real Parties in Interest.*

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SUPERIOR COURT OF CALIFORNIA FOR THE COUNTY OF RIVERSIDE

CASE No. RIC1607135

HONORABLE DANIEL A. OTTOLIA, JUDGE, DEPT. 4

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*AMICUS CURIAE* BRIEF IN SUPPORT OF DEFENDANTS AND  
PETITIONERS ATTORNEY GENERAL OF THE STATE OF  
CALIFORNIA, XAVIER BECERRA et al.

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Simona G. Strauss (State Bar Number 203062)  
*Counsel for Death with Dignity National Center*  
Simpson Thacher & Bartlett LLP  
2475 Hanover Street  
Palo Alto, CA 94304  
Telephone: (650) 251-5000  
Fax: (650) 251-5002  
E-mail: sstrauss@stblaw.com

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## INTRODUCTION

The California Legislature is empowered to consider and enact laws during a special session if those laws are related to the subject of the proclamation calling the session. In 2015, Governor Brown issued a Proclamation calling for the Legislature to consider and enact laws that, *inter alia*, would improve the health of Californians and the efficacy of California's health care system. By providing for medical aid in dying for qualifying terminally ill persons, the resulting End of Life Option Act (the "Act") is constitutional because it relates to improving (and indeed has improved) (1) end-of-life health for many Californians and (2) the efficacy of California's end-of-life health care system.

*Amicus curiae* Death with Dignity National Center respectfully submits that the Act clearly relates to health care and the calls in the Governor's Proclamation. "Health care" includes end-of-life care, and the Act has provided eligible persons with access to another end-of-life care option beyond palliative care, hospice care, and other options of last resort. Even a cursory review of the Act's provisions confirms that it incorporates reliable indicia of health care, such as requiring a medical diagnosis, a patient-physician relationship, a second medical opinion, a patient's informed consent, and health-related regulatory oversight. The fact that health insurers, including but not limited to Medi-Cal, provide coverage for medical aid in dying is further evidence that the Act relates to health care.

A direct and foreseeable result of the Act is the relief it provides to many seriously ill Californians *even if they do not take the prescribed medication*. Indeed, the mere existence of the Act provides individuals with comfort that, should they qualify for medical aid in dying, they will be able to receive it, thereby maintaining control over their end-of-life care and decisions. The Act also has resulted in more comprehensive conversations between patients and health care providers about end-of-life

care in California. Significantly, these broader conversations have led to better use of end-of-life health care options that pre-existed the Act.

### **LEGAL STANDARD**

Legislation passed during a special session is constitutional if it concerns a “subject[] specified in the proclamation” that called the Legislature into session. (Cal. Const., art. IV, § 3, subd. (b).) To pass muster, the legislation need only address “matters relating to, germane to and having a natural connection with the subject” of the proclamation at issue. (*Sturgeon v. Cty. of Los Angeles* (2010) 191 Cal. App. 4th 344, 351, citation omitted, italics removed.)

Real Parties’ argument that a proclamation’s scope must be “confined to the [subjects] enumerated *in its preamble*,” Return, p. 30, italics added, is unsupported. The sole case on which they rely, *Kraus v. Trinity Management Services Inc.* (2000) 23 Cal. 4th 116, 140-41, was decided in the context of *statutes*, not proclamations, and also is silent as to any limitation imposed by preambles. The proposition is also flatly contradicted by long-established precedent holding that when the Governor submits a subject to the Legislature, he “opens for legislative consideration matters relating to, germane to and having a natural connection with the subject” designated in the proclamation. (*Martin v. Riley* (1942) 20 Cal. 2d 28, 39.) Moreover, “[a]ny matter of restriction or limitation becomes advisory or recommendatory only and not binding on the Legislature.” (*Id.*) As such, even if a proclamation’s preamble could be interpreted to “limit” the subjects the Legislature may consider, any such limitation would be merely advisory, and thus not relevant to the constitutionality of any laws that relate to the subject of the proclamation.

Significantly, legislation is considered unconstitutional and invalid only if the “[u]nconstitutionality [is] clearly, positively, and certainly shown.” (*Copley Press, Inc. v. Superior Court* (2006) 39 Cal. 4th 1272,

1302 [explaining that courts must “resolve doubts in favor of the statute’s validity”].) The opposite is true here.

## ARGUMENT

### **I. The End Of Life Option Act Is Constitutional Based On A Reasonable Interpretation Of The Governor’s Proclamation**

The Governor’s Proclamation directed the Legislature to consider and enact legislation relating to the subject of health care in California. Specifically, the Proclamation directed the Legislature in part to consider and act upon legislation to “[i]mprove the efficiency and efficacy of the health care system” and “improve the health of Californians.” (A Proclamation by the Governor of the State of California (herein “Proclamation”) (June 16, 2015) p. 2.) As explained below, the Act addresses matters relating to, germane to and having a natural connection with these subjects.

Real Parties’ attempt to limit the Proclamation to its more specifically enumerated subjects should be rejected. First, the Governor’s Proclamation was clear when the subject of an earlier call was to be considered in a later call. For example, one call was for the Legislature to consider legislation to “[e]stablish mechanisms so that *any additional* rate increases expand access to services.” (*Id.*, italics added.) The emphasized words reflect that the Governor intended the Legislature to consider rate increases with reference to, but beyond, those enumerated in earlier calls. Second, the Proclamation also was clear when a call was limited to a narrow subject matter. For example, one call, which Real Parties concede is “specific,” Return, p. 29, referred to “services provided to consumers with developmental disabilities.” (Proclamation, *supra*, at p. 2.) The next call, however, was significantly more broadly worded, referring not to the health of California consumers with developmental disabilities, but to the

“health of Californians.” (*Id.*) This Court should deny Real Parties’ effort to read nonexistent words into that call.

## **II. The End Of Life Option Act Is Related To The Health Care System And The Health Of Californians**

### **A. The Subject of the End of Life Option Act Is Health Care, Not “Decriminalizing Assisted Suicide”**

Respondent Superior Court held that “[g]iving terminally ill patients the right to request aid-in-dying prescription medication and decriminalizing assisted suicide for doctors prescribing such medications . . . does not fall within the scope of . . . improving the efficiency and efficacy of the healthcare system, or improving the health of Californians.” (Pet. Exh. 16, p. 401:12-19.) Real Parties attempt to distance medical aid in dying from health care by similarly referring to it as “assisted suicide” and suggesting that the Act’s purpose was to decriminalize such practices. (Return, p. 32.)

Characterizing medical aid in dying as suicide is incorrect and has been rejected by various health-related organizations. The American Public Health Association, for example, rejects the term “assisted suicide to refer to the choice of a mentally competent terminally ill patient to seek medications to bring about a peaceful and dignified death.” (American Public Health Association, Patients’ Rights to Self-Determination at the End of Life (Oct. 28, 2008) APHA Policy Statement No. 20086, <<https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/29/13/28/patients-rights-to-self-determination-at-the-end-of-life>> [as of July 16, 2018].) Similarly, the American Association of Suicidology has affirmed that “physician aid in dying is not suicide.” (American Association of Suicidology, Statement of the American Association of Suicidology: “Suicide” is not the same as

“Physician Aid in Dying” (Oct. 30, 2017) p. 4

<<http://www.suicidology.org/Portals/14/docs/Press%20Release/AAS%20PAD%20Statement%20Approved%2010.30.17%20ed%2010-30-17.pdf>> [as of July 16, 2018].) Rather, “[i]n suicide, a life that could have continued indefinitely is cut short. [Physician assisted dying] . . . is a matter of a foreseeable death occurring a little sooner but in an easier way, in accord with the patient’s wishes and values, vs. death later in a potentially more painful and protracted manner.” (*Id.* at p. 2.)

Indeed the Act itself emphasizes that ingesting medical aid-in-dying drugs is not suicide and that providing medical aid in dying is not assisted suicide. (Health & Saf. Code § 443.18 [“Actions taken in accordance with this part shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse under the law.”].)

The Act’s provisions related to criminal immunity for participation in medical aid in dying appear towards the end of the Act, further evidencing the law’s true focus on health care, not decriminalization. (Health & Saf. Code § 443.14, subd. (a).) Indeed, proposed legislation is currently being considered on the topic of immunity from prosecution for persons “whose actions are compliant with the provisions of the End of Life Option Act.” (Sen. Amend. to Assem. Bill No. 282 (2017-2018 Reg. Sess.) May 16, 2018.) Had “decriminalization” been the true subject of the Act, it would have been addressed more comprehensively therein.

As further discussed below, a “reasonable construction” of the language of the Proclamation confirms that the true subject of the Act – health care – was in fact “embraced” in the Proclamation. (*Martin v. Riley*, *supra*, 20 Cal. 2d at p. 40.) Any effect on the criminality of medical aid in dying was incidental to that health care focus.

## **B. Medical Aid in Dying Is Health Care**

### **1. The Act permits physicians to provide medical aid in dying as part of end-of-life health care**

“Health care” is defined as “any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a patient’s physical or mental condition.” (Prob. Code § 4615.) As such, end-of-life care is undoubtedly health care. (Singer et al., *Quality End-of-Life Care Patients’ Perspectives* (Jan. 13, 1999) JAMA, Vol. 281, No. 2, p. 163.) Further, as discussed below, medical aid in dying is but one of a variety of end-of-life health care options.

#### **(a) Palliative Care**

Palliative care is recognized as a subset of specialty health care. (Kelley & Morrison, *Palliative Care for the Seriously Ill* (Aug. 20, 2015) The New England Journal of Medicine, Vol. 373, Issue 8, p. 747.) While it initially focused on the care of the dying, it has expanded “to include not just dying patients, but also patients diagnosed with life-limiting illness.” (Loscalzo, *Palliative Care: An Historical Perspective* (Jan. 1, 2008) American Society of Hematology, Vol. 2008, No. 1, p. 465 <<http://doi.org/10.1182/asheducation-2008.1.465>> [as of July 16, 2018].)

Palliative care is a “broad umbrella that encompasses health care focused on comfort and reduction of symptoms, support for communication between patients, families, and health professionals, and assurance of continuity of care across settings.” (Ferrell et al., *The National Agenda for Quality Palliative Care: The National Consensus Project and the National Quality Forum* (June 2007) Journal of Pain and Symptom Management, Vol. 33, No. 6, p. 738.) Palliative care, or comfort care, generally begins after a diagnosis of a serious illness and can be provided at any stage of disease, whether terminal or not. In the context of end-of-life care, the

National Institute on Aging defines the goals of comfort care as “prevent[ing] or reliev[ing] suffering,” and “improv[ing] quality of life while respecting the dying person’s wishes.” (National Institute on Aging, *Providing Comfort at the End of Life* (2017) <<https://www.nia.nih.gov/health/providing-comfort-end-life>> [as of July 16, 2018].) Palliative care often includes pain management medication, “provided concordantly with all other disease-directed or curative treatments.” (Kelley, *supra*, at p. 747.)

(b) Hospice Care

Hospice care is a specialty program generally considered to fall within the field of palliative medicine. (Connor, *Hospice and Palliative Care: The Essential Guide* (3d ed. July 6, 2017) pp. 7-8.) Hospice programs “provide state-of-the-art palliative care and supportive services to individuals at the end of their lives, their family members, and significant others, 24 hours a day, seven days a week, in both the home and facility-based care settings.” (*Id.* at p. 2.) To qualify for hospice care, however, patients must (i) have a terminal illness and (ii) decide to forgo treatment of their underlying disease. (Crowley, *The Hospice Movement: A Renewed View of the Death Process* (1988) 4 J. Contemp. Health L. & Pol’y 302.)<sup>1</sup>

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<sup>1</sup> Although hospice is the main provider of palliative care in the United States, most patients who die are not enrolled in hospice because of the requirement that they discontinue treatment of their disease. (Quill, *Physician-Assisted Death in the United States: Are the Existing ‘Last Resorts’ Enough?* (2008) Hastings Center Report 38, no. 5, p. 18.)

(c) Options of last resort

Options of last resort are available when other palliative care is insufficient to address a patient’s intractable suffering.<sup>2</sup> These options include the following:

- Intensive pain and symptom management (*e.g.*, increasing opioid dosage)
- Forgoing life-sustaining therapy (including removal from life support, with Do Not Resuscitate (“DNR”) Orders)<sup>3</sup>
- Voluntarily stopping eating and drinking (“VSED”)
- Sedation to unconsciousness
- Physician-assisted death, or medical aid in dying

(Quill, *Physician-Assisted Death in the United States: Are the Existing ‘Last Resorts’ Enough?*, *supra*, at pp. 18-19, 21.)

As with all palliative care, each of these options is exercised with the involvement and support of medical professionals. For example, palliative sedation to unconsciousness requires the involvement of a “physician with expertise in palliative care leading the intervention.” (Kirk & Mahon, *National Hospice and Palliative Care Organization Position Statement and Commentary on the Use of Palliative Sedation in Imminently Dying Terminally Ill Patients* (May 2010) *Journal of Pain and Symptom Management*, Vol. 39, No. 5, p. 915.) Similarly, VSED “needs to be ‘physician-supported’: the patient must be assessed at the outset to ensure

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<sup>2</sup> Whether considered “palliative care,” (Blinderman & Billings, *Comfort Care for Patients Dying in the Hospital* (Dec. 24, 2015) *The New England Journal of Medicine*, Vol. 376, Issue 26, p. 2559), or simply end-of-life care, the recognized legal options of last resort are “health care.”

<sup>3</sup> As provided in Section 4650, subdivision (a) of the Probate Code, “the law recognizes that an adult has the fundamental right to control the decisions relating to his or her own health care, including the decision to have life-sustaining treatment withheld or withdrawn.”

that he or she is competent and has adequate palliative care, and the physician must help the patient and family address any unforeseen complications as the process unfolds.” (Quill, *Physician-Assisted Death in the United States: Are the Existing ‘Last Resorts’ Enough?*, *supra*, at p. 19.) The same holds true for medical aid in dying.

## 2. Medical aid in dying incorporates reliable indicia of a health care practice

Indicia commonly associated with health care are reflected in the Act’s medical aid-in-dying provisions.

First, the Act not only contemplates, but requires, that a patient receive a formal *medical diagnosis* of a “terminal disease” before being eligible for aid-in-dying medication. (Health & Saf. Code § 443.2, subd. (a)(1).)<sup>4</sup>

Second, medical aid in dying is achieved only in the context of a *patient-physician relationship*. Indeed, before receiving an aid-in-dying prescription, a patient must make two oral requests and one written request “to his or her attending physician.” (Health & Saf. Code § 443.3, subd. (a).) The Act defines “attending physician” as “the physician who has primary responsibility for [1] the health care of an individual and [2] treatment of the individual’s terminal disease.” (*Id.* § 443.1, subd. (c).) As such, the Act builds upon a pre-existing patient-physician relationship that arose in connection with the treatment of the terminal disease.<sup>5</sup>

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<sup>4</sup> A “terminal disease” is defined as “an incurable and irreversible disease that has been *medically confirmed* and will, *within reasonable medical judgment*, result in death within six months.” (Health & Saf. Code § 443.1, subd. (q), italics added.)

<sup>5</sup> The Act does not require physicians to participate in providing medical aid in dying, however. Rather, the Act provides that “[p]articipation in activities authorized pursuant to this part *shall be voluntary*.” (Health &

Third, the Act requires a consulting physician to confirm the attending physician’s diagnosis, essentially requiring a *second medical opinion* on the patient’s terminal disease. (Health & Saf. Code § 443.5, subd. (a)(3) [stating that attending physician must “[r]efer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis”].) The Act defines “consulting physician” as “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.” (*Id.* § 443.1, subd. (f).) To provide this confirmation, the consulting physician must examine the individual and review the relevant medical records. (*Id.* § 443.6.) As such, the Act requires a second opinion, a common aspect of health care—indeed, approximately one in six patients seek a second medical opinion. (Payne et al., *Patient-Initiated Second Opinions: Systematic Review of Characteristics and Impact on Diagnosis, Treatment, and Satisfaction* (May 2014) Mayo Clinic Proceedings, Vol. 89, Issue 5, p. 687.)

Fourth, the Act requires the patient’s *informed consent* about his or her medical condition and treatment options, including risks. The Act explicitly requires that the attending physician and the patient discuss, among other things, all of the following topics:

- His or her medical diagnosis and prognosis.
- The potential risks associated with ingesting the requested aid-in-dying drug.
- The probable result of ingesting the aid-in-dying drug.

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Saf. Code § 443.14, subd. (e)(1), italics added.) Thus, “a person or entity that elects, for reasons of conscience, morality, or ethics, not to engage in activities authorized pursuant to this part *is not required to take any action in support of* an individual’s decision under this part.” (*Ibid.*, italics added.)

- The possibility that he or she may choose to obtain the aid-in-dying drug but not ingest it.
- The feasible alternatives or additional treatment options, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

(Health & Saf. Code § 443.5, subd. (a)(2); see also *id.* § 443.10 [emphasizing that “[a] qualified individual may not receive a prescription for an aid-in-dying drug . . . unless he or she has made an informed decision”].) Significantly, and as discussed below, *infra* 22-25, one of the Act’s requirements of informed consent is a discussion of “additional treatment” and other palliative health care options. (*Id.* § 443.5, subd. (a)(2).) Medical informed consent is indicative of a health care practice. (Grady, *Enduring and Emerging Challenges of Informed Consent* (Feb. 26, 2015) *The New England Journal of Medicine*, Vol. 372, Issue 9, p. 855.) In many states, including California, it is codified. (Paterick et al., *Medical Informed Consent: General Considerations for Physicians* (March 2008) *Mayo Clinic Proceedings*, Vol. 83, No. 3, p. 318; see also, e.g., Health & Saf. Code § 1690, subd. (a) [informed consent required for hysterectomy].)

Fifth, the medical professionals involved in the provision of medical aid in dying are subject to ***oversight by various California public health agencies and medical boards***. The attending physicians and consulting physicians involved with medical aid in dying, for example, are regulated by the Medical Board of California. Similarly, the pharmacists who prescribe aid-in-dying medication are regulated by the California State Board of Pharmacy. Moreover, the California Department of Public Health is involved in various stages of the procedures performed under the Act (*e.g.*, reviewing the compliance forms and checklists submitted by physicians involved in medical aid in dying). (Health & Saf. Code § 443.19, subsd. (a), (b); *id.* § 443.9.)

### 3. Medical aid in dying is covered by health insurance

Finally, many health insurance plans cover medical aid in dying, further confirming that it is health care. For example, Medi-Cal provides health insurance coverage for costs associated with medical aid in dying, including the following:

- Office visits in which the patient makes an oral and/or written request to the attending physician for an aid-in-dying drug.
- Office visits with a consulting physician to confirm the patient's diagnosis and life expectancy.
- End-of-life prescription drugs.
- Psychiatrist or licensed psychologist office visits made in connection with aid in dying.

(Medi-Cal, End of Life Option Act Services (Sept. 2016) at p. 2

<[https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/eloa\\_m01o03a07p00.doc](https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/eloa_m01o03a07p00.doc)> [as of July 11, 2018].)

Medi-Cal provides extensive policy guidelines and billing codes for its healthcare procedures and prescriptions. (*Id.* at p. 13.) For example, Medi-Cal instructs attending and consulting physicians to bill consultations about medical aid in dying under HCPCS (the Healthcare Common Procedure Coding System) code S0257 (which refers to “counseling and discussion regarding advance directives or end of life care planning and decisions, with patient”), with an ICD-10-CM (the International Classification of Diseases, Tenth Revision, Clinical Modification) code of Z76.89 (which refers to “persons encountering health services in other specified circumstances”). (*Ibid.*) Other billing codes are provided for the

multiple other steps laid out in the Act, including codes for diagnosing, assessing, evaluating mental competence, and filling prescriptions. (*Ibid.*)<sup>6</sup>

**C. The Act Has Improved the Health of Californians and the Efficacy of California’s Health Care System with Respect to End-of-Life Health Care**

Opponents focusing solely on the narrow question of whether ingestion of aid-in-dying medication improves a patient’s health miss the Act’s purpose and benefits. The mere *existence* of the Act and the ability of terminally ill patients to obtain life-ending medication has improved the health of Californians, in part as a result of more comprehensive discussions about and access to quality end-of-life care in California.<sup>7</sup>

**1. The existence of the Act has provided emotional relief to many seriously ill Californians**

The Act has improved the well-being of seriously ill Californians by providing them with the comfort of knowing that, should they be diagnosed with a terminal illness, they can choose to seek life-ending medication. As one researcher explained, “[w]hen terminally-ill people are given the option

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<sup>6</sup> Most private health insurance providers also cover costs for medical aid in dying, including physician visits and medications, “because it is an established medical practice that meets the standard of care.” (Grube et al., *Insurance Coverage and Aid-in-Dying Medication Costs, To the Editor* (August 2017) *JAMA Oncology*, Vol. 3, No. 8, p. 1137.) Indeed, “Blue Cross, Blue Shield of California, Kaiser Permanente and Health Net have all confirmed that their plans will pay for the drugs.” (LeBlanc et al., *California’s New End of Life Option Act Impacts Insurers* (Oct. 10, 2016) *JDSUPRA* <<https://www.jdsupra.com/legalnews/california-s-new-end-of-life-option-act-42437/>> [as of July 15, 2018].)

<sup>7</sup> Moreover, an act passed during a special session is constitutional if its *goals* fall within the Governor’s proclamation, even if it does not in fact achieve those goals. (*Sturgeon v. Cty. of Los Angeles, supra*, 191 Cal. App. 4th at p. 352.)

of legally *hastening* death, they often feel a sense of greater wellbeing and a desire to live *longer*.” (Lee, *The Oregon Paradox* (Apr. 2010) *The Journal of Socio-Economics*, Vol. 39, Issue 2, p. 205.) In other words, their spirits improve.

These therapeutic effects are reflected by the fact that, when given the option, not all terminally-ill persons who receive a medical aid-in-dying prescription decide to use it.<sup>8</sup> Of the 577 Californians who were prescribed aid-in-dying drugs in 2017, for example, only 363, or 62.9%, chose to ingest it. (Cal. Dept. of Public Health, *California End of Life Option Act 2017 Data Report* (June 2018) p. 3.) According to a recent Kaiser study, the principal reasons patients considered medical aid in dying were “existential suffering, inability to enjoy life, and loss of autonomy.” (Nguyen et al., *Characterizing Kaiser Permanente Southern California’s Experience With the California End of Life Option Act in the First Year of Implementation* (Dec. 26, 2017) *JAMA Internal Medicine*, p. E4 <doi:10.1001/jamainternmed.2017.7728> [as of July 16, 2018].) Whether or not a terminally ill patient chooses to ingest the medication, the mere fact that he or she has the ability to do so and thus control end-of-life decisions (*i.e.*, regain autonomy to some extent) gives the patient peace of mind. As one cancer patient explained, “Now [that medical aid in dying is an option,] I am filled with contentment and peace I simply did not have when the law was tied up in the courts.” (Lee, *supra*, at p. 205.)

California’s experience is not unique with respect to reports of improved well-being resulting from the legalization of the option. As an example, Oregon in 1997 enacted the Death with Dignity Act, which has

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<sup>8</sup> The Act explicitly provides that a patient can choose not to take a medical aid-in-dying drug after it is prescribed. (Health & Saf. Code § 443.4, subd. (a) [explaining that the patient can “decide not to ingest an aid-in-dying drug”].)

served as a model for other states' medical aid in dying laws, including California's. (The Los Angeles Times Editorial Board, California's right-to-die law is working (Apr. 5, 2018) <<http://www.latimes.com/opinion/editorials/la-ed-expand-assisted-suicide-20180405-story.html>> [as of July 15, 2018].) Like California, Oregon has a similar "gap between the number of persons requesting the medications and the number of those who ultimately use it." (Cain, *Implementing Aid in Dying in California: Experiences from Other States Indicates the Need for Strong Implementation Guidance* (May 2016) UCLA Center for Health Policy Research, p. 2 <<https://healthpolicy.ucla.edu/publications/Documents/PDF/2016/AID-brief-may2016.pdf>> [as of July 16, 2018] [opining that the option of medical aid in dying "may provide comfort, thereby improving quality of life, even if the individual chooses not to ingest the medication"].) Research into this gap suggests that some patients seek medical aid-in-dying drugs for purposes of maintaining some control over the dying process. (Weir, *Assisted dying: The motivations, benefits and pitfalls of hastening death* (Dec. 2017) CE Corner, Vol. 48, No. 11, p. 26.) Having the option to access medical aid-in-dying drugs "allow[s] the person to focus on the quality of life that remains rather than fear of future suffering." (*Id.*) Oregon's experience suggests that people requesting medical aid in dying do so "to maintain independence and control, minimise dependence on others, and die at home." (Ganzini, *Legalised Physician-Assisted Death in Oregon* (Mar. 11, 2016) 16 QUT L.Rev. 80.)

## **2. The Act has improved discussions about and access to all end-of-life care options**

Before the Act was implemented, although 89% of people believed that doctors should discuss end-of-life care with their patients, only 17% had had such a conversation. (DiJulio et al., Kaiser Health Tracking Poll:

September 2015 (Sept. 30, 2015) Kaiser Family Foundation <<https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-september-2015/>> [as of July 15, 2018].) The Act has increased the frequency of these conversations. (Karlamaña, *There's an unforeseen benefit to California's physician-assisted death law* (Aug. 21, 2017) Los Angeles Times <<http://www.latimes.com/health/la-me-end-of-life-care-20170821-htmstory.html>> [as of July 15, 2018].)

Significantly, while the Act may have triggered many of those discussions, the focus of the discussions was not exclusively on medical aid in dying. Indeed, one year after the Act was passed, Dr. Neil Wenger, the director of the UCLA Health Ethics Center, remarked that the Act “has created a new standard for how we ought to be helping people at the end of life.” (Karlamaña, *supra*.) A Stanford Hospital case study showed that some patients who raised the topic of medical aid in dying with their physicians chose not to pursue that option after more comprehensive discussions about other palliative care options. (Harman et al., *Early Experience With the California End of Life Option Act Balancing Institutional Participation and Physician Conscientious Objection* (May 22, 2017) JAMA Internal Medicine, p. E2 <[doi:10.1001/jamainternmed.2017.1485](https://doi.org/10.1001/jamainternmed.2017.1485)>.)

The increased frequency of comprehensive end-of-life discussions was not an accident. As part of the planning for implementation of the Act, participants in the End of Life Option Act Response Conference noted the law's benefits in pushing doctors to learn more about palliative care and their patients' end-of-life care desires.<sup>9</sup> The conclusion was that

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<sup>9</sup> The End of Life Option Act Response Conference took place in December 2015 with over one hundred participants, including California health care providers from multiple disciplines, to discuss important issues with implementing the Act. (Petrillo et al., *How California Prepared for*

“improving palliative care for patients at the end of life should be an integral part of implementation of [physician assisted death].” (Petrillo, *supra*, at p. 886.) Moreover, physicians were encouraged to be more open to discussion about end-of-life care because it “improves the therapeutic alliance and alleviates distress.” (*Ibid.*)

Similar results were observed in other states with legalized medical aid in dying. As one palliative care expert explained, “[I]egalization of [physician assisted death] has also been a wake-up call for physicians, who now frequently attend palliative care and hospice training programs knowing that they must be experts at basic palliative care if they are to be responsive to the more challenging patients who want to discuss PAD [physician-assisted death].” (Quill, *Physicians Should ‘Assist in Suicide’ When it is Appropriate* (2012) 40 J.L. Med. & Ethics 61.) In Oregon, for example, within a few years after its Death with Dignity Act was passed, 76% of physicians reported “they had made efforts to improve their knowledge of the use of pain medications ‘somewhat’ or a ‘great deal.’” (Ganzini, *supra*, at p. 80.)

The increased discussion about comprehensive end-of-life options following the Act’s passage is consistent with the increased awareness of – and use of – palliative care options, including hospice. The 2017 California Department of Public Health report on the End of Life Option Act reflects that over 83 percent of persons who took medical aid-in-dying drugs were receiving hospice or other palliative care at the time. (Cal. Dept. of Public Health, *supra*, at p. 3.) This figure mirrors years’ worth of data from Oregon. The Oregon Health Authority’s 2017 report shows that over ninety percent of Oregonians who took medical aid-in-dying drugs were

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*Implementation of Physician-Assisted Death: A Primer* (June 2017)  
American Journal of Public Health, Vol. 107, No. 6, p. 886.)

enrolled in hospice care. (Oregon Health Authority Public Health Division, Oregon Death with Dignity Act 2017 Data Summary (March 2018) p. 6.) Additionally, a study of hospice use in the United States in 2011 showed that Oregon was the only state that was at the same time “in the highest quartile of overall hospice use and the lowest quartile for potentially concerning patterns of hospice use,” such as “very short hospice enrollment, very long hospice enrollment, or hospice disenrollment.” (Wang et al., *Geographic Variation of Hospice Use Patterns at the End of Life* (Sept. 2015) *Journal of Palliative Medicine*, Vol. 18, No. 9, pp. 774-75.)<sup>10</sup> The study suggested that Oregon’s Death with Dignity Act was responsible for this outcome because it had “resulted in or at least reflects more open conversation and careful evaluation of end-of-life options, more appropriate palliative care training, and more efforts to reduce barriers to access to hospice care.” (*Id.* at p. 778.)

Thus, the existence of medical aid in dying legislation was not a substitute for hospice or other palliative care options but instead was a catalyst for discussions about – and access to – these other health care options.

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<sup>10</sup> A recent *New England Journal of Medicine* report reflected that terminal patients used hospice at home in Oregon more than in any other state. (Tolle & Teno, *Lessons from Oregon in Embracing Complexity in End-of-Life Care* (2017) *The New England Journal of Medicine*, Vol. 376, Issue 11, p. 1078.)

**CONCLUSION**

*Amicus curiae* Death with Dignity National Center respectfully requests that the Court grant Petitioners' First Amended Petition for Writ of Mandate and/or Prohibition or Other Appropriate Relief and reverse the Superior Court's judgment.

Respectfully submitted,

/s/ Simona G. Strauss

Simona G. Strauss

*Counsel for Death with Dignity  
National Center*

Simpson Thacher & Bartlett LLP

2475 Hanover Street

Palo Alto, CA 94304

Telephone: (650) 251-5000

Fax: (650) 251-5002

E-mail: [sstrauss@stblaw.com](mailto:sstrauss@stblaw.com)

**CERTIFICATE OF WORD COUNT**  
**(Cal. Rules of Court, rule 8.204, subdivision (c)(1))**

I certify that the text of this amicus curiae brief consists of 5,049 words as counted by the Microsoft Word version 2013 word processing program used to generate this brief.

Dated: July 18, 2018

                  /s/ Simona G. Strauss                    
Simona G. Strauss  
*Counsel For Amicus Curiae*  
Death with Dignity National Center

**PROOF OF SERVICE**

I, Simona G. Strauss, declare:

That I am, and was at the time of the service of the papers herein referred to, over the age of eighteen years, and not a party to the within action; and I am employed in the County of Santa Clara, California, within which county the service occurred. My business address is 2475 Hanover Street, Palo Alto, California, 94304. I served the within

- **AMICUS CURIAE BRIEF IN SUPPORT OF DEFENDANTS AND PETITIONERS ATTORNEY GENERAL OF THE STATE OF CALIFORNIA, XAVIER BECERRA et al.**

by electronically filing through TrueFiling the foregoing with the Fourth District Court of Appeal, Division Two and served via the TrueFiling system a copy of the foregoing on all parties, including:

Party	Attorneys
Attorney General of the State of California, Petitioner	Darrell Warren Spence Office of the Attorney General 1300 I Street, Suite 125 P.O. Box 944255 Sacramento, CA 94244-2550
California Department of Public Health, Petitioner	Darrell Warren Spence Office of the Attorney General 1300 I Street, Suite 125 P.O. Box 944255 Sacramento, CA 94244-2550
Dr. Sang-Hoon Ahn, Real Party in Interest	Stephen G. Larson Larson O'Brien LLP 555 S. Flower St., Ste. 4400 Los Angeles, CA 90071
Michael Hestrin, Real Party in Interest	Kelly Catlett, SDDA Riverside County District Attorney's Office 3960 Orange Street Riverside, CA 92501

