Case No. 24-02751

United States Court of Appeals for the Ninth Circuit

UNITED SPINAL ASSOCIATION et al.

Plaintiffs-Appellants,

v.

STATE OF CALIFORNIA et al.

Defendants-Appellees.

On Appeal from the United States District Court,
Central District of California,
Case No. 2:23-cv-03107 FLA(GJS),
Hon. Fernando L. Aenlle-Rocha

APPELLANTS' OPENING BRIEF

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INTRODUCTION

California's End of Life Option Act ("EOLOA" or "the Act") perpetuates a long-standing and pervasive prejudice that people with serious disabilities are leading lives not worth living. In California, when a non-disabled person utters a wish to kill himself, state and local agencies respond with a full spectrum of suicide prevention services. When a person with a life-threatening disability expresses a wish to die, a doctor can assist them in ending their life within 48 hours of meeting them.

The Plaintiffs are two individuals with disabilities that would result in their deaths without treatment, and four disability rights organizations that are dedicated to eradicating the stereotype that persons with some disabilities are better off dead. The Plaintiffs brought four claims for relief:

(1) Violations of the Americans with Disabilities Act,

(2) Violations of the Rehabilitation Act of 1974,

(3) Violations of the Equal Protection Clause of the Fourteenth Amendment,

(4) Violations of the Due Process Clause of the Fourteenth Amendment.

The Defendants moved to dismiss. The district court, without a hearing, granted the motions in full without leave to amend. The district court erred as to the First and Second Claims for relief by holding as a matter of law that the Americans with Disabilities Act ("ADA") and Rehabilitation Act do not reach

discrimination in access to programs and services where access includes an element of voluntary choice by the plaintiff. The district court erred as to the Third Claim for Relief by ruling as a matter of law that persons with life-threatening illnesses are fundamentally different from other persons who face pain and suffering, and that the government may therefore treat them differently for purposes of laws regarding assisted suicide and suicide prevention. The district court erred as to the Fourth Claim for Relief by ruling as a matter of law that Plaintiffs have no fundamental right to protection of laws regarding suicide prevention, and that the procedural protections of EOLOA are adequate to prevent suicides caused by depression, financial pressures, and undue influence of others. The court erred as to the First, Second, and Third Claims for Relief by ruling as matter of law that discrimination in the application of criminal laws regarding suicide prevention does not violate the ADA, Section 504, or the Equal Protection Clause.

The district court also erred in holding that the two individual plaintiffs lacked standing to challenge EOLOA on the grounds that they are not eligible for assisted suicide under the district court's construction of the Act.

This district court erred in denying leave to amend, and in staying discovery during the pendency of the motions to dismiss.

DISCLOSURE STATEMENT

United Spinal Association, Not Dead Yet, Institute for Patient Rights, and Communities Actively Living Independent and Free have no parent corporations and no publicly held corporations owning 10% or more of their stock.

JURISDICTIONAL STATEMENT

The district court had jurisdiction over claims arising under the United States Constitution and 42 U.S.C. § 1983 pursuant to 28 U.S.C. §§ 1331 and 1343(a)(3). It issued an order granting Defendants' motions to dismiss. Plaintiffs filed a notice of appeal on that order on April 24, 2024. On June 13, 2024, this Court granted Plaintiffs-Appellants' streamlined request for extension of time to file its opening brief to July 17, 2024. This Court has jurisdiction under 28 U.S.C. § 1291, which provides for appeals from all final decisions of district courts.

STATEMENT OF ISSUES

(1) Whether Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act apply to discrimination in government services, programs, or activities, where access to the services, programs, or activities is voluntary.

(2) Whether Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act permit a State to establish a two-track system of suicide prevention services, with one track for persons with certain disabilities, and a separate track for everyone else.

(3) Whether the Equal Protection Clause of the Fourteenth Amendment permits a State to establish a two-track system of suicide prevention services, with one track for persons with life-threatening disabilities, and a separate track for others considering suicide.

(4) Whether the Due Process Clause of the Fourteenth Amendment recognizes protection of life as a fundamental interest under substantive due process, and whether the district court erred in failing to address whether persons at risk of suicide can challenge a State's assisted suicide laws as a violation of substantive due process.

(5) Whether the procedural safeguards of the EOLOA are adequate as a matter of procedural due process under the Due Process Clause of the Fourteenth Amendment to avoid loss of life by suicide caused by depression, financial pressures, undue outside influence, or other causes not sanctioned by EOLOA.

(6) Whether the district court erred in denying individual standing to challenge EOLOA by construing the statute to add a non-textual eligibility criteria that takes the individual Plaintiffs out of the ambit of the statute.

(7) Whether the district court erred in denying individual standing to challenge EOLOA by dismissing Plaintiffs' asserted injury as speculative despite the individual Plaintiffs' allegations of direct experiences of being steered away from further treatment and toward suicide, and the direct injuries resulting

therefrom.

(8) Whether the district court erred in denying leave to amend after dismissing under Rules 12(b)(1) and 12(b)(6) with no analysis of whether amendment would be futile.

(9) Whether the district court erred in staying discovery pending a motion to dismiss where the motion to dismiss raised factual questions that cannot be resolved on the pleadings.

STATEMENT OF THE CASE

I. PLAINTIFFS-APPELLANTS ARE TWO INDIVIDUALS WHOSE LIVES ARE PUT AT RISK BY EOLOA, JOINED BY FOUR ORGANIZATIONS THAT SEEK TO PREVENT THE DEVALUATION OF DISABLED PEOPLE'S LIVES.

The individual Plaintiffs-Appellants are Lonnie VanHook and Ingrid Tischer. Both Mr. VanHook and Ms. Tischer live with very substantial physical impairments, and have conditions that would lead to their deaths within six months without life-sustaining care. 3-ER-301-03. Both Mr. VanHook and Ms. Tischer presently desire to live. 3-ER-302-04. Both, however, have faced many obstacles securing and maintaining the level of medical and home care supports that they need, and in the face of such challenges, have considered giving up and requesting assisted suicide. *Id.*

United Spinal Association ("United Spinal") is a national non-profit organization dedicated to empowering and advocating for people living with spinal

cord injuries and disorders, and all wheelchair users, to obtain greater independence and quality of life. 3-ER-294. United Spinal's work includes helping individuals who receive erroneous "terminal" diagnoses by doctors steering them away from the services and supports needed to live with a spinal cord injury. 3-ER-295.

Not Dead Yet ("NDY") is a national disability rights organization that organizes and articulates the disability rights opposition to legalization of physical assisted suicide, and opposes public policies in healthcare that devalue the lives of persons with disabilities. 3-ER-296.

Institute for Patient Rights ("IPR") is a national organization that conducts and supports research and public education on disparities in end-of-life healthcare. 3-ER-297. IPR advocates against standards of care that discriminate on the basis of race, age, and disability, and advocates for improvements in the quality of and access to hospice and palliative care services. 3-ER-297-98.

Communities Actively Living Independent and Free ("CALIF") is a non-profit community-based independent living center based in Los Angeles, California. 3-ER-299. CALIF provides direct services in the areas of assistive technology, applications for public services or benefits, housing advocacy, systems change advocacy, peer counseling, training, access to state-funded In Home Supportive Services, access to long term care services, and access to a range of

other services that allow people with disabilities to remain in their homes. 3-ER-299-300.

II. THE DEFENDANTS-APPELLEES ARE STATE AND LOCAL ENTITIES, AND OFFICIALS, CHARGED WITH ADMINISTERING EOLOA, AS WELL AS THE OVERALL SYSTEM OF PUBLIC HEALTH AND SUICIDE PREVENTION.

The Defendants-Appellees include the State of California, the state's elected governor and attorney general, the state Department of Public Health as well as its director, the state Department of Health Care Services as well as its director, the state Mental Health Services Oversight and Accountability Commission ("MHSOAC") and its chair, the Medical Board of California ("MBC") and its president (collectively "State Defendants"). 3-ER-304-07. The Defendants-Appellees also include the Los Angeles County District Attorney's Office and the Los Angeles County District Attorney. 3-ER-308.

All of the Defendants have responsibilities for enforcing not only the EOLOA, but also other laws and state programs that together function to provide two levels of government-run suicide prevention: one for people with life-threatening disabilities and another for everyone else.

III. EOLOA WAS ENACTED IN 2016, AND AMENDED TO MAKE ASSISTED SUICIDE EASIER TO OBTAIN IN 2021.

The End of Life Option Act ("EOLOA") was signed into law in 2015, and went into effect in 2016. 3-ER-288. The EOLOA is codified in the California

Health & Safety Code at Sections 443 - 443.22. A copy of the statute is attached hereto as an Addendum, as required by Circuit Rule 28-2.7. The EOLOA allows a physician to provide any qualifying patient with drugs necessary to kill themselves, if the patient makes two oral requests a minimum of 48 hours apart, plus a written request on a statutory form. 3-ER-364. The physician need not be the patient's treating doctor or someone the patient has ever seen before. 3-ER-361. The doctor does not need to see the patient at all—the Act allows all evaluation and prescription of lethal medication to happen via telehealth. *Id.* The physician may not administer the drugs; the law states that the patient must self-administer but does not provide for oversight at the time of administration. 3-ER-359-60.

Before providing the lethal drugs, the physician must confirm that the patient has an "incurable and irreversible" disease that will "result in death in six months," that the patient has "voluntarily" requested the drugs, and has "the physical and mental ability to self-administer the aid-in-dying drug." Sections 443.1, 443.2. The statute also directs the physician to determine that the patient has capacity to make medical decisions, though it provides no standards for doctors to follow. Section 443.5(a)(1)(A)(i). The Act directs doctors to advise the patient of alternative treatment options, but the requirement is only to "discuss" what is "feasible," not actually offer options such as hospice, mental health treatment, and palliative care. Section 443.5(a)(2)(E). The Act also requires doctors to advise the

patient of the risks and results associated with taking the lethal drug and to confirm that the patient's request did not result from undue influence, but the Act has no standard to determine what is duress or undue influence. Section 443.5(a)(4). The attending doctor must refer the patient to a consulting physician to confirm the terminal diagnosis and decision-making capacity. Section 443.5(a)(3). The Act does not require a mental health assessment for the patient requesting assisted suicide. Referral to a mental health specialist is only required if "there are indications of a mental disorder." Section 443.5(a)(1)(A)(ii). As originally enacted, EOLOA required a 15-day waiting period between the two oral requests for lethal drugs. 3-ER-364. In 2021, the law was amended to shorten the waiting period to 48 hours and remove the requirement for a final attestation by the patient affirming their choice before self-administering the drugs. *Id.*; Section 443.3(a).

The EOLOA shields doctors from criminal prosecution, civil liability, and discipline by the Medical Board of California ("MBC"). Assisting suicide is a crime. 3-ER-340. A follow-on law amended the California Penal Code to prohibit criminal prosecution of a "health care provider or a health care entity" who provides a lethal prescription to a patient under EOLOA. *Id.*; Cal. Penal Code § 401(a). EOLOA prevents any investigation of its misuse. Any information collected pursuant to the Act "shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding." Section

443.19(a); 3-ER-341-42. The Act prohibits the MBC from disciplining doctors for their roles in prescribing lethal drugs under EOLOA, despite its usual responsibility to revoke the license of a doctor who negligently or intentionally kills a patient. Section 443.14(c); 3-ER-337. MBC will not provide information about whether a doctor has any investigations or complaints regarding EOLOA. 3-ER-338.

IV. FOR NON-DISABLED PEOPLE, STATE AND LOCAL DEFENDANTS OPERATE ROBUST SYSTEMS OF SUICIDE PREVENTION.

Defendant CDPH considers suicide to be "a major public health concern in California" and takes the position that "[o]ne life lost to suicide is too many." 3-ER-310-11, 3-ER-332. The State has taken various efforts designed to prevent suicide in the broader community. The law empowers law enforcement and mental health professionals to place people on a 72-hour hold under California's Welfare & Institutions Code section 5150 if they pose a danger to themselves. 3-ER-334. They are assessed, treated, or even held longer if necessary, up to 14 days. *Id.* California's Strategic Plan for Suicide Prevention 2020-2025 ("Strategic Plan") recognizes the following risk factors for suicide: "[u]nmet or persistent physical health and behavioral health needs, including chronic pain [and] disability," "mood disorders, such as depression; medical illness; and access to methods to attempt suicide." 3-ER-333. Taking the approach that "access to effective medical and

mental health care" reduces suicidal risk, the Strategic Plan recommends "(1) lethal means restriction, (2) depression screening and treatment, (3) collaborative interventions with older adults experiencing depression, (4) provider education on risk and protective factors, and (5) expansion of data collection and recording." *Id.* However, the Strategic Plan explicitly excludes people who seek out assisted suicide under EOLOA. 3-ER-335.

V. PROCEDURAL POSTURE: DISTRICT COURT STAYS DISCOVERY, AND GRANTS MOTION TO DISMISS WITHOUT LEAVE TO AMEND.

Plaintiffs-Appellants filed this action in April 2023. The State Defendants and the Los Angeles County Defendants filed separate motions to dismiss in July 2023. Plaintiffs served discovery requests in July 2023. 2-ER-170. The State Defendants moved to stay discovery in July 2023. 2-ER-237. The district court granted the motion to stay discovery. 2-ER-134. On March 27, 2024, the district court granted the State and Los Angeles County defendants' motions to dismiss without leave to amend. 1-ER-1-17. The district court ruled that the organizational plaintiffs have standing to challenge EOLOA based on diversion of resources and frustration of mission. 1-ER-8. The district court ruled that the two individual plaintiffs lacked standing because under the district court's construction of EOLOA, they were not eligible for assisted suicide. 1-ER-10. The district court ruled that even if the individual plaintiffs had standing, their claims as well as the

organizational plaintiffs' claims failed to state a claim for relief as matter of law. 1-ER-10 n.4. The district court dismissed with prejudice without addressing Plaintiffs' request for leave to amend. 1-ER-17. Plaintiffs-Appellants timely appealed.[1]

STANDARD OF REVIEW

Dismissal for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6) is reviewed *de novo*. *Keams v. Tempe Tech. Inst., Inc.*, 39 F.3d 222, 224 (9th Cir. 1994). In deciding a motion to dismiss, the district court must take "[a]ll allegations of material fact in the complaint … as true and considered in the light most favorable to the Plaintiffs." *Moore v. Mars Petcare US, Inc.*, 966 F.3d 1007, 1016 (9th Cir. 2020); *Ashcroft v. Iqbal*, 556 U.S. 662, 679 (2009) ("When there are well-pleaded factual allegations, a court should assume their veracity and then determine whether they plausibly give rise to an entitlement to relief."). Dismissal is only proper "if it appears beyond doubt that the non-movant can prove no set of facts to support its claims." *Ass'n for L.A. Deputy Sheriffs v. Cnty. of L.A.*, 648 F.3d 986, 991 (9th Cir. 2011) (quoting *Adams v. Johnson*, 355 F.3d 1179, 1183

[1] Proposed Intervenors—consisting of Compassion & Choices Action Network (CCAN), three individuals, and two doctors—moved to intervene in the district court. The court denied their motion as moot in its order granting dismissal. 1-ER-17. Proposed Intervenors have appealed, Appeal No. 24-2755, filed a motion to intervene in this appeal (Dkt. 11), which Plaintiffs-Appellants opposed (Dkt. 13).

(9th Cir. 2004)). "If there are two alternative explanations, one advanced by defendant and the other advanced by plaintiff, both of which are plausible, plaintiff's complaint survives a motion to dismiss under Rule 12(b)(6)." *Starr v. Baca*, 652 F.3d 1202, 1216 (9th Cir. 2011).

Dismissals under 12(b)(1) for lack of standing are also reviewed *de novo*. *White v. Lee*, 227 F.3d 1214, 1242 (9th Cir. 2000). "For purposes of ruling on a motion to dismiss for want of standing, both the trial and reviewing courts must accept as true all material allegations of the complaint and must construe the complaint in favor of the complaining party." *Maya v. Centex Corp.*, 658 F.3d 1060, 1068 (9th Cir. 2011) (quoting *Warth v. Seldin*, 422 U.S. 490, 501 (1975)). To survive a 12(b)(1) motion based on lack on Article III standing, the Plaintiff need not show that relief is plausible on the merits, but only that the Plaintiffs' injury is traceable to defendants' conduct, and redressable by a favorable decision. *Maya*, 658 F.3d at 1067-68.

SUMMARY OF ARGUMENT

This case addresses the injuries that California's assisted suicide law, the End of Life Option Act ("EOLOA") causes to persons with disabilities. The Complaint alleged that EOLOA forms part of a two-track government response to the problem of suicide: an inferior track for persons with life-threatening disabilities grounded in centuries of stereotypes regarding lives not worth living,

and a mainstream track for other persons, grounded in the protection of life. This two-track system violates federal laws against disability discrimination, and the Fourteenth Amendment guarantees of Equal Protection Under Law and Due Process of Law.

The district court erred in dismissing the First and Second Claims for Relief by reasoning that because assisted suicide is a supposedly voluntary choice, the two-track system described above cannot violate federal disability laws. This ruling is erroneous in two ways. First, there is nothing in Title II of the ADA or in Section 504 of the Rehabilitation Act that allows governments to discriminate in programs, services, or activities because participation in such programs, services, or activities are voluntary. Second, even if voluntary choice mattered here, the Complaint adequately alleges that the Defendants' programs, services, and activities constrain the choices of persons with disabilities in a manner that violates the ADA and Section 504.

The district court erred in dismissing the Third Claim for Relief, Equal Protection. The Complaint adequately alleged that the State's two-track suicide prevention system irrationally discriminates between two groups of persons considering suicide, those with and without life-threatening illness. The district court ruled that the imminence of death, and pain associated with the dying process, fundamentally distinguish the two groups. The district court erred by

inferring such a fundamental distinction in contradiction to the detailed facts alleged in the Complaint to demonstrate that both groups face anxiety regarding pain, loss of control, financial pressures, and concerns for family.

The district court erred in dismissing the Fourth Claim for Relief, Due Process. The Fourth Claim for Relief has both substantive and procedural components. The substantive due process component is grounded in the fundamental right to protection of life, which is deeply rooted in this Nation's history and traditions. The Complaint adequately alleges that EOLOA violates this fundamental right by withdrawing multiple systems of protection against self-harm from persons with life-threatening disabilities, including suicide prevention programs, medical licensing and regulations, and the criminal laws against assisting suicide. The district court erred by failing to address the fundamental right at issue.

The district court erred in its analysis regarding withdrawal of the protection of criminal law by mischaracterizing the issue as one of individualized medical treatment decisions rather than a blanket decision by the state based on invidious stereotypes regarding lives not worth living. The district court erred in its analysis of the state-created danger component of the substantive due process claim. Plaintiffs adequately alleged all three elements of the state created danger doctrine, *i.e.*, that EOLOA placed persons with life-threatening illnesses in danger of

succumbing to depression, anxiety, or outside pressure to end their lives, the foreseeability of such danger, and Defendants' deliberate indifference in the face of clear knowledge of the danger.

The Fourth Claim for Relief also contains a procedural due process component. Procedural due process requires examination and balancing of the private interests at stake, the risk of erroneous deprivation in the absence of additional safeguards, and the government's interest in a summary procedure. The district court erred by failing to examine and balance any of these concerns. Instead, the district court concluded that EOLOA's safeguards are adequate to prevent "involuntary" suicides. The risk of error, however, is not between involuntary and voluntary suicides. The risk is that EOLOA allows voluntary suicides for reasons that EOLOA itself recognizes as erroneous, such as coercion, undue influence, or impaired judgment due to a mental disorder. Cal. Health & Safety Code § 443.5. The Complaint adequately alleges that EOLOA's system of safeguards cannot prevent such errors. The district court could only conclude otherwise by drawing inferences that the EOLOA safeguards would always operate in a particular manner to filter out such errors. The district court erred by choosing among equally plausible inferences those which favored the EOLOA scheme's reliability, and therefore dismissed the Fourth Claim for Relief.

Although the district court correctly found that the organizational plaintiffs

had Article III standing, the district court erred in ruling that the two individual plaintiffs lacked standing. The district court reached this erroneous result by construing EOLOA to include a non-textual criterion for assisted suicide that would make the individual plaintiffs ineligible under the statute. Specifically, the district read into the statute a non-textual requirement that the prescribing physician consider the effect of further treatments in determining whether a person is likely to die within six months. The statute includes no such requirement, and on the contrary, allows assisted suicide for persons who could live longer than six months with continued treatment—persons in precisely the situation of the two individual plaintiffs. The district court also erred by applying the wrong legal standard, assessing the Article III standing challenge under Rule 12(b)(6) instead of Rule 12(b)(1). This error in legal standard matters because it allowed the district court to deny standing based on whether the individual plaintiffs showed a path to relief on the merits, rather than the correct standard which looks only to whether the plaintiffs have alleged a concrete injury, traceable to the defendants, and redressable by a favorable ruling.

The district court erred by denying leave to amend with no analysis of whether such amendment would be futile.

The district court erred in staying discovery because the motions to dismiss raised factual issues that could have been address in discovery and because

defendants did not meet their burden to justify a stay.

ARGUMENT

VI. FIRST AND SECOND CLAIMS FOR RELIEF: DISTRICT COURT ERRED IN DISMISSING THE FEDERAL DISABILITY CLAIMS.

Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. Section 504 of the Rehabilitation Act provides that "no otherwise qualified individual with a disability in the United States … shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." 29 U.S.C. § 794(a). Section 504 is interpreted similarly to the ADA. *See Vinson v. Thomas*, 288 F.3d 1145, 1152 n.7 (9th Cir. 2002).

None of the Defendants challenged that the individual plaintiffs, and all persons whom EOLOA defines as having a "terminal disease," are qualified individuals with disabilities under the ADA and Section 504. All EOLOA-defined "terminal diseases" are disabilities under the ADA because they are physical impairments that substantially limit major life activities and the operation of major bodily functions, including but not limited to functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory,

circulatory, endocrine, and reproductive functions. 42 U.S.C § 12102(2)(B). These conditions also substantially limit people in other major life activities, including caring for oneself, performing manual tasks, eating, sleeping, walking, and breathing. 42 U.S.C § 12102(A). No party challenged the Complaint's allegation that "EOLOA is thus available only to people with disabilities." Compl. ¶ 71 (3-ER-319). In this brief, the terms persons with "life-threatening disabilities" and "life-threatening illness" refer to persons with disabilities under the ADA and Section 504.

The district court found that Plaintiffs could not advance an ADA or Section 504 claim due to the "fatal" fact that participation in EOLOA is "voluntary." 1-ER-12. The district court erred because Title II of the ADA and Section 504 apply to government programs that channel disabled individuals into lesser services, even where the decision to accept such lesser services is voluntary. *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 601 (1999). In *Olmstead*, the plaintiffs were voluntarily admitted into institutions but challenged the State of Georgia's decision to make certain types of assistance more readily available in institutions than in the community. 527 U.S. at 593-94. The Court made clear that plaintiffs can state a Title II claim even where the plaintiffs chose the lesser, segregated government service, especially where the defendant public entities have acted to constrain plaintiffs' choices by withholding necessary services outside the segregated

setting. *Id.* at 612 (Kennedy, J., concurring).

Here, the Complaint addressed two forms of discrimination against persons with life-threatening disabilities, the first in the form of a two-track suicide prevention system, and the second in the form of an overall system of public health that presents a false choice between hard-to-obtain end-of-life care and easy-to-obtain assisted suicide. Both systems are facially discriminatory regardless of the "voluntary" choices involved.

A. Two-Track Response to Persons Considering Suicide

The EOLOA segregates persons with life-threatening illnesses from others who consider and express a wish for suicide. Life-threatening illnesses make the first group "eligible" for assisted suicide while simultaneously steering them away from the state's suicide prevention system. The Complaint supports this allegation with specific references to California's suicide prevention statutes and published plans, policies, and procedures. Compl. ¶¶ 96-103 (3-ER-332-36). The district court erred by ignoring these specific allegations regarding the two-track response to persons considering suicide.

The district court grounded its ruling on voluntariness in *Bowen v. Am. Hosp. Ass'n*, 476 U.S. 610 (1986). *Bowen* has nothing to do with the type of two-track system that the Plaintiffs challenge here, one track for people with life-threatening disability and one track for non-disabled people. *Bowen* arose from the

1980s "Baby Doe" controversies over withholding medical care from newborns with disabilities. In response to the controversy, the Reagan Administration issued regulations under Section 504 requiring doctors and hospitals to provide treatment for newborns regardless of disabilities, and requiring state child protective agencies to investigate cases in which such care was withheld. The Court held that Section 504 did not authorize such regulations where the administrative record showed that care had been withheld from the newborns due to parental, not medical decisions. *Bowen*, 476 U.S. at 630; Samuel R. Bagenstos, *Disability, Life, Death, and Choice*, 29 Harv. J. L. & Gender 425, 430 (2006). In *Bowen*, there was no allegation or evidence in the administrative record that the doctors and hospitals had devised two systems of care, one for newborns with disabilities, and one for newborns without disabilities. Here, by contrast, the Complaint alleges that the Defendants have instituted such a two-track system, entirely on the basis of disability.

This Court has held that a two-track public benefits system based on disability violates Title II of the ADA. *See Lovell v. Chandler*, 303 F.3d 1039, 1055 (9th Cir. 2002). In *Lovell*, the State of Hawaii created a public insurance system for persons with incomes or assets that disqualified them from Medicaid, but expressly excluded "the aged, blind, and disabled," leaving them on the Medicaid track, with its strict income and asset requirements. *Id.* at 1045-46. This Court held that such a two-track system denied the plaintiffs meaningful access to

public benefits on the basis of disability. *Id.* at 1054-55. Such a two-track system is precisely what the EOLOA creates here for persons considering suicide, entirely based on the presence or absence of a disability in the form of a life-threatening illness.

The district court also rested its "voluntariness" analysis on EOLOA's Section 443.5(a)(2)(E), and (a)(6), which state that the prescribing physician must discuss "feasible alternatives or additional treatment options," and that the patient "may withdraw or rescind the request for an aid-in-dying drug." 1-ER-13. These discussion provisions in the EOLOA in no way negate the discrimination of California's two-track suicide prevention system. Persons considering suicide who are not disabled are not counseled to consider killing themselves as one of several "feasible alternatives." Nor are they provided with the lethal means to carry out their plan. They are provided with services aimed at saving their lives. Compl. ¶¶ 96-101 (3-ER-332-35).

B. False Choices Between End-of-Life Care and Assisted Suicide

Plaintiffs challenge a set of government programs that work in concert with EOLOA to steer persons with life-threatening disabilities away from services and programs that would permit them to live longer—expensive and difficult to obtain programs and services such as in-home supports, adaptive devices, and palliative care—and into the cheaper option of "volunteering" for state-assisted suicide. The

Complaint alleges that California's health care systems underfund home health care, treatment and palliative care, while making inexpensive assisted suicide easily accessible. Compl. ¶¶ 125-134 (3-ER-344-50). The Complaint again supports this allegation with detailed references to government and non-governmental studies and reports. *Id.* The district court erred in ignoring all of this evidence of how Defendants constrain the choices of persons with life-threatening disabilities.

Here, too, the district court relied heavily on the discussion provisions of EOLOA, requiring the prescribing physician to talk about "feasible alternatives." 1-ER-13. The discussion provisions of EOLOA do not create any real choice for a person seeking to avoid pain and loss of control. The Complaint alleges, with extensive factual support, that California's system of public services and benefits under-resources end-of-life care in favor of the cheaper option of assisted suicide. Compl. ¶¶ 125-134 (3-ER-344-50). The district court reduced the Plaintiffs' ADA rights to something that can be satisfied by mere words requiring the prescribing doctor to check a box on a form claiming that they talked to the patient about hypothetical "feasible" alternatives, with no regard to whether such alternatives have been offered or are practically available.

The district court erred in ruling Plaintiffs cannot state a Title II claim against a public benefit program that presents them with a free choice with no

regard for whether the Defendants make both sides of the choice meaningful. The Complaint adequately alleges that California's public health system does not make the non-suicide option meaningfully available to persons with life-threatening illnesses in fear of pain and loss of control. *See Olmstead*, 527 U.S. at 602 (holding that Title II requires that disabled persons have the option to decline the less integrated public service); *id.* at 612 (Title II plaintiff can show discrimination based on choice of public services where the choice is conditioned on accepting the less integrated setting) (Kennedy, J., concurring); *see also Day v. D.C.*, 894 F. Supp. 2d. 1, 22-23 (D.D.C. 2012) (denying motion to dismiss, rejecting argument that plaintiffs' choice negates Title II/Section 504 claim); *id.* at 25-33 (denying motion for summary judgment, rejecting defendants' argument that existence of plans to provide services negated Title II/Section 504 claim, where triable questions existed regarding whether the plans provided meaningful access to services); *Cramer v. Chiles*, 33 F. Supp. 2d 1342, 1353 (S.D. Fla. 1999) (granting plaintiffs' motions for summary judgment and preliminary injunction, finding that underfunding of integrated programs negates "meaningful choice.").

The district court cited *Martin v. California Dep't of Veterans Affs.*, 560 F.3d 1042 (9th Cir. 2009), for the proposition that "discrimination occurs when an individual is excluded from participation in or denied the benefits of a service (*see Martin*, 560 F.3d at 1047)—not when he or she chooses not to participate in or

receive the benefits of the service." 1-ER-13. *Martin*, however, is not a case about voluntary choice to forego a service. The plaintiff in *Martin* was a veteran with Alzheimer's who sought placement in the state-run "Veterans' Home of California." *Id.* at 1044. Ms. Martin did not refrain from seeking access to a public service—on the contrary, her estate sued because she was denied the veteran's home placement she had sought. *Id.* The case proceeded to a jury trial, and the plaintiff lost. *Id.* at 1046. This Court affirmed denial of plaintiff's new trial motion, on the grounds that the jury could reasonably find that Ms. Martin was denied access to the veteran's home due to a bed shortage, not due to disability. *Id.* at 1048-49.

Here, the district court completely ignored Plaintiffs' allegations that the under-resourcing of alternatives to assisted suicide, in concert with EOLOA's easy access to assisted suicide, violates Title II and Section 504 by denying persons with life-threatening disabilities any meaningful choice to access public services that would allow them to continue living. The district court ruled sub-silentio that such claims fail as a matter of law. In *Martin*, by contrast, the access claims went to trial. The same should happen here, which requires reversal of the dismissal order.

VII. THIRD CLAIM FOR RELIEF: DISTRICT COURT ERRED IN DISMISSING THE EQUAL PROTECTION CLAIM.

The Fourteenth Amendment provides that no state shall "deny to any person

within its jurisdiction the equal protection of the laws." *City of Cleburne, Tex. v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 439 (1985). "[A]ll persons similarly situated should be treated alike." *Id.* When a classification is not "rationally related to a legitimate state interest," it violates the Equal Protection Clause. *Id.* at 440. A "classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational" is improper. *Id.* at 446. Courts first identify the classification of groups, which "need not be similar in all respects, but they must be similar in those respects relevant to Defendants' policy." *Arizona Dream Act Coal. v. Brewer*, 757 F.3d 1053, 1064 (9th Cir. 2014). Courts then determine the proper standard of scrutiny to apply. *Id.* at 1065. The district court below did not reach that level of analysis, because it found that the groups were not similarly situated. 1-ER-16.

The Complaint alleged the following two classifications: (1) Persons diagnosed with a life-threatening disability and therefore eligible for EOLOA assisted suicide. (2) Persons without a life-threatening disability "who nevertheless share similar concerns about losing autonomy, the loss of dignity, losing control of bodily functions, becoming a burden on caregivers, pain, and/or financial costs associated with continued living." Compl. ¶ 190-191 (3-ER-373-74). The district court erred by ruling that the presence of a life-threatening illness makes the first group "fundamentally different" from the second, due to a

"distinctive prospect of pain and suffering associated with the dying process, along with heightened emotional anxiety related to that process." 1-ER-16 (internal quotations omitted). In so ruling, the district court ignored the allegations of the Complaint that the second group, whose illnesses are not diagnosed as life-threatening, can also have conditions that include pain, suffering, and emotional anxiety. Compl. ¶ 88 (3-ER-328). ("many non-terminal people experience existential suffering from losing autonomy, feeling a loss of dignity, losing control of bodily functions, becoming a burden on caregivers, and/or the financial costs associated with continued living"). The district court also ignored the Complaint's allegations, backed up by reference of numerous studies, that terminal diagnoses are inherently uncertain, and that predicting death within a specific period is even more uncertain. Compl. ¶¶ 10, 87-95 (3-ER-291, 3-ER-327-32).

What makes the two groups similar, and what negates any justification for withholding suicide prevention efforts from the first group and reserving them for the second, is the high risk of depression, impaired judgment, financial pressures, stigma, and undue influence that would cause both groups to consider suicide. Compl. ¶¶ 101-103 (3-ER-334-36). This is the gravamen of the equal protection claim that the district court erred by dismissing.

The district court erred under Rule 12(b)(6) by resolving a factual dispute regarding the circumstances in which people consider suicide. The Complaint

alleged, with ample scientific support, that there are pressures toward suicide that apply equally to persons with and without life-threatening illnesses. The district court simply ignored these allegations to hold that the two groups are dissimilar as a matter of law. Whether and how they are dissimilar is a question of fact that requires first-hand testimony from the people in both situations, as well as expert testimony on the nature of life-threatening illness and the nature of suicidal ideation. The district court erred by assuming that the pain, suffering, and anxiety of patients with life-threatening illnesses make them unique in a way that justifies the state affirming their suicidality and the house of medicine assisting them to an early demise. Pain and anxiety are matters that have been studied extensively, and as to which medical science has devoted many thousands of pages of research, and many millions of dollars in the development of treatments. A district court should not attempt to resolve on a pleading motion whether someone who has six months left to live is fundamentally different than someone who has seven or eight months to live. Nor can the court decide that someone without such a diagnosis cannot experience anxiety related to dying. To resolve such factual questions on a 12(b)(6) motion is error. *See Starr*, 652 F.3d at 1216.

VIII. FOURTH CLAIM FOR RELIEF: DISTRICT COURT ERRED IN DISMISSING THE DUE PROCESS CLAIM.

Plaintiffs' due process claim contains two components—one sounding in substantive due process, and the other in procedural due process.

A. Substantive Due Process

The Due Process Clause of the Fourteenth Amendment provides that "[n]o State shall … deprive any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV, § 1. The Supreme Court has stated that "[t]he Clause … provides heightened protection against government interference with certain fundamental rights and liberty interests." *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997). Substantive due process analysis proceeds by a two-step process. The first step is to determine whether the claimed violation involves one of "those fundamental rights and liberties which are, objectively, 'deeply rooted in this Nation's history and tradition.'" *Glucksberg*, 521 U.S. at 720-21. If the asserted interest is determined to be "fundamental," the challenged legislation is subject to strict scrutiny review. *Id.* at 721. To pass strict scrutiny, legislation must be "narrowly tailored to serve a compelling state interest." *Id.* (quoting *Reno v. Flores*, 507 U.S. 292, 302 (1993)).

Here, the district court erred by conducting no analysis whatsoever of the fundamental interest asserted by Plaintiffs. The fundamental interest at issue here is the protection of life itself. The protection of life through laws prohibiting assisted suicide is "deeply rooted in this Nation's history and tradition." *Glucksberg*, 521 U.S. at 710 ("In almost every State—indeed in almost every western democracy—it is a crime to assist a suicide."). The Court in *Glucksberg*

grounded this traditional protection against assisted suicide in "over 700 years" of common law tradition. *Id.* at 711-18. This tradition includes protection for those at end of life, who remained under the protection of law, "equally as the lives of those who [were] in the full tide of life's enjoyment." *Id.* at 714-15 (internal quotation marks omitted). In *Glucksberg*, the Court held that this history and tradition foreclosed the possibility of a constitutional right to assisted suicide at the end of life. This history and tradition does more than foreclose a right to assisted suicide, it also serves as a bulwark against laws that would devalue the protection of some lives over others, and that seek to ease "'individuals who are ill and vulnerable'" out of the world. *Id.* at 719 (quoting New York State Task Force on Life and the Law).

The district court erred by ignoring this 700-year-old tradition to protect life, even the life of persons diagnosed as "terminal," and dismissing the substantive due process claim as a matter of law. The Complaint alleges numerous ways in which EOLOA violates Plaintiffs' substantive due process right to have their lives protected by the many government systems that have operated for decades to protect ill and disabled people, including the operation of criminal laws against aiding a suicide, Compl. ¶¶ 110-119 (3-ER-338-42), suicide prevention programs, *Id.* ¶¶ 96-103 (3-ER-332-36), medical licensing and regulations, *Id.* ¶¶ 104-109 (3-ER-336-38), and medical malpractice and elder abuse laws, *Id.* ¶¶ 120-121 (3-ER-

342-43). The district court did not examine the allegations regarding how withdrawal of any of these protections, much less all of them at once, violates the fundamental right to protection of life. On this basis alone the decision should be reversed.

The district court examined one aspect of the substantive due process claim, the state-created danger theory of recovery. Under this theory, government actors are liable if [1] their "affirmative actions created or exposed her to an actual, particularized danger she would not have otherwise faced," [2] the injury was foreseeable, and [3] the officials were "deliberately indifferent to the known danger." *Martinez v. City of Clovis*, 943 F.3d 1260, 1271 (9th Cir. 2019).

Plaintiffs have plead facts to support all three of these elements.

(1) Due to EOLOA, persons with life-threatening illnesses are exposed to the risk that depression, financial pressures, medical steering, and other factors can lead them to end their lives by suicide. Compl. ¶¶ 7 (3-ER-290), 21-22 (3-ER-294-96), 35-38 (3-ER-302-04), 65 (3-ER-315), 68 (3-ER-316-17), 95 (3-ER-330-32), 123 (3-ER-343-44), 126 (3-ER-344-45), 137 (3-ER-351-52), 139-165 (3-ER-352-64).

(2) It is not only foreseeable that EOLOA will cause deaths, EOLOA's stated purpose is to cause deaths.

(3) The Defendants in this action are aware of and deliberately indifferent

to the susceptibility of older adults and sick and disabled people to depression, and thoughts of suicidality. Compl. ¶¶ 62-69 (3-ER-313-18) (enhanced risks of depression and suicide among elderly and ill); 96-97 (3-ER-332-33) (California strategic plan on suicide prevention acknowledges risks presented by health problems, chronic pain, and disabilities); ¶ 102 (3-ER-335) (alleging that Defendant agencies and officials "are aware of the heightened risk factors" of depression and impaired decision making associated with life-threatening disability).

The district court ruled that EOLOA's enumerated procedural safeguards can be relied upon to prevent "involuntary death." 1-ER-14-15. The district court erred in evaluating the claim. The state-created danger is not an "involuntary" suicide. The Complaint raises a different state-created danger. It is the danger of suicides based on "voluntary" choices under pressures that are contrary to the interests of both the State and the individual: depression, impaired judgment due to mental illness, financial pressures, internalized ableism, or pressures from family members and society at large. EOLOA itself recognizes that most of these pressures are contrary to the State's interests. *See* Cal. Health & Safety Code section 443.5(a)(1)(A)(iii), (a)(4). Suicides under such pressures can all be deemed "voluntary," yet they are also the type of injury from which government has traditionally tried to protect people, and implicate the fundamental interest in

protection of life that is firmly grounded in this Nation's tradition and history. The Complaint adequately alleges that EOLOA creates a danger of loss of life due to the withdrawal of such protections against suicides caused by depression, impaired judgment, financial pressure, or outside influence. The district court erred in dismissing this claim.

B. Procedural Due Process

Procedural due process analysis considers (1) the private interest affected by the state action; (2) "the risk of an erroneous deprivation" of the interest through the current procedures and any value of additional safeguards; and (3) the government's interest and the burden of additional safeguards. *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976). How much process must be afforded depends on "the extent to which [the plaintiff] may be condemned to suffer grievous loss … and depends upon whether the [plaintiff's] interest in avoiding that loss outweighs the governmental interest in summary adjudication." *Goldberg v. Kelly*, 397 U.S. 254, 262-63 (1970) (internal citations omitted).

Here, the private interest is avoidance of suicide caused by depression, stigma, impaired judgment, financial pressures, or undue influence. For purposes of due process analysis, such suicides should be deemed "erroneous" in the EOLOA framework, which is intended to prevent them, while allowing suicides based on unimpaired decisions to avoid end-of-life suffering. Accepting for the

sake of argument, that the state has an interest in allowing such "EOLOA-sanctioned" suicides, while avoiding erroneous suicides, due process analysis turns on whether the process provided in the EOLOA scheme does enough to prevent the erroneous suicides. *See Mathews*, 424 U.S. at 335.

The district court skipped the entire *Mathews/Goldberg* analysis, and instead focused only on whether the physician-assisted suicide was involuntary. 1-ER-15. All suicide is "voluntary." The district court conducted no analysis of the Complaint's detailed allegations that the EOLOA system does not do enough to prevent deaths caused by depression and anxiety, being a burden to their family, financial concerns of treatment, and fear of disability or painful death.

The lack of safeguards starts with the dangerously vague definition of "terminal illness" in EOLOA. Compl. ¶¶ 91-92 (3-ER-329), 143-145 (3-ER-354-55). Persons who could survive for years or decades with treatment can be deemed terminal within six months under the statute. *Id.* at ¶¶ 91-92 (3-ER-329). In fact, people with anorexia have already died by physician-assisted suicide in the United States. Compl. ¶ 92 and *id.* n. 92 (3-ER-329) (citing medical journal describing diagnosis of "terminal anorexia nervosa" and case studies of patients who died by physician assisted suicide). EOLOA's definition of "terminal" applies to persons whose lives depend on insulin treatment, and to the individual Plaintiffs, Mr. VanHook and Ms. Tischer, whose lives depend on an array of medical

interventions and services that are inconvenient, uncomfortable, difficult to obtain, and, in many cases, stigmatizing. Choosing assisted suicide to avoid these difficulties would be a "voluntary" decision under EOLOA. EOLOA's procedural safeguards do nothing to prevent stretching the meaning of "terminal" to encompass any condition that could end in death depending on how the doctor and patient decide to respond to the patient's distress in the face of such difficulties. Such an elastic concept of terminal is not consistent with the statute's stated purpose of addressing purportedly unavoidable end-of-the-life suffering. Thus, even accepting EOLOA's own assertion of the State's legitimate interests, the procedural safeguards are inadequate to advance those interests.

The Complaint adequately alleges that EOLOA's mental health safeguards are inadequate to prevent, again for the sake of argument, "erroneous suicides." EOLOA presumes that no mental health concerns are at play; therefore no mental health provider is involved unless the prescribing physician makes a referral, which is only to determine capacity to make medical decisions, not to diagnose or treat mental health concerns. Compl. ¶¶ 149-150 (3-ER-357-58). The Complaint alleges, with citation to numerous studies, that depression and impaired judgment are very common among those with life-threatening illnesses. Compl. ¶¶ 62-65 (3-ER-313-15). The Complaint thus raises serious questions about the risk of "erroneous suicides" in a system without any required mental health consultation

or evaluation. The Complaint alleges that the recent change in the law, reducing the interval between requests for lethal medications under EOLOA from 15 days to 48 hours, increased the already grave risk of "erroneous suicides."[2] Compl. ¶¶ 163-165 (3-ER-363-64). Again, the district court examined none of this.

In place of the required *Mathews/Goldberg* analysis, the district court in one paragraph drew out what it saw as a chain of improbable contingencies that would have to line up to result in an "involuntary" suicide. 1-ER-15. As noted above, the risk at issue is not an "involuntary" suicide. In addition, the district court built its chain of contingencies by making factual inferences regarding how every case of assisted suicide under EOLOA must progress. This is improper on a Rule 12(b)(6) motion, which requires that the complaint be evaluated based on the facts alleged, and reasonable factual inferences therefrom. *See Iqbal*, 556 U.S. at 678. Instead of applying that standard, the district court lined up a chain of contingencies based on its own inferences of everything going right at each EOLOA step, for example, that the prescribing physician will always make a mental health referral when

[2] After the law was amended to shorten the waiting period, suicides through EOLOA rose dramatically. In July of 2023, three months after Plaintiffs submitted their Complaint, State Defendant California Department of Public Health released a report on EOLOA. *See* Pls-Appellants' RJN Ex. A (California End of Life Option Act 2022 Data Report). Between 2021 and 2022, prescriptions written under EOLOA rose 54%, from 863 to 1270. *Id.* Deaths under EOLOA rose 63%, from 522 to 853, after staying relatively constant since 2017. *Id.*

necessary, or that the two witnesses will "recognize" any impairment, even though EOLOA requires only lay witnesses. 1-ER-15. By drawing these inferences against the allegations of the Complaint, the district court necessarily omitted the equally reasonable allegations and inferences that physician-assisted suicide need not happen in the confined steps the court lays out in its "chain of contingencies." This is precisely what Rule 12(b)(6) does not allow: the selection among reasonable inferences of those which favor dismissal over those that favor allowing the complaint to move forward. *Starr*, 652 F.3d at 1216. EOLOA's enumerated safeguards are loose enough to allow an equally plausible chain of events leading to death for reasons not sanctioned by EOLOA's stated purpose. It requires no mental health evaluation except in narrow circumstances. 3-ER-357-58. It allows for doctor shopping. 3-ER-352. It does not require and does not allow physicians to administer the drug. 3-ER-359-60. It does not require the drug be administered on any deadline. 3-ER-359. It does not require a witness during the actual suicide, nor third party reporting of whether the drugs were self-administered and done so voluntarily. *Id.* A patient who presents at the time of prescription as rational and able to independently choose assisted suicide may be depressed or acting under coercion at the time of ingestion. The district court erred by drawing inferences to close these gaps in EOLOA's procedural safeguards.

IX. PLAINTIFFS SUFFICIENTLY ALLEGED DISCRIMINATION IN CRIMINAL LAW ENFORCEMENT.

Plaintiffs did not plead a separate claim for relief arising from discrimination in law enforcement. The discrimination in criminal law enforcement created by EOLOA violates federal disability law, the equal protection clause, and substantive due process, and Plaintiffs therefore challenge it under the First (ADA), Second (Section 504), Third (Equal Protection) and Fourth (Due Process) Claims for Relief. Plaintiffs address it separately here, because the district court addressed it separately in a brief section of the dismissal order. 1-ER-13-14.

The district court erred in treating the criminal justice claim as if it were directed at medical treatment decisions. *See* 3-ER-340-42. The district court applied the rule that "differing treatment decisions based on the degree of one's disability" cannot support a discrimination claim. 1-ER-13. That rule arises from cases challenging clinical judgments in diagnosis and choice of treatment, where a disability claim is added on to or substituted for a malpractice claim. *See Simmons v. Navajo Cnty., Ariz.*, 609 F.3d 1011, 1022 (9th Cir. 2010) ("The ADA prohibits discrimination because of disability, not inadequate treatment for disability."), *overruled on other grounds by Castro v. Cnty. of Los Angeles*, 833 F.3d 1060 (9th Cir. 2016) (en banc).

Here, the Plaintiffs are not challenging treatment decisions by doctors, but rather the State's decision to withdraw criminal law protections from the entire

class of persons with life-threatening disabilities considering suicide. The district court relied on a Second Circuit decision involving involuntary confinement, and an unpublished Ninth Circuit decision in a pro se prisoner case regarding mental health treatment.[3] 1-ER-13. Neither case states a rule that controls here. In *McGugan v. Aldana-Bernier*, 752 F.3d 224 (2d Cir. 2014), the plaintiff had been involuntarily confined and forcibly medicated after a mental health crisis. *Id.* at 227. She brought a Section 504 claim against the medical providers for discriminating on the grounds of mental illness. *Id.* at 231. The Second Circuit rejected the Section 504 claim on the grounds that the state's involuntary confinement and forced medication laws required providers to act on the basis of mental health symptoms. *Id.* at 232. The Second Circuit explained that the term "discrimination" is confusing in the medical context, because it can have both a "positive" and a "pejorative" meaning. *Id.* at 231. In medicine, we rely on doctors to "discriminate" based on symptoms and conditions in order to choose useful treatment options. This is benign, even beneficial discrimination. *Id.* at 231-32. On the other hand, we prohibit doctors and hospitals from withholding treatment or providing a second class of treatment based on disability criteria that are irrelevant

[3] The *pro se* criminal case, *O'Guinn v. Nevada Dep't of Corr.*, 468 F. App'x 651 (9th Cir. 2012)) contains no analysis of the discrimination claim but simply disposes of it by referring to the rule that anti-discrimination law does not require treatment for disabling conditions. *Id.* at 653.

to the selection of treatments to assist the patient. *Id*. That is prohibited, harmful discrimination.

The district court here erred by applying *McGugan*. The issue here is the blanket withholding of criminal law protections as a matter of statute, with no individual medical judgment. At best, the only "medical judgment" baked in to EOLOA is a global one—that persons with life-threatening disabilities may be better off with suicide than with treatment. This global decision is precisely the type of discrimination based on stereotype and "irrational bias" the ADA and Section 504 prohibits in all contexts including medical care. *McGugan*, 752 F.3d at 231.

X. DISTRICT COURT ERRED IN DENYING INDIVIDUAL STANDING.

Plaintiffs establish standing by showing: (1) a "concrete and particularized" and "actual or imminent" injury, (2) a "causal connection between the injury and the conduct complained of," and (3) that the injury will likely be "redressed by a favorable decision." *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560-61 (1992). Courts "must take a broad view of standing in civil rights cases, particularly in the ADA context where private enforcement is the primary method of securing compliance with the act's mandate." *Langer v. Kiser*, 57 F.4th 1085, 1099 (9th Cir. 2023) (internal quotations omitted), *cert. denied*, 144 S. Ct. 823 (2024). "Causation may be found even if there are multiple links in the chain connecting

the defendant's unlawful conduct to the plaintiff's injury, and there's no requirement that the defendant's conduct comprise the last link in the chain." *Mendia v. Garcia*, 768 F.3d 1009, 1012 (9th Cir. 2014). When there are multiple causes of the injury, standing is met when plaintiffs "sufficiently alleged that defendants, not third parties" perpetuated the actions that caused harm. *See Maya*, 658 F.3d at 1070.

A. District Court Applied Wrong Standard for Constitutional Standing.

The district court erred by applying the wrong pleading standard for Article III standing. The court generally applied the standard for 12(b)(6) in its order. 1-ER-5-6. This standard is governed by *Twombly* and *Iqbal*, which require a complaint to allege facts to plausibly entitle the plaintiffs to relief, ignoring legal conclusions. *Maya*, 658 F.3d at 1067-68. This standard only applies to statutory standing. *Id.* at 1067. Article III standing should be analyzed under Fed. R. Civ. P. 12(b)(1). *Id.* In analyzing standing, the court "must accept as true all material allegations of the complaint and any other particularized allegations of fact, in affidavits or in amendments to the complaint." *Table Bluff Rsrv. (Wiyot Tribe) v. Philip Morris, Inc.*, 256 F.3d 879, 882 (9th Cir. 2001). By misapplying the standard, the court necessarily addressed the merits even though "the threshold question of whether plaintiff has standing … is distinct from the merits of his claim." *Maya*, 658 F.3d at 1068. General allegations to show redressable injury

from defendant's conduct are sufficient to demonstrate Article III standing. *Id.* (citing *Lujan*, 504 U.S. at 561). The *Twombly/Iqbal* requirement to show a plausible path to relief on the merits does not apply. *Maya*, 658 F.3d at 1067-68.

B. District Court Misconstrued Plain Text of EOLOA Defining "Terminal Disease."

The district court ruled that the Individual Plaintiffs, Mr. VanHook and Ms. Tischer, faced no prospect of harm from EOLOA because, in the district court's construction of the statute, Mr. VanHook and Ms. Tischer are not "eligible" for lethal drugs under the statute. 1-ER-10. The district court reached this result by construing EOLOA to add an eligibility criterion that is not in the plain text of the statute. The district court read into the statute a requirement that the prescribing doctor consider the impact of possible continued treatment in deciding whether the patient would die within six months. *Id.* The EOLOA defines a "terminal disease" as one that is an "incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months." Cal. Health & Safety Code Ann. § 443.1. Under the plain text of the statute, doctors are not required to consider possible further treatment in their diagnosis. 2-ER-80. It was improper for the district court to assume "reasonable medical judgment" "must necessarily take into consideration" possible further treatment. 1-ER-10. Nothing in the statute supports this logical leap. The statute's plain text allows physicians to prescribe lethal drugs whenever

a disease will result in death in six months without regard to further treatment. If the legislature intended to require consideration of further treatment it would have done so. Both Mr. VanHook and Ms. Tischer have conditions what would be fatal within six months without life-sustaining care and are therefore eligible for the EOLOA. 3-ER-301-03. The ruling below incorrectly reads a non-textual screening criteria into EOLOA that would defeat their standing to challenge the statute by making them ineligible.

The harms to Mr. VanHook and Ms. Tischer are far from hypothetical. Both have been steered away from further treatment and felt steered to assisted suicide. The district court erred by concluding that such "steering" was hypothetical and attenuated. 1-ER-10. Mr. VanHook has had doctors opine that his quality of life is low and question whether he would be better off dead. 3-ER-326 (Compl. ¶ 83). Indeed, during a hospitalization for suicidality, Mr. VanHook refused water and food in a request to die, which medical professionals affirmed, until his long-time doctor intervened. 3-ER-302. (Compl. ¶ 35). Experience with medical discrimination has caused Mr. VanHook to remove his organ donor designation from his license for fear that doctors would prefer to harvest his organs than keep him alive. 3-ER-301 (Compl. ¶ 34). Ms. Tischer, who has been diagnosed with depression and anxiety, was refused access to rehabilitation for her muscular deterioration because of her disability. 3-ER-323. (Compl. ¶ 79). A neurologist

told her that her progressive disability made her ineligible for rehabilitation and she "must have always known that death was around the corner and 'there's nothing we can really do about it.'" *Id.* Both individual plaintiffs alleged that during medical crises, they have felt that physician-assisted suicide may be their only alternative due to their experiences accessing medical care with dignity. 3-ER-344 (Compl. ¶125).

Mr. VanHook and Ms. Tischer are eligible for lethal drugs under EOLOA because they have conditions that will result in death within six months without further treatment. The district court erred by adding an extra eligibility criterion into EOLOA, i.e., that physicians screen out patients based on prospects for continued or additional treatment. In addition, Mr. VanHook and Ms. Tischer have been steered away from treatment and toward assisted suicide because of their serious disabilities. They alleged non-hypothetical fears that they will again become despondent and suicidal and will be steered toward physician assisted suicide because of the Defendants-Appellees' EOLOA scheme. The district court erred in concluding they did not have individual standing to challenge the EOLOA.

C. District Court Erred By Not Addressing Individual Standing to Challenge the Overall System Comprised by EOLOA Alongside the State's Suicide Prevention Programs.

To survive a motion to dismiss based on standing, Plaintiffs need not allege that their injury arose from a singular cause. *Maya*, 658 F.3d at 1070. Instead,

Plaintiffs need only establish a line of causation that includes the challenged conduct by Defendants. *Id.* In *Maya,* for example, homeowners in neighborhoods impacted by the subprime mortgage collapse of 2008 sued mortgage companies for harms the homeowners suffered when mortgage companies targeted their neighborhoods for subprime lending. *Id.* at 1065. The plaintiffs themselves did not get subprime mortgages; the harms were caused by the prevalence of such mortgages among their neighbors. *Id.* The district court in *Maya* held that the line of causation from the mortgage lenders, through the neighbors, to the impact on home values was too tenuous, and dismissed the action for lack of standing. *Id.* at 1067-68. This Court reversed, holding that the impact of broad factors such as the overall housing bubble did not deprive the plaintiffs of standing to challenge the mortgage companies' particular contribution to their injury. *Id.* at 1070, 1073.

Here, the district court erred by examining EOLOA in isolation, without considering how the statute operates in concert with other elements of the state public health system. The Complaint challenges EOLOA as part of a broader public health system, with elements controlled by Defendants that work in concert to harm Mr. VanHook, Ms. Tischer, and other people with life-threatening disabilities.

In concluding that Individual Plaintiffs had no standing, the court misapplied the rule stated in *Maya* for analyzing standing for injuries with multiple causes. In

Maya, this Court held that the homeowners alleged adequate injury even where most of the extraneous causes, such as the overall housing bubble, were independent of defendants' alleged misconduct. Here, by contrast, Plaintiffs-Appellants alleged in their complaint that these Defendant officials operate a system of care that includes EOLOA, which harms Plaintiffs through its application. State Defendant MHSOAC developed the Strategic Plan for Suicide Prevention which explicitly excludes physician-assisted suicide in its suicide prevention services. 3-ER-306-07. State Defendant Medical Board of California protects the public from medical injury except in the case of the EOLOA. 3-ER-336-38. State operated Medi-Cal fully covers physician-assisted suicide for eligible patients but not necessarily palliative care, hospice, in-home nursing care, or appointments where patients want to discuss end of life options. 3-ER-345, 3-ER-350.

The district court erred in treating the above-described system as somehow extraneous to EOLOA. Plaintiffs alleged harms arising from multiple programs by Defendant-Appellees in concert. The district court erred in holding that Individual Plaintiffs did not have standing to challenge the EOLOA, and this Court should reverse.

In denying individual standing, the district court cited *Lee v. State of Oregon*, 107 F.3d 1382 (9th Cir. 1997), with no analysis. 1-ER-10. This Court in *Lee* dismissed a challenge to Oregon's "Death with Dignity Act," on lack of

standing grounds. This Court decided *Lee* before and therefore without the benefit of the Supreme Court's decision in *Gluckberg*, which reached the merits of the case asserting a constitutional right to physician assisted suicide despite the plaintiffs being individual patients and doctors indistinguishable from the plaintiffs in *Lee*. Indeed, after *Gluckberg*, at least one district court has held that an individual plaintiff had standing to challenge parts of EOLOA. *See Shavelson v. Bonta*, 608 F.Supp.3d 919, 925-26 (N.D. Cal. 2022).

In addition, the factual allegations of Plaintiffs VanHook and Tischer are substantially different than the allegations made by the patient in *Lee*. The contingencies dismissed as "speculative" in *Lee* have in large part already happened to VanHook and Tischer, as discussed in detail above. *Lee* was brought before Oregon's law was implemented. *Lee*, 107 F.3d at 1386. Here, EOLOA has been in force for nine years.

Assisted suicide is far easier to access under EOLOA than under the version of Oregon's law at issue in *Lee*. For example, the waiting time between a person's request and a doctor's prescription is far shorter under EOLOA—48 hours rather than 15 days. *Compare* Compl. ¶ 164 (3-ER-364), *with Lee*, 107 F.3d at 1393 (reproducing Oregon Act § 3.06); *see also* Compl. ¶ 162 (3-ER-363) (Oregon's law has reporting and documentation requirements missing from California's law). These differences are significant and, as a result, "EOLOA operates on the fiction

that on the basis of a two-day telephonic relationship, a prescribing doctor can: (1) make the terminal prognosis, (2) ensure the patient is not acting under impaired judgment or duress, (3) decide whether to refer the patient for a mental health assessment, and (4) counsel the patient on their options and alternatives." *Id.* ¶ 159 (3-ER-361-62). This "two-day doctor-patient relationship facilitates 'doctor shopping'" where patients can go to different physicians until one is willing to give them the prescription they want. *Id.* State Defendants make no effort to track or restrict this practice, which puts Plaintiffs at risk. *Id.* All of these differences mean that the result in *Lee* cannot control the result here.

XI. DISTRICT COURT ERRED IN DENYING LEAVE TO AMEND.

Leave to amend should be granted when a complaint is dismissed for failure to state a claim "unless the court determines that the allegation of other facts consistent with the challenged pleading could not possibly cure the deficiency." *Schreiber Distrib. Co. v. Serv-Well Furniture Co.*, 806 F.2d 1393, 1401 (9th Cir. 1986). "Dismissal with prejudice and without leave to amend is not appropriate unless it is clear on de novo review that the complaint could not be saved by amendment." *Eminence Cap., LLC v. Aspeon, Inc.*, 316 F.3d 1048, 1052 (9th Cir. 2003). "A district court's failure to consider the relevant factors and articulate why dismissal should be with prejudice instead of without prejudice may constitute an abuse of discretion." *Id.* In its order granting the motion to dismiss with prejudice,

the court never determined that Plaintiffs could not allege any other facts that could cure the complaint's purported deficiency and therefore abused its discretion. *See Schreiber*, 806 F.2d at 1401. ("Because the district court did not determine, nor can we conclude, that the allegation of other facts could not possibly cure the deficiencies in Schreiber's complaint, the district court abused its discretion in dismissing the RICO counts with prejudice.").

Plaintiffs sought leave to amend. 2-ER-104, 2-ER-132. The district court did not address leave to amend at all, and on that basis alone should be reversed.

Amendment would not have been futile. On individual standing, where the district court construed the statute to make the individual plaintiffs ineligible, an amended complaint could have included additional factual allegations to demonstrate that EOLOA does not in fact operate as construed by the district court. On the First and Second Claims for Relief under federal disabilities law, the district court dismissed on the grounds that assisted suicide is a voluntary choice. An amended complaint could have included more factual allegations showing how such choice is constrained, within the meaning of the federal disability cases that reject voluntary choice as negating discrimination in the provision of government services.

Voluntary choice was also the lynchpin of the district court's dismissal of the Third (Equal Protection) and Fourth (Due Process) Claims for relief. Here, too,

an amended complaint could have addressed the interplay between free choice and constraint. The district court dismissed the Equal Protection claim on the grounds that the two groups at issue, those with life-threatening disabilities and those without them, are not similarly situated. As discussed above, the similarity of the two groups is a matter of factual dispute. An amended complaint could have drawn out more specifically the ways in which the two groups are similarly concerned with fear of pain and death.

In dismissing the procedural due process claim, the district court omitted the *Mathews/Goldberg* analysis and balancing of the competing interests in greater process versus greater speed in decision-making. *See* Section VIII.B, above. Instead of assuming the facts alleged in the Complaint to be true, and applying the *Mathews/Goldberg* analysis, the Court sketched out its own hypothetical scenario in which EOLOA's safeguards were good enough to avoid the error of an "involuntary" suicide. *Id.* An amended complaint could have clarified that the error to be avoided is not an "involuntary" suicide, but rather a suicide for reasons other than those which EOLOA seeks to advance. An amended complaint could also have addressed the many factual alternatives to the hypothetical chain of events sketched out in the district court's opinion. *Id.*; 1-ER-15.

Because leave to amend should be freely granted and the district court did not make any finding that the complaint could not have been cured by amendment,

the court improperly denied leave to amend, and this Court should reverse.

XII. DISTRICT COURT ERRED IN STAYING DISCOVERY.

Discovery stay orders are reviewed for abuse of discretion. *Little v. City of Seattle*, 863 F.2d 681, 685 (9th Cir. 1988); *Rae v. Union Bank*, 725 F.2d 478, 481 (9th Cir. 1984). Moving to dismiss does not entitle defendants to a discovery stay; on the contrary, to obtain such a stay, defendants carry "a heavy burden." *Gray v. First Winthrop Corp.*, 133 F.R.D. 39, 40 (N.D. Cal. 1990). This burden requires more than pointing to the costs of answering discovery. *Id.* Where a motion to dismiss raises "factual issues that required discovery for their resolution," staying discovery is an abuse of discretion. *Jarvis v. Regan*, 833 F.2d 149, 155 (9th Cir. 1987); *Rae*, 725 F.3d at 481.

Here, the district court concluded with no analysis that "no discovery is necessary for this court to decide the pending motion." 2-ER-134-35. The motions to dismiss in fact raised several factual issues that required discovery. The motions to dismiss, in their challenge to the equal protection claim, raised factual issues regarding whether persons without life-threatening illnesses experience pressures toward suicide that are similar to those experienced by persons without such illnesses. *See* Section VII, above.

The challenge to the procedural due process claim raised factual issues regarding whether EOLOA's safeguards operate to screen out non-EOLOA-

sanctioned suicides. It also raised factual issues about the nature of the error to be avoided by EOLOA's procedure safeguards, that is, whether the error is "involuntary" suicide, or suicide that does not advance EOLOA's stated purposes. *See* Section VIII.B, above. All of these facts require development through discovery.

The challenge to individual standing turns on the facts regarding VanHook's and Tischer's interactions with the state's medical care systems. *See* Section X.C, above. In addition, although the district court did not reach them, the motions to dismiss raised Eleventh Amendment immunity questions that turned on the connections between the named defendant officials and the operations of California's suicide-prevention and assisted suicide systems. 2-ER-164.

The district court also pointed to "burden on resources" to justify the discovery stay. 2-ER-135. The resources needed to answer discovery, however, are "nothing more than the traditional burdens of litigation," and do not justify a discovery stay. *Optronic Techs., Inc. v. Ningbo Sunny Elec. Co., Ltd.*, No. 5:16-CV-06370-EJD, 2018 WL 1569811, at *1 (N.D. Cal. Feb. 16, 2018); *Gray*, 133 F.R.D. at 40.

CONCLUSION

The district court erred in granting the motions to dismiss, in denying leave to amend, and in staying discovery during the pendency of the motions to dismiss.

Plaintiffs-Appellants request that this Court reverse the order granting the motions to dismiss, as well as the order staying discovery pending the motion to dismiss, and remand for further proceedings. In the event that this Court affirms the dismissal in any part, Plaintiffs-Appellants request that this Court reverse the denial of leave to amend, and remand to allow Plaintiffs-Appellants to file an amended complaint.

DATED: July 17, 2024

Respectfully submitted,

ROSEN BIEN GALVAN & GRUNFELD LLP

By: */s/ Ernest Galvan*
Ernest Galvan

Attorneys for Plaintiffs-Appellants

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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9th Cir. Case Number(s) 24-02751

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Appeal No. 24-02755, United Spinal Association v. State of California, was brought by parties who sought to intervene in the proceedings below.

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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ADDENDUM

End of Life Option Act
Cal. Health and Safety Code secs. 443 – 443.22

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HEALTH AND SAFETY CODE - HSC

DIVISION 1. ADMINISTRATION OF PUBLIC HEALTH [135 - 1179.102] *(Division 1 enacted by Stats. 1939, Ch. 60.)*

PART 1.85. End of Life Option Act [443 - 443.22] *(Part 1.85 added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1.)*

443. This part shall be known and may be cited as the End of Life Option Act.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.1. As used in this part, the following definitions shall apply:

(a) "Adult" means an individual 18 years of age or older.

(b) "Aid-in-dying drug" means a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about their death due to a terminal disease.

(c) "Attending physician" means the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease.

(d) "Attending physician checklist and compliance form" means a form, as described in Section 443.22, identifying each and every requirement that must be fulfilled by an attending physician to be in good faith compliance with this part should the attending physician choose to participate.

(e) "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 and communicate an informed decision to health care providers.

(f) "Consulting physician" means 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.

(g) "Department" means the State Department of Public Health.

(h) "Health care provider" or "provider of health care" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code; any person licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act; and any person certified pursuant to Division 2.5 (commencing with Section 1797) of this code.

(i) "Health care entity" means any clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200), including a general hospital, medical clinic, nursing home or hospice facility. A health care entity does not include individuals described in subdivision (h).

(j) "Informed decision" means 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.

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

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

(m) "Mental health specialist" means a psychiatrist or a licensed psychologist.

(n) "Physician" means a doctor of medicine or osteopathy currently licensed to practice medicine in this state.

(o) "Public place" means any street, alley, park, public building, any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access. "Public place" does not include a health care entity.

(p) "Qualified individual" means an adult who has the capacity to make medical decisions, is a resident of California, and has satisfied the requirements of this part in order to obtain a prescription for a drug to end their life.

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

(r) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

(Amended by Stats. 2021, Ch. 542, Sec. 1. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.2. (a) An individual who is an adult with the capacity to make medical decisions and with a terminal disease may make a request to receive a prescription for an aid-in-dying drug if all of the following conditions are satisfied:

(1) The individual's attending physician has diagnosed the individual with a terminal disease.

(2) The individual has voluntarily expressed the wish to receive a prescription for an aid-in-dying drug.

(3) The individual is a resident of California and is able to establish residency through any of the following means:

(A) Possession of a California driver's license or other identification issued by the State of California.

(B) Registration to vote in California.

(C) Evidence that the person owns or leases property in California.

(D) Filing of a California tax return for the most recent tax year.

(4) The individual documents his or her request pursuant to the requirements set forth in Section 443.3.

(5) The individual has the physical and mental ability to self-administer the aid-in-dying drug.

(b) A person shall not be considered a "qualified individual" under the provisions of this part solely because of age or disability.

(c) A request for a prescription for an aid-in-dying drug under this part shall be made solely and directly by the individual diagnosed with the terminal disease and shall not be made on behalf of the patient, including, but not limited to, through a power of attorney, an advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decisionmaker.

(Amended by Stats. 2017, Ch. 561, Sec. 99. (AB 1516) Effective January 1, 2018. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.3. (a) An individual seeking to obtain a prescription for an aid-in-dying drug pursuant to this part shall submit two oral requests, a minimum of 48 hours apart, and a written request to their attending physician. An attending physician shall directly, and not through a designee, receive a request required pursuant to this section and shall ensure the date of a request is documented in an individual's medical record. An oral request documented in an individual's medical record shall not be disregarded by an attending physician solely because it was received by a prior attending physician or an attending physician who chose not to participate.

(b) A valid written request for an aid-in-dying drug under subdivision (a) shall meet all of the following conditions:

(1) The request shall be in the form described in Section 443.11.

(2) The request shall be signed and dated, in the presence of two witnesses, by the individual seeking the aid-in-dying drug.

(3) The request shall be witnessed by at least two other adult persons who, in the presence of the individual, shall attest that to the best of their knowledge and belief the individual is all of the following:

(A) An individual who is personally known to them or has provided proof of identity.

(B) An individual who voluntarily signed this request in their presence.

(C) An individual whom they believe to be of sound mind and not under duress, fraud, or undue influence.

(D) Not an individual for whom either of them is the attending physician, consulting physician, or mental health specialist.

(c) Only one of the two witnesses at the time the written request is signed may:

(1) Be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual's estate upon death.

(2) Own, operate, or be employed at a health care entity where the individual is receiving medical treatment or resides.

(d) The attending physician, consulting physician, or mental health specialist of the individual shall not be one of the witnesses required pursuant to paragraph (3) of subdivision (b).

(Amended by Stats. 2021, Ch. 542, Sec. 2. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.4. (a) An individual may at any time withdraw or rescind their request for an aid-in-dying drug, or decide not to ingest an aid-in-dying drug, without regard to the individual's mental state.

(b) A prescription for an aid-in-dying drug provided under this part may not be written without the attending physician directly, and not through a designee, offering the individual an opportunity to withdraw or rescind the request.

(c) If the individual decides to transfer care to another physician, upon request of the individual the physician shall transfer all relevant medical records including written documentation including the dates of the individual's oral and written requests seeking to obtain a prescription for an aid-in-dying drug.

(Amended by Stats. 2021, Ch. 542, Sec. 3. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.5. (a) Before prescribing an aid-in-dying drug, the attending physician shall do all of the following:

(1) Make the initial determination of all of the following:

(A) (i) Whether the requesting adult has the capacity to make medical decisions.

(ii) If there are indications of a mental disorder, the physician shall refer the individual for a mental health specialist assessment.

(iii) If a mental health specialist assessment referral is made, no aid-in-dying drugs shall be prescribed until the mental health specialist determines that the individual has the capacity to make medical decisions and

is not suffering from impaired judgment due to a mental disorder.

(B) Whether the requesting adult has a terminal disease.

(C) Whether the requesting adult has voluntarily made the request for an aid-in-dying drug pursuant to Sections 443.2 and 443.3.

(D) Whether the requesting adult is a qualified individual pursuant to subdivision (q) of Section 443.1.

(2) Confirm that the individual is making an informed decision by discussing with them all of the following:

(A) Their medical diagnosis and prognosis.

(B) The potential risks associated with ingesting the requested aid-in-dying drug.

(C) The probable result of ingesting the aid-in-dying drug.

(D) The possibility that they may choose to obtain the aid-in-dying drug but not take it.

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

(3) Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions and has complied with the provisions of this part.

(4) Confirm that the qualified individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, outside of the presence of any other persons, except for an interpreter as required pursuant to this part, whether or not the qualified individual is feeling coerced or unduly influenced by another person.

(5) Counsel the qualified individual about the importance of all of the following:

(A) Having another person present when they ingest the aid-in-dying drug prescribed pursuant to this part.

(B) Not ingesting the aid-in-dying drug in a public place.

(C) Notifying the next of kin of their request for an aid-in-dying drug. A qualified individual who declines or is unable to notify next of kin shall not have their request denied for that reason.

(D) Participating in a hospice program.

(E) Maintaining the aid-in-dying drug in a safe and secure location until the time that the qualified individual will ingest it.

(6) Inform the individual that they may withdraw or rescind the request for an aid-in-dying drug at any time and in any manner.

(7) Offer the individual an opportunity to withdraw or rescind the request for an aid-in-dying drug before prescribing the aid-in-dying drug.

(8) Verify, immediately before writing the prescription for an aid-in-dying drug, that the qualified individual is making an informed decision.

(9) Confirm that all requirements are met and all appropriate steps are carried out in accordance with this part before writing a prescription for an aid-in-dying drug.

(10) Fulfill the record documentation required under Sections 443.8 and 443.19.

(11) Complete the attending physician checklist and compliance form, as described in Section 443.22, include it and the consulting physician compliance form in the individual's medical record, and submit both forms to the State Department of Public Health.

(b) If the conditions set forth in subdivision (a) are satisfied, the attending physician may deliver the aid-in-dying drug in any of the following ways:

(1) Dispensing the aid-in-dying drug directly, including ancillary medication intended to minimize the qualified individual's discomfort, if the attending physician meets all of the following criteria:

(A) Is authorized to dispense medicine under California law.

(B) Has a current United States Drug Enforcement Administration (USDEA) certificate.

(C) Complies with any applicable administrative rule or regulation.

(2) With the qualified individual's written consent, contacting a pharmacist, informing the pharmacist of the prescriptions, and delivering the written prescriptions personally, by mail, or electronically to the pharmacist, who may dispense the drug to the qualified individual, the attending physician, or a person expressly designated by the qualified individual and with the designation delivered to the pharmacist in writing or verbally.

(c) Delivery of the dispensed drug to the qualified individual, the attending physician, or a person expressly designated by the qualified individual may be made by personal delivery, or, with a signature required on delivery, by United Parcel Service, United States Postal Service, FedEx, or by messenger service.

(Amended by Stats. 2021, Ch. 542, Sec. 4. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.6. Before a qualified individual obtains an aid-in-dying drug from the attending physician, the consulting physician shall perform all of the following:

(a) Examine the individual and his or her relevant medical records.

(b) Confirm in writing the attending physician's diagnosis and prognosis.

(c) Determine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision.

(d) If there are indications of a mental disorder, refer the individual for a mental health specialist assessment.

(e) Fulfill the record documentation required under this part.

(f) Submit the compliance form to the attending physician.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.7. Upon referral from the attending or consulting physician pursuant to this part, the mental health specialist shall:

(a) Examine the qualified individual and his or her relevant medical records.

(b) Determine that the individual has the mental capacity to make medical decisions, act voluntarily, and make an informed decision.

(c) Determine that the individual is not suffering from impaired judgment due to a mental disorder.

(d) Fulfill the record documentation requirements of this part.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.8. All of the following shall be documented in the individual's medical record:

(a) All oral requests for aid-in-dying drugs.

(b) All written requests for aid-in-dying drugs.

(c) The attending physician's diagnosis and prognosis, and the determination that a qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the attending physician has determined that the individual is not a qualified individual.

(d) The consulting physician's diagnosis and prognosis, and verification that the qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the consulting physician has determined that the individual is not a qualified individual.

(e) A report of the outcome and determinations made during a mental health specialist's assessment, if performed.

(f) The attending physician's offer to the qualified individual to withdraw or rescind his or her request at the time of the individual's second oral request.

(g) A note by the attending physician indicating that all requirements under Sections 443.5 and 443.6 have been met and indicating the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.9. (a) Within 30 calendar days of writing a prescription for an aid-in-dying drug, the attending physician shall submit to the State Department of Public Health a copy of the qualifying patient's written request, the attending physician checklist and compliance form, and the consulting physician compliance form.

(b) Within 30 calendar days following the qualified individual's death from ingesting the aid-in-dying drug, or any other cause, the attending physician shall submit the attending physician followup form to the State Department of Public Health.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.10. A qualified individual may not receive a prescription for an aid-in-dying drug pursuant to this part unless he or she has made an informed decision. Immediately before writing a prescription for an aid-in-dying drug under this part, the attending physician shall verify that the individual is making an informed decision.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.11. (a) A request for an aid-in-dying drug as authorized by this part shall be in the following form:

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 entity where the person is a patient or resident.

(b) (1) The written language of the request shall be written in the same translated language as any conversations, consultations, or interpreted conversations or consultations between a patient and their attending or consulting physicians.

(2) Notwithstanding paragraph (1), the written request may be prepared in English even when the conversations or consultations or interpreted conversations or consultations were conducted in a language other than English if the English language form includes an attached interpreter's declaration that is signed under penalty of perjury. The interpreter's declaration shall state words to the effect that:

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./Mx. (insert name of patient/qualified individual) affirmed to me that they understood the content of this form and affirmed their desire to sign this form under their 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

(3) An interpreter whose services are provided pursuant to paragraph (2) shall not be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the person's estate upon death. An interpreter whose services are provided pursuant to paragraph (2) shall 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 the department for health care providers in California.

(Amended by Stats. 2021, Ch. 542, Sec. 5. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.12. (a) A provision in a contract, will, or other agreement executed on or after January 1, 2016, whether written or oral, to the extent the provision would affect whether a person may make, withdraw, or rescind a request for an aid-in-dying drug is not valid.

(b) An obligation owing under any contract executed on or after January 1, 2016, may not be conditioned or affected by a qualified individual making, withdrawing, or rescinding a request for an aid-in-dying drug.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.13. (a) (1) The sale, procurement, or issuance of a life, health, or annuity policy, health care service plan contract, or health benefit plan, or the rate charged for a policy or plan contract may not be conditioned upon or affected by a person making or rescinding a request for an aid-in-dying drug.

(2) Pursuant to Section 443.18, death resulting from the self-administration of an aid-in-dying drug is not suicide, and therefore health and insurance coverage shall not be exempted on that basis.

(b) Notwithstanding any other law, a qualified individual's act of self-administering an aid-in-dying drug shall not have an effect upon a life, health, or annuity policy other than that of a natural death from the underlying disease.

(c) An insurance carrier shall not provide any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. Any communication shall not include both the denial of treatment and information as to the availability of aid-in-dying drug coverage. For the purposes of this subdivision, "insurance carrier" means a health care service plan as defined in Section 1345 of this code or a carrier of health insurance as defined in Section 106 of the Insurance Code.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.14. (a) Notwithstanding any other law, a person shall not be subject to civil or criminal liability solely because the person was present when the qualified individual self-administers the prescribed aid-in-dying drug. A person who is present may, without civil or criminal liability, assist the qualified individual by preparing the aid-in-dying drug so long as the person does not assist the qualified person in ingesting the aid-in-dying drug.

(b) A health care provider, health care entity, or professional organization or association shall not subject an individual to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating in good faith compliance with this part or for refusing to participate in accordance with subdivision (e).

(c) Notwithstanding any other law, a health care provider or a health care entity shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for participating in this part. This subdivision does not limit the application of, or provide immunity from, Section 443.15, 443.16, or 443.17.

(d) (1) A request by a qualified individual to an attending physician to provide an aid-in-dying drug in good faith compliance with the provisions of this part shall not provide the sole basis for the appointment of a guardian or conservator.

(2) Actions taken in compliance with the provisions of this part shall not constitute or provide the basis for any claim of neglect or elder abuse for any purpose of law.

(e) (1) Participation under this part shall be voluntary. Notwithstanding Sections 442 to 442.7, inclusive, a person or entity that elects, for reasons of conscience, morality, or ethics, not to participate is not required to participate under this part. This subdivision does not limit the application of, or excuse noncompliance with, paragraphs (2), (4), and (5) of this subdivision or subdivision (b), (i), or (j) of Section 443.15, as applicable.

(2) A health care provider who objects for reasons of conscience, morality, or ethics to participate under this part shall not be required to participate. If a health care provider is unable or unwilling to participate under this part, as defined in subdivision (f) of Section 443.15, the provider shall, at a minimum, inform the individual that they do not participate in the End of Life Option Act, document the individual's date of request and provider's notice to the individual of their objection in the medical record, and transfer the individual's relevant medical record upon request.

(3) A health care provider or health care entity is not subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for refusing to participate under this part, as defined in paragraph (2) of subdivision (f) of Section 443.15.

(4) If a health care provider is unable or unwilling to carry out a qualified individual's request under this part and the qualified individual transfers care to a new health care provider or health care entity, the individual's relevant medical records shall be provided to the individual and, upon the individual's request, timely transferred with documentation of the date of the individual's request for a prescription for aid-in-dying drug in the medical record, pursuant to law.

(5) A health care provider or a health care entity shall not engage in false, misleading, or deceptive practices relating to a willingness to qualify an individual or provide a prescription to a qualified individual under this part.

(Amended by Stats. 2021, Ch. 542, Sec. 6. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.15. (a) Subject to subdivision (b), notwithstanding any other law, a health care entity may prohibit its employees, independent contractors, or other persons or entities, including health care providers, from participating

under this part while on premises owned or under the management or direct control of that health care entity or while acting within the course and scope of any employment by, or contract with, the entity.

(b) A health care entity shall first give notice upon employment or other affiliation and thereafter annual notice of the policy concerning this part to the individual or entity. An entity that fails to provide notice to an individual or entity in compliance with this subdivision shall not be entitled to enforce such a policy against that individual or entity. For purposes of this subdivision, posting on the entity's public internet website the entity's current policy governing medical aid in dying shall satisfy the annual notice requirement.

(c) Subject to compliance with subdivision (b), the health care entity may take action, including, but not limited to, the following, as applicable, against any individual or entity that violates this policy:

(1) Loss of privileges, loss of membership, or other action authorized by the bylaws or rules and regulations of the medical staff.

(2) Suspension, loss of employment, or other action authorized by the policies and practices of the health care entity.

(3) Termination of any lease or other contract between the health care entity and the individual or entity that violates the policy.

(4) Imposition of any other nonmonetary remedy provided for in any lease or contract between the health care entity and the individual or entity in violation of the policy.

(d) This section does not prevent, or allow a health care entity to prohibit, any health care provider, employee, independent contractor, or other person or entity from any of the following:

(1) Participating, or entering into an agreement to participate, under this part, while on premises that are not owned or under the management or direct control of the health care entity or while acting outside the course and scope of the participant's duties as an employee of, or an independent contractor for, the health care entity.

(2) Participating, or entering into an agreement to participate, under this part as an attending physician or consulting physician while on premises that are not owned or under the management or direct control of the health care entity.

(e) In taking actions pursuant to subdivision (c), a health care entity shall comply with all procedures required by law, its own policies or procedures, and any contract with the individual or entity in violation of the policy, as applicable.

(f) For purposes of this part:

(1) "Notice" means a separate statement in writing advising of the health care entity policy with respect to participating under this part.

(2) "Participating, or entering into an agreement to participate, under this part" means doing or entering into an agreement to do any one or more of the following:

(A) Performing the duties of an attending physician as specified in Section 443.5.

(B) Performing the duties of a consulting physician as specified in Section 443.6.

(C) Performing the duties of a mental health specialist, in the circumstance that a referral to one is made.

(D) Delivering the prescription for, dispensing, or delivering the dispensed aid-in-dying drug pursuant to paragraph (2) of subdivision (b) of, and subdivision (c) of, Section 443.5.

(E) Being present when the qualified individual takes the aid-in-dying drug prescribed pursuant to this part.

(3) "Participating, or entering into an agreement to participate, under this part" does not include doing, or entering into an agreement to do, any of the following:

(A) Diagnosing whether a patient has a terminal disease, informing the patient of the medical prognosis, or determining whether a patient has the capacity to make decisions.

(B) Providing information to a patient about this part.

(C) Providing a patient, upon the patient's request, with a referral to another health care provider for the purposes of participating under this part.

(g) Any action taken by a health care entity pursuant to this section shall not be reportable under Sections 800 to 809.9, inclusive, of the Business and Professions Code. The fact that a health care provider participates under this part shall not be the sole basis for a complaint or report of unprofessional or dishonorable conduct under Sections 800 to 809.9, inclusive, of the Business and Professions Code.

(h) This part does not prevent a health care provider from providing an individual with health care services that do not constitute participation in this part.

(i) Each health care entity shall post on the entity's public internet website the entity's current policy governing medical aid in dying.

(j) A health care entity shall not engage in false, misleading, or deceptive practices relating to its policy concerning end-of-life care services nor engage in coercion or undue influence under this part.

(Amended by Stats. 2021, Ch. 542, Sec. 7. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.16. (a) A health care provider may not be sanctioned for any of the following:

(1) Making an initial determination pursuant to the standard of care that an individual has a terminal disease and informing him or her of the medical prognosis.

(2) Providing information about the End of Life Option Act to a patient upon the request of the individual.

(3) Providing an individual, upon request, with a referral to another physician.

(b) A health care provider that prohibits activities under this part in accordance with Section 443.15 shall not sanction an individual health care provider for contracting with a qualified individual to engage in activities authorized by this part if the individual health care provider is acting outside of the course and scope of his or her capacity as an employee or independent contractor of the prohibiting health care provider.

(c) Notwithstanding any contrary provision in this section, the immunities and prohibitions on sanctions of a health care provider are solely reserved for actions of a health care provider taken pursuant to this part. Notwithstanding any contrary provision in this part, health care providers may be sanctioned by their licensing board or agency for conduct and actions constituting unprofessional conduct, including failure to comply in good faith with this part.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.17. (a) Knowingly altering or forging a request for an aid-in-dying drug to end an individual's life without their authorization or concealing or destroying a withdrawal or rescission of a request for an aid-in-dying drug is punishable as a felony if the act is done with the intent or effect of causing the individual's death.

(b) Knowingly coercing or exerting undue influence on an individual to request or ingest an aid-in-dying drug for the purpose of ending their life or to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without their knowledge or consent, is punishable as a felony.

(c) For purposes of this section, "knowingly" has the meaning provided in Section 7 of the Penal Code.

(d) The attending physician, consulting physician, or mental health specialist shall not be related to the individual by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the individual's estate upon death.

(e) This section does not limit civil liability or damages arising from negligent conduct or intentional misconduct in carrying out actions otherwise authorized by this part by any person, health care provider, or health care entity.

(f) The penalties in this section do not preclude criminal penalties applicable under any law for conduct inconsistent with the provisions of this part.

(Amended by Stats. 2021, Ch. 542, Sec. 8. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.18. Nothing in this part may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this part shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse under the law.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.19. (a) The State Department of Public Health shall collect and review the information submitted pursuant to Section 443.9. The information collected shall be confidential and shall be collected in a manner that protects the privacy of the patient, the patient's family, and any medical provider or pharmacist involved with the patient under the provisions of this part. The information shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

(b) On or before July 1, 2017, and each year thereafter, based on the information collected in the previous year, the department shall create a report with the information collected from the attending physician followup form and post that report to its Internet Web site. The report shall include, but not be limited to, all of the following based on the information that is provided to the department and on the department's access to vital statistics:

(1) The number of people for whom an aid-in-dying prescription was written.

(2) The number of known individuals who died each year for whom aid-in-dying prescriptions were written, and the cause of death of those individuals.

(3) For the period commencing January 1, 2016, to and including the previous year, cumulatively, the total number of aid-in-dying prescriptions written, the number of people who died due to use of aid-in-dying drugs, and the number of those people who died who were enrolled in hospice or other palliative care programs at the time of death.

(4) The number of known deaths in California from using aid-in-dying drugs per 10,000 deaths in California.

(5) The number of physicians who wrote prescriptions for aid-in-dying drugs.

(6) Of people who died due to using an aid-in-dying drug, demographic percentages organized by the following characteristics:

(A) Age at death.

(B) Education level.

(C) Race.

(D) Sex.

(E) Type of insurance, including whether or not they had insurance.

(F) Underlying illness.

(c) The State Department of Public Health shall make available the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form, as described in Section 443.22, by posting them on its Internet Web site.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.20. A person who has custody or control of any unused aid-in-dying drugs prescribed pursuant to this part after the death of the patient shall personally deliver the unused aid-in-dying drugs for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means in accordance with guidelines promulgated by the California State Board of Pharmacy or a federal Drug Enforcement Administration approved take-back program.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.21. Any governmental entity that incurs costs resulting from a qualified individual terminating his or her life pursuant to the provisions of this part in a public place shall have a claim against the estate of the qualified individual to recover those costs and reasonable attorney fees related to enforcing the claim.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.215. This part shall remain in effect only until January 1, 2031, and as of that date is repealed.

(Repealed and added by Stats. 2021, Ch. 542, Sec. 10. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, by its own provisions. Note: Repeal affects Part 1.85, comprising Sections 443 to 443.22.)

443.22. (a) The Medical Board of California may update the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form, based on those provided in subdivision (b). Upon completion, the State Department of Public Health shall publish the updated forms on its Internet Web site.

(b) Unless and until updated by the Medical Board of California pursuant to this section, the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form shall be in the following form:

* *

NOTICE OF INCOMPLETE TEXT: The physician compliance and follow-up forms appear in the published chaptered bill. See Sec. 1 of Chapter 1 (pp. 18–25), 2nd Ex. Session, Statutes of 2015.

* *

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215. Note: See published bill for complete section text. The physician compliance forms appear on pages 18 to 25 of Ch. 1 (2nd Ex.).)

ADDENDUM

End of Life Option Act Physician Compliance and Follow up Forms
Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1., pp. 18-25 (AB 15 2x)

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

ATTENDING PHYSICIAN CHECKLIST &
COMPLIANCE FORM

E	ADDITIONAL COMPLIANCE REQUIREMENTS

- ☐ 1. Counseled patient about the importance of all of the following:
- ☐ a) Maintaining the aid-in-dying drug in a safe and secure location until the time the qualified individual will ingest 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;
- ☐ 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
- ☐ e) Participating in a hospice program or palliative care program.
- ☐ 2. Informed patient of right to rescind request (1st time)
- ☐ 3. Discussed the feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.
- ☐ 4. Met with patient one-on-one, except in the presence of an interpreter, to confirm the request is not coming from coercion
- ☐ 5. First oral request for aid-in-dying: _____/_____/_____ Attending physician initials:_____
- ☐ 6. Second oral request for aid-in-dying:_____/_____/_____ Attending physician initials:_____
- ☐ 7. Written request submitted: _____/_____/_____ Attending physician initials:_____
- ☐ 8. Offered patient right to rescind (2nd time)

F	PATIENT'S MENTAL STATUS

Check one of the following **(required)**:

- ☐ 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.
- ☐ 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.
- ☐ 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)

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

G	MEDICATION PRESCRIBED	
	PHARMACIST NAME	TELEPHONE NUMBER ( ) —

1. Aid-in-dying medication prescribed:
   - ☐ a. Name:_____
   - ☐ b. Dosage:_____
2. Antiemetic medication prescribed:
   - ☐ a. Name:_____
   - ☐ b. Dosage:_____
3. Method prescription was delivered:
   - ☐ a. In person
   - ☐ b. By mail
   - ☐ c. Electronically
4. Date medication was prescribed:_____/_____/_____

	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.

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. *(Both the attending and consulting physicians must make these determinations.)*

- ☐ 1. Determination that the patient has a terminal disease.
- ☐ 2. Determination that patient has the mental capacity to make medical decisions.**
- ☐ 3. Determination that patient is acting voluntarily.
- ☐ 4. Determination that patient has made his/her decision after being fully informed of:
- ☐ a) His or her medical diagnosis; and
- ☐ b) His or her prognosis; and
- ☐ c) The potential risks associated with taking the drug to be prescribed; and
- ☐ d) The potential result of taking the drug to be prescribed; and
- ☐ 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)**:

- ☐ 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.
- ☐ 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.
- ☐ 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.

ATTENDING PHYSICIAN FOLLOW-UP FORM

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.

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.

This form should be mailed or sent electronically to the State Department of Public Health. All information is kept strictly confidential.

Date: _____/_____/_____

Patient name: _____

Attending physician name: _____

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?

- ☐ **Aid-in-dying drug** (lethal dose) → Please sign below and go to page 2.
  Attending physician signature:_____
- ☐ **Underlying illness** → There is no need to complete the rest of the form. Please sign below.
  Attending physician signature:_____
- ☐ **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:
  _____
  _____

Attending physician signature:_____

PART A and PART B should only be completed if the patient died from ingesting the lethal dose of the aid-in-dying drug.

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.

- ☐ The attending physician was present at the time of death.
  → The attending physician must complete this form in its entirety and sign Part A and Part B.
- ☐ The attending physician was not present at the time of death, 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.
- ☐ Neither the attending physician nor another licensed health care provider was present at the time of death.
  → Part A may be left blank. The attending physician must complete and sign Part B of the form.

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

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: _____

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: _____

ADDENDUM

CA Pen. Code sec 401 (Amended by Stats. 2018, Ch. 245, Sec. 1. (AB 282) Effective January 1, 2019)

2018 Cal. Legis. Serv. Ch. 245 (A.B. 282) (WEST)

CALIFORNIA 2018 LEGISLATIVE SERVICE

2018 Portion of 2017-2018 Regular Session

Additions are indicated by **Text** ; deletions by
* * * .
Vetoes are indicated by ~~Text~~ ;
stricken material by ~~**Text**~~.

CHAPTER 245
A.B. No. 282
SUICIDE—AID—CRIMES AND OFFENSES

AN ACT to amend Section 401 of the Penal Code, relating to suicide.

[Filed with Secretary of State September 5, 2018.]

LEGISLATIVE COUNSEL'S DIGEST

AB 282, Jones–Sawyer. Aiding, advising, or encouraging suicide: exemption from prosecution.

Existing law, the End of Life Option Act, until January 1, 2026, authorizes an adult who meets certain qualifications and who has been determined by his or her attending physician to be suffering from a terminal disease to request a prescription for an aid-in-dying drug. The act, with some exceptions, provides immunity from civil or criminal liability for specified actions taken in compliance with the act. Actions taken in accordance with the act do not, for any purpose, constitute suicide, assisted suicide, homicide, or elder abuse under the law.

Existing law makes a person who deliberately aids, advises, or encourages another to commit suicide guilty of a felony.

This bill would prohibit a person whose actions are compliant with the End of Life Option Act from being prosecuted for deliberately aiding, advising, or encouraging suicide.

The people of the State of California do enact as follows:

SECTION 1. Section 401 of the Penal Code is amended to read:

<< CA PENAL § 401 >>

401. * * * **(a) Any** person who deliberately aids, * * * advises, or encourages another to commit suicide * * * is guilty of a felony.

(b) A person whose actions are compliant with the provisions of the End of Life Option Act (Part 1.85 (commencing with Section 443) of Division 1 of the Health and Safety Code) shall not be prosecuted under this section.

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