AMENDED IN SENATE AUGUST 13, 2008

AMENDED IN SENATE JULY 2, 2008

AMENDED IN ASSEMBLY MAY 15, 2008

AMENDED IN ASSEMBLY APRIL 24, 2008

AMENDED IN ASSEMBLY APRIL 7, 2008

AMENDED IN ASSEMBLY MARCH 25, 2008

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL No. 2747

Introduced by Assembly Members Berg and Levine
(Coauthors: Assembly Members Bass, *Brownley, Huffman,* Jones, Mullin, Salas, Torrico, and Wolk)

February 22, 2008

An act to add Part 1.8 (commencing with Section 442) to Division 1 of the Health and Safety Code, relating to end-of-life care.

LEGISLATIVE COUNSEL'S DIGEST

AB 2747, as amended, Berg. End-of-life care.

Existing law provides for the licensure and regulation of health facilities and hospices by the State Department of Public Health. Existing law provides for the regulation and licensing of physicians and surgeons by the Medical Board of California.

This bill would provide that when a health care provider, as defined, makes a diagnosis that a patient has a terminal illness, the health care provider shall, upon the patient's request, provide the patient with *comprehensive* information and counseling regarding legal end-of-life options, as specified, and provide for the referral or transfer of a patient, *as provided,* if the patient's health care provider does not wish to comply with the patient's request for information on end-of-life options.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) Palliative and hospice care are invaluable resources for terminally ill Californians in need of comfort and support at the end of life.

(b) Palliative care and conventional medical treatment for terminally ill patients should be thoroughly integrated rather than viewed as separate entities.

(c) Even though Californians with a prognosis of six months or less to live are eligible for hospice care, nearly two-thirds of them receive hospice services for less than one month.

(d) Many terminally ill patients benefit from being referred to hospice care earlier, where they receive better pain and symptom management and have an improved quality of life.

(e) Significant information gaps may exist between health care providers and their patients on end-of-life care options potentially leading to delays in, or lack of referrals to, hospice care for terminally ill patients. The sharing of important information regarding specific treatment options in a timely manner by health care providers with terminally ill patients is a key component of quality end-of-life care. Information that is helpful to patients and their families includes, but is not limited to, the availability of hospice care, the efficacy and potential side effects of continued ~~curative~~ *disease-targeted* treatment, and withholding or withdrawal of life-sustaining treatments.

(f) Terminally ill and dying patients rely on their health care providers to give them timely and informative data. Research shows a lack of communication between health care providers and their terminally ill patients can cause problems, including poor availability of, and lack of clarity regarding, advance health care directives and patients' end-of-life care preferences. This lack of information and poor adherence to patient choices can result in “bad deaths” that cause needless physical and psychological suffering to patients and their families.

(g) Those problems are complicated by social issues, such as cultural and religious pressures on the providers, patients, and their family members. A recent survey found that providers that object to certain practices are less likely than others to believe they have an obligation to present all of the options to patients and refer patients to other providers, if necessary.

(h) Every medical school in California is required to include end-of-life care issues in its curriculum and every physician in California is required to complete continuing education courses in end-of-life care.

(i) Palliative care is not a one-size-fits-all approach. Patients have a range of diseases and respond differently to treatment options. A key benefit of palliative care is that it customizes treatment to meet the needs of each individual person.

(j) Informed patient choices will help terminally ill patients and their families cope with one of life’s most challenging situations.

SEC. 2. Part 1.8 (commencing with Section 442) is added to Division 1 of the Health and Safety Code, to read:

PART 1.8. END-OF-LIFE CARE

442. For the purposes of this part, the following definitions shall apply:

(a) “Actively dying” means the phase of terminal illness when death is imminent.

~~(b) “Curative treatment” means treatment intended to cure or alleviate symptoms of a given disease or condition.~~

(b) “Disease-targeted treatment” means treatment directed at the underlying disease or condition that is intended to alter its natural history or progression, irrespective of whether or not a cure is a possibility.

(c) “Health care provider” means an attending physician and surgeon. It also means a nurse practitioner or physician assistant *practicing* in accordance with standardized procedures or protocols developed and approved by the supervising physician and surgeon and the nurse practitioner or physician assistant.

(d) “Hospice” means a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and provide supportive care to the primary caregiver and the family of the hospice patient, and that meets all of the criteria specified in subdivision (b) of Section 1746.

(e) "Palliative care" means medical treatment, interdisciplinary care, or consultation provided to a patient or family members, or both, that has as its primary purpose the prevention of, or relief from, suffering and the enhancement of the quality of life, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life as described in subdivision (b) of Section 1339.31. *In some cases, disease-targeted treatment may be used in palliative care.*

(f) "Refusal or withdrawal of life-sustaining treatment" means forgoing treatment or medical procedures that replace or support an essential bodily function, including, but not limited to, cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and any other treatment or discontinuing any or all of those treatments after they have been used for a reasonable time.

442.5. When a health care provider makes a diagnosis that a patient has a terminal illness, the health care provider shall*, upon the patient's request,* provide the patient with comprehensive information and counseling regarding legal end-of-life care options~~, upon the patient's request and~~ pursuant to this section. When a terminally ill patient is in a health facility, as defined in Section 1250, the health care provider, or medical director of the health facility, if the patient's health care provider is not available, may refer the patient to a hospice provider or private or public agencies and community-based organizations that specialize in end-of-life care case management and consultation to receive *comprehensive* information and counseling regarding legal end-of-life care options.

(a) If the patient indicates a desire to receive the information and counseling, the comprehensive information shall include, but not be limited to, the following:

(1) Hospice care at home or in a health care setting.

(2) A prognosis with and without the continuation of ~~curative~~ *disease-targeted* treatment.

(3) The patient's right to refusal of or withdrawal from life-sustaining treatment.

(4) The patient's right to continue to pursue ~~curative treatment~~ *disease-targeted treatment, with or without concurrent palliative care*.

(5) The patient's right to comprehensive pain and symptom management at the end of life, including, but not limited to, adequate pain medication, treatment of nausea, palliative chemotherapy, relief of shortness of breath and fatigue, and other clinical treatments useful when a patient is actively dying.

(6) The patient's right to give individual health care instruction pursuant to Section 4670 of the Probate Code, which provides the means by which a patient may provide written health care instruction, such as an advance health care directive, and the patient's right to appoint a legally recognized health care decisionmaker.

(b) The information described in subdivision (a) may, but is not required to be, in writing. Health care providers may utilize information from organizations specializing in end-of-life care that provide information on factsheets and Internet Web sites to convey the information described in subdivision (a).

(c) Counseling may include, but not be limited to, discussions about the outcomes for the patient and his or her family, based on the interest of the patient. Information and counseling as described in subdivision (a) may occur over a series of meetings with the health care provider or others who may be providing the information and counseling based on the patient's needs. ~~The health care provider may encourage the patient to include his or her family in the counseling described in this subdivision.~~

(d) The information and counseling sessions may include a discussion of ~~benefits and burdens of~~ treatment options in a manner that the patient and his or her family can easily understand. If the patient requests information on the costs of treatment options, *including the availability of insurance and eligibility of the patient for coverage,* the patient shall be referred to the appropriate entity for that information.

442.7. If a health care provider does not wish to comply with his or her patient's request for information on end-of-life options, the health care provider shall do both of the following:

(a) Refer or transfer a patient to another health care provider *that shall provide the requested information*.

(b) Provide the patient with information on procedures to transfer to another health care provider *that shall provide the requested information*.

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