



*End of Life*

**CHOICES**

**C A L I F O R N I A**

*Your life. Your death. Your choice.*

## **End-of-Life Decisions**

Mark Greenberg, Executive Director

January 16, 2025

# Mission Statement



We provide Californians the **information** and **support** to successfully navigate their legal end-of-life options

# What we hope you take away...

**1**

Importance of sharing your values and end-of-life wishes with loved ones

**2**

Legal end-of life options in California

**3**

Resources and support provided by End of Life Choices California (EOLCCA)



# How we want our lives to end\*

- At home with our loved ones
- With our pain and discomfort managed
- Having our spiritual needs respected
- Without being a burden to loved ones

\*Journal of the American Society on Aging, June 2015



# Advance care planning benefits

Your values and wishes known and honored

Less confusion and family conflict

A gift of love



# Advance care planning: My Particular Wishes

My particular wishes for therapies that could sustain life...

This list helps you think about what you want and don't want.

It can be added to your Advance Care Directive.

## DECISIONS FOR SPECIFIC THERAPIES

(Note: If you are unsure of the purpose of any of the following medical therapies, please speak with a health professional for clarification.)

If my mental or physical state has deteriorated, the prognosis is grave, and there is little chance that I will ever regain mental or physical function, I would like the following:

	YES	TRIAL PERIOD*	NO
<b>1.</b> Antibiotics if I develop a life-threatening infection of any kind.			
<b>2.</b> Dialysis if my kidneys cease to function, either temporarily or permanently.			
<b>3.</b> Artificial ventilation if I stop breathing.			
<b>4.</b> Electroshock if my heart stops beating.			
<b>5.</b> Heart-regulating drugs including electrolyte replacement if my heartbeat becomes irregular.			
<b>6.</b> Cortisone or other steroid therapy if tissue swelling threatens vital centers in my brain.			
<b>7.</b> Stimulants, diuretics or any other treatment for heart failure if the strength and function of my heart is impaired.			
<b>8.</b> Blood, plasma or replacement fluids if I bleed or lose fluid circulating in my body.			
<b>9.</b> Artificial nutrition.			
<b>10.</b> Artificial hydration.			

\* Doctors may see whether the therapy quickly reverses my condition. If it does not, I want it discontinued.

# Advance care planning: Advance Directive

- Written by you
- Names a health care agent
- Instructions for health care
  - Prolong life
  - Do not prolong life
  - Pain relief
  - Other wishes
- Signatures
  - Yours
  - Two witnesses

ADVANCE HEALTH CARE DIRECTIVE FORM PAGE 3 of 7

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to donate my organs, tissues, and parts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:  
:  
:  
:  
(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

**PART 2**  
**INSTRUCTIONS FOR HEALTH CARE**

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below.

(a) Choice Not to Prolong Life  
I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

(b) Choice to Prolong Life  
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:  
:  
:  
(Add additional sheets if needed.)

(2.3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:  
:  
:  
(Add additional sheets if needed.)



# Advance care planning: POLST

## Physician Orders for Life- Sustaining Treatment

Translates your advance directive into physician orders for emergency personnel

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

**Physician Orders for Life-Sustaining Treatment (POLST)**

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

EMSA #111 B (Effective 1/1/2009)

Last Name \_\_\_\_\_  
First /Middle Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Date Form Prepared \_\_\_\_\_

**A CARDIOPULMONARY RESUSCITATION (CPR):** *Person has no pulse and is not breathing.*  
Check One  Attempt Resuscitation/CPR  Do Not Attempt Resuscitation/DNR (Allow Natural Death)  
(Section B: Full Treatment required)  
When not in cardiopulmonary arrest, follow orders in B and C.

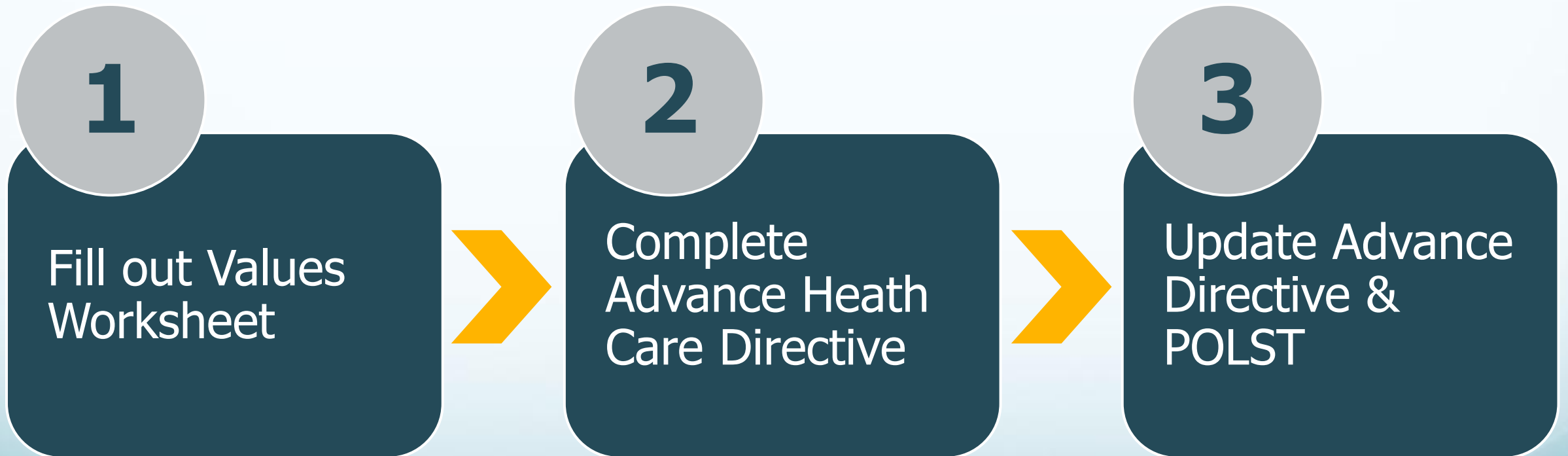
**B MEDICAL INTERVENTIONS:** *Person has pulse and/or is breathing.*  
Check One  **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. **Transfer** if comfort needs cannot be met in current location.  
 **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.  
 **Do Not Transfer to hospital for medical interventions.** **Transfer** if comfort needs cannot be met in current location.  
 **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. **Transfer to hospital if indicated.** Includes intensive care.  
Additional Orders: \_\_\_\_\_

**C ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible and desired.*  
Check One  No artificial nutrition by tube.  Defined trial period of artificial nutrition by tube.  
 Long-term artificial nutrition by tube.  
Additional Orders: \_\_\_\_\_

**D SIGNATURES AND SUMMARY OF MEDICAL CONDITION:**  
Discussed with:  
 Patient  Health Care Decisionmaker  Parent of Minor  Court Appointed Conservator  Other:  
**Signature of Physician**  
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.  
Print Physician Name \_\_\_\_\_ Physician Phone Number \_\_\_\_\_ Date \_\_\_\_\_  
Physician Signature (required) \_\_\_\_\_ Physician License # \_\_\_\_\_  
**Signature of Patient, Decisionmaker, Parent of Minor or Conservator**  
By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.  
Signature (required) \_\_\_\_\_ Name (print) \_\_\_\_\_ Relationship (write self if patient) \_\_\_\_\_  
Summary of Medical Condition \_\_\_\_\_ Office Use Only \_\_\_\_\_

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

# Advance care planning: Summary



# End of life options



# End of life options

Continuing medical treatment

Stopping unwanted medical treatment

Palliative care

Hospice care

Voluntarily stopping eating and drinking (VSED)

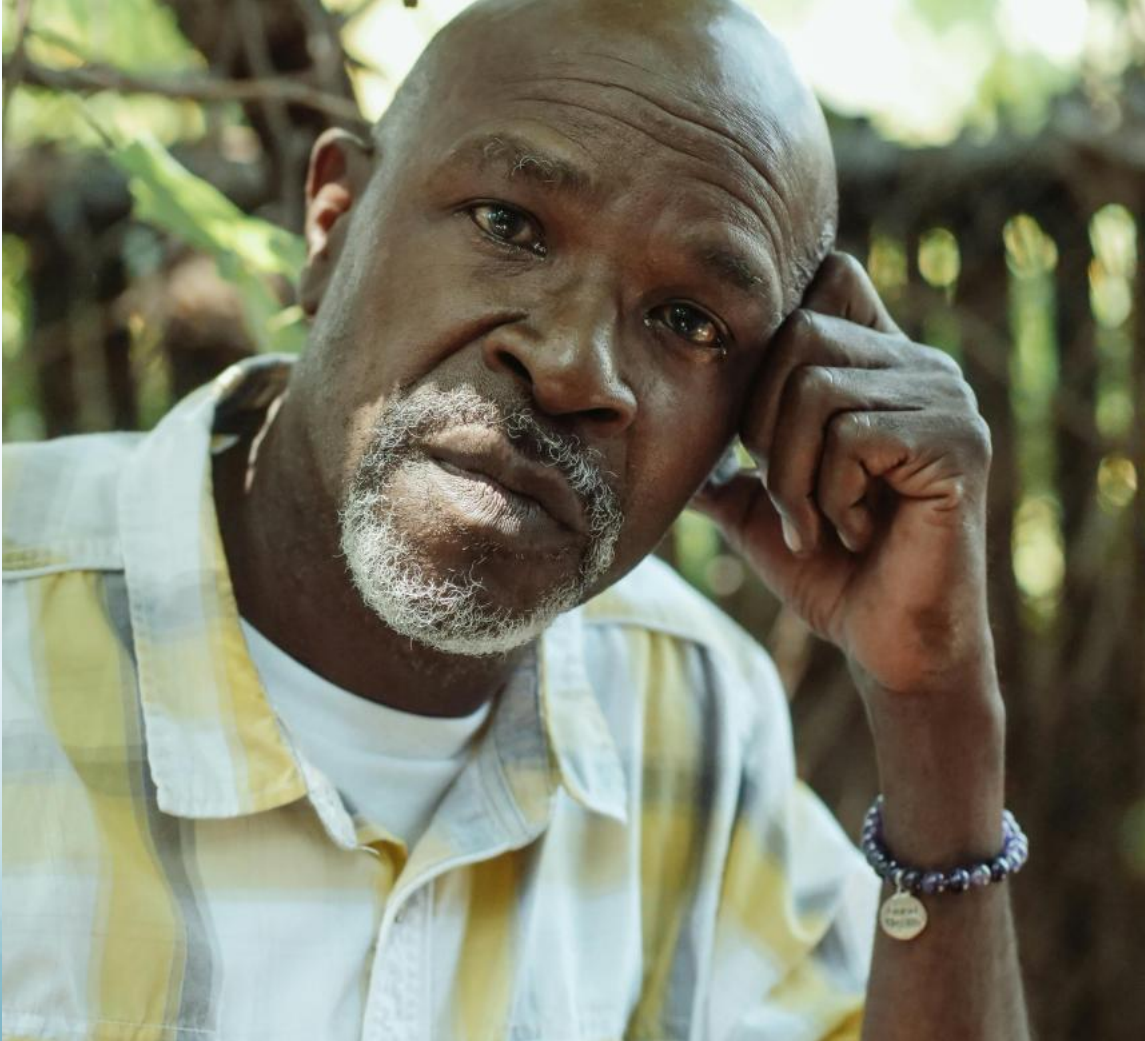
Medical aid in dying (California End of Life Option Act)

# Continuing medical treatment

Talk with your doctors about true expected outcomes



# Continuing medical treatment



Sometimes the treatments offered can feel worse than the condition itself.

# Continuing medical treatment

Personal decision:  
quantity of time  
vs  
quality of life



# Stopping unwanted medical treatment

Physician support is important

Examples include stopping:



Use of a ventilator



Antibiotic therapy for infection



Kidney dialysis



Heart defibrillation or pacemaker

# Palliative and hospice care

## Palliative care

- Any stage of disease
- Can have curative treatment if wanted
- Home, facility, or hospital
- Paid for by most insurance

## Common goals

- Manage symptoms of complex medical illnesses
- Physical relief
- Psychological relief
- Quality of life

## Hospice care

- 6 months or less to live
- Relief of pain and anxiety only (no curative treatment)
- Home, facility, or hospital
- Paid for by Medicaid Medicare, insurance
- Resources for support team (loved ones)

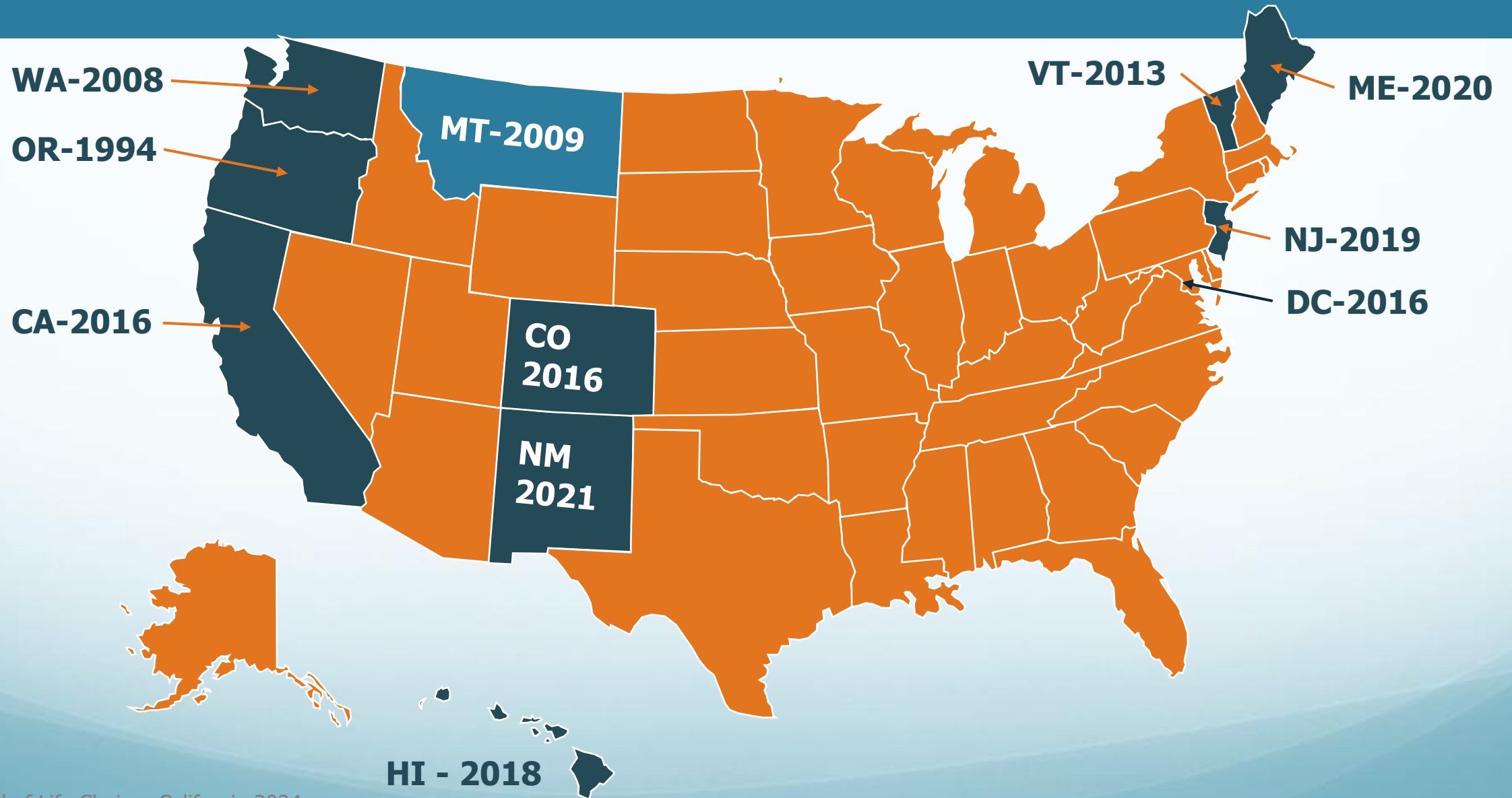
# Voluntarily stopping eating & drinking (VSED)

- Person stops taking ALL food and fluids
- Does not require evaluation of authorization by physician
- 24-hr support is critical (hospice, family, friends)
- Legal option for people who do not qualify for MAID
  - Neurodegenerative diseases
  - Autoimmune diseases
  - Chronic pain
  - Any other condition

# Medical Aid in Dying (MAID)

A legal option allowing a physician to prescribe life-ending medications to a **terminally-ill** and **mentally-capable** adult to control the timing of their death.

# End-of-life movement in the US



# CA End of Life Option Act: 2016



“I do not know what I would do if I were dying in prolonged and excruciating pain.

I am certain, however, it would be a comfort to be able to consider the options afforded by this law.

And I wouldn't deny that right to others.”

-Governor Brown

# CA End of Life Option Act: Eligibility

- Adult / CA resident
- Terminally ill = life expectancy of six months or less as determined by a physician
- Capable of making informed medical decisions
- Able to take the medication in a small amount of liquid independently (self-ingest)



# CA End of Life Option Act: Process



- Two verbal requests made to Attending Physician, minimum of 48 hours apart
- One written request signed by 2 witnesses
  - One = unrelated to the person
  - Attending & Consulting physicians & others on MAID healthcare team cannot be witnesses
- Second (Consulting) physician must confirm eligibility

# Medical Aid in Dying: Prescription

- Physician provides Rx directly to pharmacy
- Medication = powder mixed with 2 oz liquid just before person takes it
- Deep sleep generally occurs 2-10 minutes afterwards and progresses to deep coma
- 80% of people die in 2 hours or less



# Aid in dying medication is a comfort in itself

- One-third of people who fill prescription never take it
- Person can change their mind and not take medication
- Just having it provides comfort
- Puts person in control



# Numerous safeguards provided

Safeguards guarantee that:

- Choice is voluntary
- Person is:
  - Terminally ill
  - Making the choice themselves
  - Clear about consequences
- Person has considered alternatives



# By law, MAID is not suicide

CERTIFICATION OF VITAL RECORD

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH SERVICES

Death certificate shows underlying disease as cause of death

STATE FILE NUMBER	1A. NAME OF DECEASED	2. SEX
	Helen	F
4. RACE	5. STATE OF BIRTH	6. STATE OF DEATH
White	NY	NY
7. MILITARY SERVICE	8. USUAL OCCUPATION	9. USUAL RESIDENCE
	Bridge Tech	24882 St
10. TO 19	11. PLACE OF DEATH	12. STREET ADDRESS—CITY AND ZIP CODE
	Savilleback Memorial Del	24451 Health Center Laguna Hills
13. DEATH WAS CAUSED BY—IMMEDIATE CAUSE	14. DUE TO	15. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH
(a) Sepsis	(b) Bowel Infarction	(c) Congestive heart failure, Atrial Fibrillation
(d) Atherosclerosis		
16. DATE OF DEATH	17. TIME OF DEATH	18. TIME INTERVAL BETWEEN ONSET AND DEATH
12/22/91	12/22/91	1 day
19. TYPE OF DEATH	20. TYPE OF DEATH	21. TYPE OF DEATH
22. MANNER OF DEATH	23. PLACE OF INJURY	24. DATE OF INJURY
25. LOCATION (STREET AND NUMBER OR LOCATION AND CITY)	26. DESCRIBE HOW INJURY OCCURRED (EVENTS WHICH RESULTED IN INJURY)	27. SIGNATURE OF REGISTRAR
28. DISPOSITIONS	29. PLACE OF FINAL DISPOSITION—NAME AND ADDRESS	30. DATE
	TR/H Lakewood Cemetery, Chicago, ILL	Dec 25 1991
31. NAME OF FURNERAL DIRECTOR OR PERSON ACTING AS SUCH	32. LICENSE NO.	33. SIGNATURE OF LOCAL REGISTRAR
Pack-Kaibars Baggott & Schacht	FD-194	A. Lee Elling, D. Engraged
34. STATE REGISTRAR	35. REGISTRATION DATE	36. CENSUS TRACT
	DEC 24 1991	



# Words matter!

## Best practice

- Medical Aid in Dying
- Aid in Dying
- Assisted Dying
- Assistance in Dying
- Planned death
- Patient-controlled death
- Voluntary stopping eating & drinking (VSED)

## Misleading / incorrect

- Suicide
- Assisted suicide
- Euthanasia
- Hasten death
- Killing
- Staggered death

**How we can help**



# End of Life Choices California

Free, confidential support for end-of-life planning



# End of Life Choices California

Free, confidential support for end-of-life planning



**How you can help**



# How YOU can help



**TELL** people about us and the California End-of-Life Option Act



**ASK** your doctor now if they will support your request for MAID if you have a terminal illness in the future



**SIGN UP** for our newsletter and blog to stay up to date on these topics



**VOLUNTEER** your skills and talents to maintain and expand our outreach



**DONATE** to support our mission and keep our services free of charge to all



# Do I Qualify?

Learn more about the California End of Life Option Act (ELOA)

LEARN MORE



Who We Are ▾

Options ▾

The Law ▾

Planning ▾

Ways to Help ▾

Resources ▾

Contact Us ▾

Events ▾

# Do I Qualify?

Learn more about the California End of Life Option Act (ELOA)

LEARN MORE



# *End of Life* CHOICES

*Your life. Your death. Your choice.*

**CALIFORNIA**