MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eightieth Session
February 25, 2019

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 3:01 p.m. on Monday, February 25, 2019, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Julia Ratti, Chair
Senator Pat Spearman, Vice Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

GUEST LEGISLATORS PRESENT:

Senator David R. Parks, Senate District No. 7

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Committee Counsel
Vickie Polzien, Committee Secretary

OTHERS PRESENT:

Dr. Peg Sandeen, Executive Director, Death with Dignity
Dr. Robert Rabkin
Dr. Charles Held
Debbie Black
Ashley Cardenas, Compassion & Choices
Dan Diaz, Compassion & Choices
John Fudenberg, Coroner, Office of the Coroner/Medical Examiner, Clark County
Jaime Rodriguez, Office of the County Manager, Washoe County

Holly Welborn, American Civil Liberties Union, Nevada
Mackenzie Baysinger, Human Services Network
Jason Henkle, Nevada Death with Dignity Action Project
Fred Voltz
Sam Toll, Libertarian Party of Nevada
Kristen Hanson, Patients' Rights Action Fund
Dr. T. Brian Callister, Compassion & Choices
Marilyn Golden, Disability Rights Education and Defense Fund
Concetta Tedesco, Catholic Daughters of the Americas
Belen Gabato, Philippine Nurses Association of Nevada
Dr. William Frankell
Kathleen Rossi
Dr. Kirk Bronander
Dr. Timothy Doyle
Rowena Harrison
Tom Baker
Margaret Dore
David Walker
Catherine O'Mara, Nevada State Medical Association
Dr. Peter Fenwick
Herb Santos, Jr.
Lisa Bedotto Laughlin
Theresa DeGraffenreid
Bob Russo
Mary Fechner
Jean Sokol, Right to Life
Lynn Chapman, American Independent Party
Janine Hansen, Nevada Families for Freedom
Don Nelson, Pro-Life League of Nevada
Melissa Clement, Nevada Right to Life

CHAIR RATTI:
We will open the hearing on Senate Bill (S.B.) 165.

SENATE BILL 165: Makes various changes to provisions governing prescribing, dispensing and administering controlled substances designed to end the life of a patient. (BDR 40-292)

SENATOR DAVID R. PARKS (Senatorial District No. 7):
I will read the preamble to S.B. 165 found on pages 3 and 4 of the bill.

> WHEREAS, A patient should have the right to self-determination concerning his or her health care decisions based on communications with his or her physician; and
>
> WHEREAS, Principles of law having their roots in common law and the United States Constitution that date back to the late 19th century establish the right of every person to the possession and control of his or her own body, free from restraint or interference by others; and
>
> WHEREAS, It is necessary to promote awareness and discussion of health care issues in preparation for decisions concerning the end of the life of a person; and
>
> WHEREAS, A person should have the right to self-determination concerning medically assisted, informed, voluntary decisions about dying with dignity and avoiding unnecessary suffering; and
>
> WHEREAS, A person who suffers from a terminal condition should have the right to determine whether to fight for his or her life using all reasonable care until life's end, to enroll in hospice care, to seek palliative care, to ingest a drug to end his or her life or to take any combination of those actions.

Senate Bill 165 is our third, and hopefully, last and successful attempt to enact this legislation. I have been asked by people from across Nevada in many different legislative districts to pass this legislation. Some are cancer patients who want to have the peace of mind knowing they can control their final days. Others are Nevadans who are healthy now, but want to know that if they are diagnosed with a terminal illness, and after exploring all traditional options, a legal, safe and peaceful option is available to them to control the end of their life on their own terms.

There are some who will quote one of the several versions of the Hippocratic Oath in opposition to this measure. There are other portions of this Oath they seem to have forgotten. For those who actually abide by the Oath, and many doctors no longer take it, I remind them of this portion of the Oath.

> I will apply for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism. I will remember that there is no art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

What this means is they take an oath to realize they must consider the patient and what is best for them.

When the patient says, "enough is enough, I am done," a good physician who swears by the Hippocratic Oath should respect that. We are fortunate in this Country to have many good physicians and I consider my colleague, Dr. Hardy, to be in that company.

I invite other supporters to present their testimony to the Committee. I would like Dr. Peg Sandeen of the National Death with Dignity organization to walk you through S.B. 165 and answer any questions you may have concerning the language and the process as it stands.

DR. PEG SANDEEN (Executive Director, Death with Dignity):
I am going to review each section of S.B. 165 and attempt to be as brief as possible, highlighting the important sections.

Section 1 deals with details of the medical certificate of death listing the underlying cause of death as the disease.

Sections 3 through 10 provide important definitions I will refer to as I go through each section.

Section 11 is a legislative justification for end of life options.

Section 12 is an important section as it identifies what must happen for a patient to be eligible and qualify for assistance in dying. There are six points about qualification. They must be an adult 18 years of age or older and a State resident. They must be diagnosed with a terminal disease by two physicians;

the attending physician and one consulting physician. The definition from section 10 states a person has a 6 month prognosis.

The patient must have an informed voluntary decision, informed consent essential to the process. The patient must be mentally competent, meaning they have the ability to make and understand the nature of the decision. The concept of competence is set forth in this statute in section 5. No coercion or undue influence can be present for a patient to qualify for a prescription to hasten death.

There are safeguards that are related to the requests; the waiting periods and the witnesses that are set forth in section 13 of S.B. 165. The patient must make 2 verbal requests to the attending physician and there is a waiting period of 15 days. The second verbal request needs to be made at least 15 days after the first request. A written request must also be made to the attending physician. The written request must be signed by two witnesses. One of the witnesses cannot be a person related to the patient, nor standing to benefit from their death in a will.

Section 14 codifies the form of the written request; all states have a codified form of the written request. Nevada is in line with all states that have this type of legislation.

Section 15 is the medical standard of care. It sets forth, in the terms of responsibilities of the physician, all steps a physician must follow if a patient requests a hastened death. The physician must inform the patient they may revoke the request at any time during the process. The physician must verify the patient understands both the diagnosis and the prognosis, and verify the patient understands the entire process he or she must undergo to qualify. The physician must review all available means of treating or managing the patient's terminal condition; comfort care, hospice and pain control. The physician must describe the probable effects of the prescribed substance. The physician must meet alone with the patient, or if an interpreter is necessary, they may attend to determine there is no evidence of coercion and the patient is acting voluntarily. The physician must discuss the importance of having another person present when the patient self-administers or ingests the medication. The physician must refer the patient for a second opinion with a consulting physician to confirm the diagnosis and the prognosis. The physician must instruct the patient against administering the prescription in a public place. The physician must recommend the patient notify the next of kin about their decision and reconfirm the patient is competent and acting without coercion before writing the prescription.

Section 16 deals with mental competence, the patient's ability to make and communicate health care decisions. In this section it spells out if either the physician, the attending physician or the consulting physician have any concerns the patient may not be competent. The attending physician shall refer the patient for a consultation by a psychiatrist or psychologist and must not write the prescription until after the competency status is determined. The process must stop until a psychologist or psychiatrist determines the patient is competent to make health care decisions.

Section 17 regards the process of writing and dispensing the prescription. This section allows the physician to write a prescription for the medication to hasten death if the safeguards in sections 12 through 14 are met, as well as the standard of care set out in sections 15 and 16 have been followed. The physician must notify the pharmacist of the prescription and transmit it directly to the pharmacist either electronically or in person. The drug may be dispensed directly only to the patient, the prescribing physician or an agent of the patient identified to the pharmacist as such. This medication cannot be dispensed by mail.

Section 18 provides a physician shall not prescribe the controlled substance designed to end the life of a patient based solely on age or disability of the patient.

Section 19 refers to medical record and charting requirements and spells out the attending physician and consulting physician. If the mental health consultation occurred, all three must document in the patient record all steps described in the sections above. If the patient requests a change of physician, the attending physician must transmit or forward the medical records of the patient to the new physician on the request of the patient.

Section 20 clarifies the patient's right to revoke their decision at any time and revocation is effective immediately.

Section 21 spells out only the patient who receives the prescription may self-administer the drug. If the substance is not self-administered, it must be disposed of in accordance with Nevada law.

Section 22 refers to reporting requirements for the physician and pharmacist. The attending physician who prescribes the drug must report to the Health and Human Services Division of Public and Behavioral Health the name and amount of the substance prescribed. The pharmacist must also report the same information. After the death of the patient, within 30 days, the physician must report to the same Division non-personal identification demographics. The Division may adopt regulations to require the physician or pharmacist to report other information, as long as it is not personally identifiable. All such information submitted is deemed confidential.

Section 23 states the responsibilities of the Division, including compiling an annual report with the number of patients for whom a prescription is written, the number who self-administer the drug, the drugs prescribed, the frequency each drug was prescribed, aggregate patient demographics and the rate of death per 10,000 deaths. The Division must report on the internet and submit to the Legislative Counsel Bureau, which will be transmitted to the Interim Health Committee or to the Legislature, depending on the year.

Section 24 states physicians, psychologists and pharmacists who participate in the process described in S.B. 165 are not subject to professional discipline and do not violate applicable standards of care if they adhere to the safeguards and the standards of care set out in the law.

Section 25 states the death of a patient, under the protocol described in S.B. 165, is not a suicide or homicide and may not be reported as such.

Section 26 prohibits any person from requiring a patient to make or revoke a request for the prescription as a condition of receiving health care.

Section 27 states it is unlawful for any person to forge a request for a prescription described in this piece of legislation, exert undue influence on an ill person to request such a prescription or encourage an ill person to self-administer the life-ending drug.

Section 28 provides important protections of conscience for attending physicians and consulting physicians who are not required to provide such prescriptions to their patients.

Section 29 provides the same protections to the owners and operators of health care facilities. It provides details about health care facilities and how they may opt out and the steps to follow in order to do so.

Section 30 includes the dispensing of a controlled substance within the definition of medical treatment.

Section 31 excludes the activities set forth in S.B. 165 from drug trafficking statutes.

Section 32 allows a person to self-administer and possess the drug pursuant to Section 21.

Section 33 provides that on the effective date of S.B. 165, a will requiring a person to request, or prohibiting a person from requesting, a prescription as described in this bill, is unenforceable and is void.

Section 34 provides a person is not deemed to need a guardian based solely on their request for, or revocation of, a request for a prescription designed to end their life.

Section 35 excludes these records from public record laws, ensuring confidentiality.

Section 36 limits the provisions of this bill to attending physicians only, although there are other health care providers who may prescribe controlled substances under other circumstances.

Section 37 reinforces that prescriptions are not public records and must not be divulged by pharmacists except under certain circumstances, including the report to the Nevada Division of Public and Behavioral Health described in section 22.

Sections 38-40 deal with insurance and provide insurers writing life insurance, or group life insurance, may not deny a claim, cancel a policy or impose additional charges. They may not refuse to sell or issue a policy or charge a higher rate to cover a person solely because the insured has requested or revoked a request for a prescription designed to end their life.

Section 41 specifies legislative reports submitted pursuant to this act are exempt from the requirements in *Nevada Revised Statutes* (NRS) 218D.380.

Section 42, the final section, states the act becomes effective upon passage and approval.

SENATOR HARDY:
We are concerned as to what "competent" means in section 5. We all know that competence may vary depending on the circumstance. In section 12, the 15 days required for written requests, can this be accomplished through telemedicine?

DR. SANDEEN:
A written request must be delivered to the attending physician, which would mean in person. I am unsure what Nevada telehealth statutes state.

SENATOR HARDY:
In our opioid laws, we have a genuine relationship with the doctor. This legislation does not elaborate on this. Not that this would happen in Oregon, but obviously some people in Nevada may be going to Oregon and seeking out a doctor who will allow them to die the way they would like. I suspect some of that tourism effect may come to us if we do not have that relationship with a person. The person wanting to participate in physician-assisted suicide would not be face to face, as a written request is first required, followed by another written request 15 days later. The same written request requires two witnesses; one who is not a relative to the person, meaning one interested person, and one disinterested person. Am I understanding that correctly?

DR. SANDEEN:
That is correct, one disinterested person.

SENATOR HARDY:
One of them could well be interested or have that conflict of interest. In section 13, subsection 2:

> If a patient resides in a facility for long-term care or a facility for hospice care at the time the patient makes a written request pursuant to this section, one of the witnesses described in paragraph (b) of subsection 1 must be designated to serve as a

> witness by the facility and may include, without limitation, an ombudsman, a chaplain or a social worker.

The patient receives 120 days of skilled care coverage from Medicare. When that runs out, the facility also cares for that patient financially. Could that facility wishing to facilitate this patient in ending their life be one of the witnesses, or would that be a conflict of interest?

DR. SANDEEN:
One of the reasons this bill requires a witness from a facility is due to the underlying principle that this is voluntary for everyone involved, including a health care institution. We are mandating that a health care institution has one of the persons as a witness, so they know that it is taking place in their property.

SENATOR HARDY:
If this is happening in a facility, would you be able to say they must notify the person, as opposed to one of the witnesses, because it is a direct conflict of interest as the facility has a vested interest in having that person move on?

DR. SANDEEN:
The reason this is in the bill is because it provides the facility the opportunity to be informed.

SENATOR HARDY:
In section 15, when a person revokes their request, what happens to the medication they currently have that will allegedly by law be destroyed? I am unsure what the law is that states we must destroy this medication. Is there a law in Nevada that states the medication must be returned after the request is revoked? We do not want a patient revoking their request and have a person with a conflict of interest obtaining the medication and inadvertently giving it to another person.

DR. SANDEEN:
We are very concerned about controlled substances available to the general population. In states and jurisdictions providing death with dignity, people do not fill the prescription until they intend to use them, as it is exceedingly expensive. We do not have the prescriptions available to the general public. In the event that someone is fortunate enough to be able to afford the medication,

as they feel the prescription gives them peace of mind, and they unfortunately die of their underlying condition before having the opportunity to ingest the medication, the prescription must be destroyed according to Nevada law.

I have met with individuals stating there are take back situations where medications can be returned to be destroyed where legal. It is legal under their federal guidelines related to destruction and who can possess controlled substances. I have been told Nevada law has the ability to authorize this and it does happen in your towns and communities.

SENATOR HARDY:
With regard to my comment on competency, have you an answer for that comment about the varying periods of competency? How do you handle this in Oregon?

DR. SANDEEN:
Competence is a multi-faceted issue. The way we have addressed this issue in the piece of legislation before you is to ask two physicians to determine competence. If they have any question whether there is concern with competence, the patient must be referred to a psychiatrist or psychologist for evaluation. Before the physician may write the prescription, he or she again must determine competence. At the end of the two waiting periods, the physician must again determine competence before the prescription can be written. This is what we have done statutorily to address the issue of competence.

What happens in Oregon and Washington demonstrates about 90 percent of patients requesting and ingesting medications through death with dignity are also enrolled in hospice; they are receiving health care. When enrolled in hospice you have entire teams addressing all of your health issues. We know these patients are receiving quality health care as an indicator their mental health issues are being addressed through that vector. There are indications we are looking at competence in the implementation happening after the structure of the policy you have in front of you.

SENATOR HAMMOND:
Section 1 states the person who signs the death certificate specifies the cause of death as the primary disease. I am wondering if Nevada may run afoul of

federal laws where Medicare is asking for specific language, due to Medicare fraud. I want to make sure that is not happening.

DR. SANDEEN:
This does not run afoul of any federal legislation. We have had this law in Oregon with the same standards for 20 years and not encountered this. In Washington, they have had this legislation since 2008, and have not encountered this. A patient is hastening an already impending death, already going to pass from this condition. What goes on the death certificate is the underlying condition leading to the person's death.

SENATOR HAMMOND:
Section 12, subsection 6, speaks to coercion and undue influence.

There is a court case out of Oregon involving a Kate Cheney. She had early onset dementia, and although she was of sound mind, her daughter asked her mother to see a physician for medication to end her life. They contacted a different physician for a second opinion who ordered a psychiatric evaluation. In our law, she lacked the high level capacity required to weigh the options. The request was denied and her daughter became angry. Another evaluation took place, and the psychiatrist deemed her mother competent while noting her choices might be influenced by her family's wishes and the daughter's coercion. She took the medications prescribed and passed away.

Safeguards are what I am worried about. Senate Bill 165 states we are going to make sure there is no coercion or undue influence, which is hard to determine. Are we sure we are stringent enough in these safeguards?

DR. SANDEEN:
The case of Ms. Cheney is well-documented; it is not a case of which I have personal knowledge. I can only share my knowledge from the documentation I have read. The conclusions have always been that in the end, she was competent to make the decision and there was no report to the medical board. There were no difficulties associated with any court cases, and this case has been examined very carefully in Oregon as is set out in the law. Some consider this a failure of the Oregon law; I consider this a success. Competency was evaluated very closely, it was looked at in several venues and vetted as a case study in a peer review medical journal. It was determined there was an appropriate prescription given. We consider this the way Oregon and Nevada

laws would shine a light on this process and require when difficult issues of competency arise there are multiple steps that are followed.

SENATOR HAMMOND:
I would ultimately like to see the coercion issues addressed. Section 12, subsection 3 states you must be a resident of the State. I understand residency to be living in the State for a month.

The bill also states if someone knows they are within six months of their life ending, they can request the medication to end their life. If Nevada's residency requirement is only one month, I am worried we are going to have more people relocating to Nevada, coining suicide tourism and requesting end of life medications. Perhaps we need to say residents need to be here for six months in order to make that request.

SENATOR PARKS:
It is my understanding in most other states the residency requirement of 30 days is the standard. This being our legislation, I believe we could take that into consideration as to whether we may want to do things differently.

SENATOR SPEARMAN:
My question is regarding palliative care. Can you describe this and what medications are used in palliative care?

DR. SANDEEN:
Palliative care is an area of medicine that has arisen to address quality of life, mostly at the end of life. It is meant to ensure someone's quality of life is valued as much as treatment, especially at the end of life, to ensure people's pain is fully controlled. We consider unaddressed pain as a medical emergency, ensuring people's pain is controlled, or making sure someone's anxiety at the end of life is addressed. We think of palliative medicine as comfort care, ensuring quality of life is provided at the end of life. The big provider in palliative care is hospice, a Medicare beneficiary-specific type of palliative medicine.

SENATOR SPEARMAN:
So this care is given at the request of the family or patient?

DR. SANDEEN:
Yes, that is correct. Palliative medicine would be given voluntarily at the request of the patient. If a patient is unable to make a request, and they have someone making decisions for them, that person would request the palliative care. Palliative medicine would also be available on request, as it would be a standard of care to ensure the quality of life is administered if he or she cannot make decisions.

SENATOR SPEARMAN:
Is a psychiatrist required to determine they are competent at that time?

DR. SANDEEN:
No that is not required.

CHAIR RATTI:
My questions are around the extent to which this process has been used in other states. I want to ensure we are not opening Pandora's box and those who deserve care will not get care, as this will be an option. I need to understand the numbers we are talking about, the scope and scale.

DR. SANDEEN:
The Oregon Health Department statistics show 90 percent of those involved with the process are enrolled in hospice. We know they are receiving solid medical care; this is not a group of individuals not receiving medical care. A very high number, between 90 percent and 95 percent in Oregon, have health insurance. This is before the Affordable Care Act. These are numbers that extend to before we were attempting to cover health care for everyone. These folks have health insurance, access to physicians and have access to good quality end of life care. They are not seeking death with dignity as an alternative to care, it is running in tandem with care. Death with dignity is part of an end of life option, not an alternative to treatment at the end of life.

CHAIR RATTI:
Do we have a sense of numbers?

DR. SANDEEN:
In Oregon, just over 1,000 people over 20 years have used the law. This is a very low number of individuals every year seeking to use death with dignity. This is a rarely used option at the end of life.

SENATOR HARDY:
How do you do your prescription monitoring program as we have ICD-10 codes in which we state what the controlled substance is for. What are your requirements for prescribing and filling prescriptions?

DR. SANDEEN:
My knowledge of this is cursory. I am reluctant to go into details that I am not aware of.

SENATOR HARDY:
Section 25 shows the act does not constitute suicide or homicide. Did you have to change your death certificate forms to include the reason for the death and list the diagnoses leading to the ultimate cause of death?

DR. SANDEEN:
Our forms were not changed. The patient dies from the underlying condition.

SENATOR HARDY:
The patient did not die from the underlying condition; they died from taking the medication prescribed to end their life, which would technically be an overdose.

DR. SANDEEN:
The way Oregon looks at this, and the way Nevada would look at this, is the patient dies from the underlying condition. The death was hastened, but the underlying condition brought about the death.

SENATOR HARDY:
Section 29 protects the facility or owner of the facility from prohibiting an employee from participating. This gives them the same protection as the physician, nurse or pharmacist, so they are not mandated to participate in the process, is this correct?

DR. SANDEEN:
Yes, that is correct.

SENATOR HARDY:
When we use the word advanced practice nurses; is this intended to go beyond the physician, physician assistant, medical assistant, we know as in NRS 630 and NRS 633?

DR. SANDEEN:
Section 36 of the bill states NRS 639.1375 is amended to the advanced practice registered nurse, not limiting the provisions of the bill to the attending physician only.

SENATOR HAMMOND:
You mentioned what the laws were in Oregon. I have found statistics reporting in the last 15 years the suicide rate, according to the Centers for Disease Control and Prevention, has gone up about 23 percent here in the United States. In that same time frame in Oregon, it has gone up about 48 percent. How many people have been denied the medication once it has been requested?

DR. SANDEEN:
Oregon does not track denials of those that do not qualify for the medication. Suicide is a complicated thing, and I will assert the rise since Oregon has enacted death with dignity, and the increased number of suicides, is a spurious correlation. There is no relationship; the numbers did go up at the same time, but there is no evidence there is a relationship. There was a journal article published that looked at this relationship statistically and it was determined there is no statistical relationship between death with dignity in Oregon and the rise in the number of suicides in our state. This number is not borne out as a statistical relationship; there is no evidence that one caused the other.

A national organization that looks at suicide has come to the conclusion that death with dignity does not lead to suicide. It is not part of the increase in suicide.

SENATOR HAMMOND:
Not having read all the journals you have spoken about, I am going to vote on policy for those who live in this State. My underlying worry is coercion and undue influence. When you talk about verbal requests, nowhere does it state the person requesting must be there in person. Do they have to be there in person or can they call in a request, for example, telemedicine?

CHAIR RATTI:
We spoke about this earlier and I believe the answer was Dr. Sandeen was not familiar with telehealth laws in our State, so I will ask legal counsel to look into that question for us.

SENATOR HAMMOND:
Can I ask him to look into whether there is intention to allow someone to call in versus in person, or is it the intention they be there in person?

DR. SANDEEN:
The Nevada law was based on the Oregon law which was written 20 years ago, and there was no telemedicine at that time, so the request has to be made in person.

SENATOR HAMMOND:
You mentioned that of the two witnesses, one could not be related to the patient. Does that mean one could be related to the person and have financial gain?

CHAIR RATTI:
I believe this question was asked by Senator Hardy.

SENATOR HAMMOND:
This issue is also being addressed in the New Mexico Legislature, stating if a patient is looking at an illness that could terminate their life within six months they would be able to start the procedure. They used a different term, in the "foreseeable future." I want to make sure this is not step one to later looking at removing language stating six months for someone looking at a terminal illness in the "foreseeable future."

DR. SANDEEN:
This concerns me as well. I am interested in this being a limited option available to a limited number of people. My organization has fought diligently to maintain the six months as a standard. To the point of the New Mexico legislation, we recommended and could not go on record as supporting this legislation until they amended it to have a six month diagnosis.

SENATOR HAMMOND:
If a physician refers a patient for psychiatric review, it only asks the psychiatrist have one visit with the patient. Is this correct?

DR. SANDEEN:
The psychiatrist or psychologist must follow his or her standard of care for establishing competence as they have been trained, and what Nevada requires.

The number is not up to us to put in statute. Therefore, we left it to those two groups of individuals as this is what they do in practice.

SENATOR HAMMOND:
The other safeguard that is worrisome is insurance. If a patient makes the decision they want assisted suicide through this method, I am worried insurance companies are going to deny insurance. It will be established, in certain categories, the patient is terminal and there is nothing that can be done, even though the insurance company could give them the coverage to help them overcome or extend their life. Are there additional safeguards we could look at to ensure insurance companies do not deny coverage?

DR. SANDEEN:
This bill does codify the steps that are inherent in medicine. Going to see a physician for a second opinion is part of medicine, as is a referral to a psychiatrist is part of medicine. There are things written in this bill that dictate those pieces we are already familiar with in medicine. We also depend on medicine to do its job well. Nevada has a strong statute about medicine and a strong medical board.

We currently have no health care system where people can be denied for their terminal illness. When we think about insurance companies denying insurance coverage because of death with dignity, these people no longer want health care.

SENATOR HAMMOND:
Section 28 has the physician or pharmacist "escape clause." Nurses were not included there. Is this needed?

DR. SANDEEN:
Nurses are not technically involved in this process. We do know that nurses provide support to doctors, but in terms of the details of this process there is not a nurse involved.

ERIC ROBBINS (Committee Counsel):
I am unable to locate any specific Nevada law on how pharmaceuticals are to be disposed. I believe that provision is primarily aimed at saying the laws concerning controlled substances and hazardous materials would apply if someone was found to be in possession of these materials. The executors of

the estate would have to find a way to dispose of the drugs in a manner that no one was in unauthorized possession of them and did not create an environmental hazard.

CHAIR RATTI:
Would this apply if a patient was to pass and they had a significant supply of opioids that had been prescribed, or any other controlled substance prescribed?

MR. ROBBINS:
Yes. I would like to point out that NRS 453.333 states it is murder if someone was to furnish a controlled substance that is then used in someone's death.

Telehealth issues do not contain any expressed limitations on services that can be provided through telehealth. As long as the service does not require a physician to be physically present, it could be provided via telehealth. Medical ethics and scope of practice limitations would apply. If the services in this bill could be ethically provided via telehealth, there is nothing that would limit that. If the intent was they must be provided in person, I would advise amending the bill to include a specific provision to that effect.

CHAIR RATTI:
There is language you could add to this bill to make it an exception to add telehealth in NRS?

MR. ROBBINS:
Exactly.

DR. ROBERT RABKIN:
I will read from my written testimony in favor of S.B. 165 (Exhibit C).

DR. CHARLES HELD:
I will read from my written testimony in favor of S.B. 165 (Exhibit D).

SENATOR SPEARMAN:
I have a question about morphine and palliative care. What does morphine do other than calm the pain? Does it have any other effect on the body?

DR. HELD:
Morphine helps with pain relief, is sedating and has a secondary effect of suppressing respirations. It has been long accepted, including by the Catholic Church. The secondary effect, which might, in fact, hasten death, is allowed in the context of relieving suffering.

SENATOR SPEARMAN:
Morphine not only calms pain, but a secondary effect would be respiratory?

DR. HELD:
Yes, it suppresses breathing. It has a direct suppressive effect on the central respiratory centers in the brain. Given enough morphine, any of us would stop breathing.

SENATOR SPEARMAN:
Is there something in place for the person who is in hospice and has requested palliative care?

DR. HELD:
Yes, although I am not a hospice physician, I did have experience with my father in hospice. They gave him the necessary amounts of medication to alleviate his pain, even though near the end of his life, it more than likely contributed to his death by making his breathing shallow and ultimately, he stopped breathing.

SENATOR SPEARMAN:
Palliative care, in a roundabout way, relieves the pain some of these people are trying to get out of.

DR. HELD:
My distinction between death with dignity and palliative care is that palliative care is ongoing until the patient dies of their underlying disease. The Death with Dignity Act allows someone, at a point in time once they have been determined to be within six months of death, to stop all care, take the medication and pass at that point in time.

SENATOR HARDY:
As a pulmonologist, you understand the concept of air hunger that people experience as they are dying. Morphine relieves air hunger and leads to

respiratory depression. That air hunger is well-alleviated in a palliative way in order to facilitate the stopping of their breathing.

DR. HELD:
Yes, that is true.

DEBBIE BLACK:
I testified in favor of S.B. 165 in 2017 and am in support of it today. I have been living with metastatic breast cancer for nine years and am blessed to say I have no evidence of the disease. I want to be able to spend my last days and hours with my family and friends able to celebrate life, and when I feel the time has come, I should be able to make the choice of how I end my life, rather than let the cancer take me. I want to leave this life knowing I was in peace with suffering and died with some dignity, not only for myself, but also for my family. I hope you will consider what I have said and make this possible for others living with a terminal disease.

ASHLEY CARDENAS (Compassion & Choices):
I am here representing Compassion & Choices in support of S.B. 165 and will read from my written testimony (Exhibit E).

SENATOR HAMMOND:
We heard previously there was no correlation between the numbers in physician-assisted suicide and suicide in the United States. I have found information on a new study stating there is a correlation. Controlling various socio-economic factors unobservable in the State in specific linear trends, we find that legalizing physician-assisted suicide was associated with the 6.3 percent increase in total suicides. There is some evidence that suggests it does increase. You have stated you can easily refute that evidence. We may be jumping to the conclusion there is no alternative.

DAN DIAZ (Compassion & Choices):
I am the husband of Brittany Maynard. Brittany died on November 1, 2014 in Portland, Oregon. We are Californians, but had to move to Oregon so Brittany would have access to medical aid in dying, in order to ensure her dying process was gentle should it become necessary for her. On New Year's Day we discovered her brain tumor. The tumor was very large and there was no cure. The eight hour surgery she endured at the University of California, San Francisco Medical Center was able to remove only 35 percent of the tumor.

There are areas of the brain that cannot be operated on. We researched every treatment option that was available, but the tumor was growing aggressively, and had we stayed in California, the tumor would have ended Brittany's life in a horrific manner.

To be clear, the terminally ill person who applies for this option is not deciding between living and dying. This is not a right to life or right to choose issue. The option of living was no longer on the table for Brittany. Her option was between two different methods of dying. One would be gentle; the other filled with unrelenting pain. The assertion by any physician that in 100 percent of the cases we can control an individual's pain and suffering at the end of life is not true. That would be irresponsible. I will line up scores of physicians to refute any such arrogant claim. My wife, Brittany, refused to accept the paternalistic view of a physician telling the patient when they have suffered enough and hooking them up to a morphine drip to potentially die a frightening death.

Nationwide, 72 percent of the population agrees that a terminally ill individual should have this option at the end of life. The support here in Nevada is slightly higher than that. Nationwide support among Catholics is 70 percent; I say that as a Catholic. While the church leadership may have a position of being opposed, the congregants agreed with Brittany that a terminally ill individual should have this option at the end of life. I am here testifying for this legislation, because it is a promise I made to my wife before she died. No one in Nevada should have to leave their home and move to another state as we did in order to have this option.

There were a few questions that were asked where you were not provided with a satisfactory answer. Regarding the terminology, a person pursuing the option of physician-assisted suicide is not suicidal. Brittany wanted to live; a suicidal person wants to die. A person who is suicidal is depressed, despondent and making irrational decisions. Brittany was none of those things. She was safely taking the control back from her brain tumor so she could have a say in how her final days would play out.

This legislation for the first time protects the most vulnerable in our society, the elderly and disabled, because their voices are heard. This legislation requires the conversation be had. Only the terminally ill individual can sit across from their physician and request this. It cannot be done by proxy or by power of attorney. Secobarbital is a medication that is primarily used; it is a sleeping medicine. It has been around for over 80 years. In Brittany's case, the prescription was for 100 capsules which had to be opened, the powder emptied into a glass mixed with 4-5 ounces of water, and Brittany had to be able to consume that on her own. It was not administered to her.

In the absence of this legislation, we had in our possession dilaudid, which is four times stronger than morphine. Fifty secobarbital would be 200 mg of dilaudid, the equivalent of 800 mg of morphine. I am 190 pounds, which is enough to put me to sleep for good. Why stop there? There are 240 in the bottle so I could certainly get the job done. For the terminally ill individual or anyone to qualify for this, they simply have to be in pain. There is no process, no two physicians scrutinizing the individual establishing their mental competency, making sure they are not simply going through a bout of depression. They determine the patient has qualified for the secobarbital.

When Brittany received her prescription, she put it away and focused on living her life. The goal is always to live as long as you possibly can. This program simply allowed Brittany to ensure she did not have to suffer what the brain tumor was already doing to her; pain not even dilaudid could alleviate. The seizures were increasingly more frequent and severe. She was unable to sleep for days on end, and the nausea and vomiting were getting worse. Coming next, as the tumor would continue to grow, it would put pressure on other parts of the brain and she would lose her eyesight or eventually go blind. If she were to suffer a stroke, depending on what part of the brain is damaged due to lack of oxygen, she would be partially paralyzed and die a suffering mass in bed. Brittany said no, I refuse to die that way. She would rather live as long as she possibly can, and if and when she gets to a point where modern medicine is unable to keep her comfortable, she can say I love you to the people in the room and pass away gently.

Unfortunately in the last four years, as I have testified in support of this legislation, I am unsure of how many family members I have had come to me and tell me they did not do it by hoarding medications. I was just in New Mexico and a woman provided testimony that her mother, who had never handled a gun, simply got the shotgun belonging to her husband and shot herself. That is not health care. This legislation for the first time will protect patients as it allows physicians to address whatever portion of that individual's care is not being addressed. Because it forces the conversation, the physician now has the opportunity to say I need to speak with my colleagues, you do not qualify for medical aid to die and are nowhere near six months end of life. There are parts of your care that are not being addressed and let us take care of those so a person does not reach the level of thinking they need to get a firearm.

The law in New Mexico states there must be a six month prognosis. The language you mentioned earlier was in the bill initially and we requested it be changed to a six month prognosis and the bill was amended to do so.

The idea that insurance will withhold treatment and instead offer the "bait and switch"; there has not been a documented case where someone has said we are going to withhold this treatment.

The only option available to any terminally ill individual, in any state across the Country, is that of terminal sedation. That is the medical practice of putting a person into sedation, withholding food and water until that person dies of dehydration and the effects of the underlying disease. I have seen that play out first hand.

There was a question on the use of morphine. Unfortunately, that is what sometimes happens behind closed doors, utilizing medication like secobarbital where a family member may say we have the medication, why not increase the dosage. That is unfortunately what can happen right now, versus once this legislation is passed, that terminally ill patient is in control.

JOHN FUDENBERG (Coroner, Office of the Coroner/Medical Examiner, Clark County):
I am presenting and will review (Exhibit F) a proposed amendment to S.B. 165.

The intent of the language added to section 22, subsection 4, was to make sure when we as law enforcement or the coroner's jurisdictions respond to a death scene, we would have access to the database to determine whether or not the decedent did, in fact, get prescribed the medication.

The language added to section 24, subsection 4, after speaking with our civil district attorney representative, was added because there are 3 sections preceding that have some protection for different folks.

SENATOR HAMMOND:
Are you saying that is going to be subsection 4 of section 24?

MR. FUDENBERG:
That is correct, subsection 4 is a new subsection.

The purpose for that protection is that we have other legislation that requires us to take jurisdiction over these types of deaths, and rule those suicides. We want to ensure when we are following the law and not ruling them suicides, we have some protection against other family members not supporting the assisted suicide and bringing action against the county or the coroner with that county.

We are having a difficult time understanding how section 25, subsection 1, would happen in reality. If we respond to a death scene with a decedent, whether accompanied by a family member or friend, we have no way of verifying they did, in fact, die from the ingestion of that prescription. We want to make it clear, although we may respond to the scene, we will not take jurisdiction and will not be held to certifying the death.

One of the issues we have with death with dignity folks is ensuring these types of deaths are not ruled suicides and do not fall under the jurisdiction of a county coroner, putting the family through an autopsy. We feel this section would minimize that and take care of the Coroner's Office not handling the certification of death and ruling them suicides.

JAIME RODRIGUEZ (Office of the County Manager, Washoe County):
Our medical examiner has the same concerns Mr. Fudenberg covered. We are here in support of Clark County's amendment to the bill.

SENATOR HARDY:
With 20 years of experience in Oregon, how does their process work?

MR. FUDENBERG:
I am unaware of how their process works. I have heard from different offices in Oregon and have been told these deaths are not reported to the coroner and medical examiner's office in Oregon, so they are not involved. In Clark County, if it is an unattended death and it happens in a residence and the decedent is not on hospice care, we do respond to the death. I am also unaware if the police have a way of verifying the decedent was someone prescribed the end of life prescription and not call us. We want to make sure if we are called, we are at least covered and not have to certify the death. Under our other statutes, we have to certify these deaths as suicides and that defeats the purpose of this bill.

HOLLY WELBORN (American Civil Liberties Union, Nevada):
The American Civil Liberties Union of Nevada strongly supports the right of an individual who is terminally ill to make the deeply personal decision to end his or her life, and how that person will face those final days. This includes support for the patient's right to ask a physician for help in carrying out their decision. The right of individual autonomy protects all people and the right to control their bodies during the course of their lives.

There is also legal and transparent value in having aid in dying. States have created and tolerated gray markets for people with recourses to find sympathetic doctors to help them die peacefully. Other desperate patients try self-induced and sometimes unsuccessful methods for ending their lives.

Bringing aid in dying out of the shadows creates an open process and gives patients with terminal diseases peace of mind knowing they can choose the timing of their own death. End of life choice is already recognized as an accepted legal principle. A competent adult's unqualified legal right to decline medical care, even when the result is certain death, is universally accepted where clear and convincing evidence exists that the patient wished to end life support, such as through an advanced directive.

Finally, aid in dying laws open up communication between the doctor and patient that promote the right of the patient to choose life. For example, in Oregon only 1 in 25 patients who ask a physician about aid in dying actually request the medication. One third of the people who request the medication actually take it. This allows patients the freedom to discuss their fears openly and physicians can offer information on alternative forms of care.

MACKENZIE BAYSINGER (Human Services Network):
The Human Services Network would like to express our support for S.B. 165 on the basis of the National Association of Social Workers code of ethics. This includes the obligation to give particular attention to the needs and empowerment of people who are vulnerable or oppressed.

JASON HENKLE (Nevada Death with Dignity Action Project):
As far as the telehealth issue is concerned, I would say that as you have to be eligible and receive a diagnosis as a terminally ill patient with a follow up, I am unsure this could be handled through strictly telemedicine. Moving beyond that process, perhaps the telemedicine statutes come into play.

As to Chairwoman Ratti's scope and scale argument, I have put together the data from Oregon and Washington from the Nevada Death with Dignity Action Project and created a linear projection (Exhibit G) showing the kind of boundary analysis we would see if this became law. According to the data from 1999 to 2015, on average we would see 146 Nevadans participating in death with dignity if it became enacted.

I would like to clarify the latest data out of Oregon from 1998 to 2017 showing 1,265 Oregonians participating in death with dignity. In Washington from 1995 to 2017 there were 926 participating. This makes a total of 2,191 participating in death with dignity. These statistics are updated every year with the latest information. Oregon, at the end of this week or early next week, will have a report for 2017.

As far as the medical examiner's concerns, we know when the prescriptions are issued there is going to be a return of unconsumed medications. This leads to the statistics on why they chose to participate in death with dignity. I believe that return process will help address some of the concerns of the medical examiners.

SENATOR HARDY:
There are over 146 Nevadans participating per day, per year, for 20 years?

MR. HENKLE:
This projection is 146 annually on average over 5 years.

FRED VOLTZ:
I believe terminally ill people who have been determined competent should be able to decide how they are going to live the rest of their lives. I strongly support S.B. 165.

I believe some of the objections that have been brought up can be overcome. I have three issues I would like to bring up to enhance the bill further. In section 14, page 7, there should be an affirmative understanding statement by the person signing this about their own life; that they understand the implications their choice might have about life insurance coverage or annuities they have. It could be a disclosure statement showing the implications that go along with the form they are given. They may be referred to the State Insurance Commissioner to have the implications explained to them.

In section 38, subsection 2, most people with a terminal illness are not going to be issued an insurance policy. No insurance company will issue one. That particular section may need to be removed. We may need a section added for the individual with a life insurance policy that is paid for and no renewal happening and the policy is in force; hence a need for extra language covering that eventuality.

SAM TOLL (Libertarian Party of Nevada):
I am here representing the Libertarian Party of Nevada in support of S.B. 165. This subject touches on one of the core principles of our party we hold very dear, the notion of self-ownership. Within the context of our lives, we believe there is no more superior moral arbiter of what happens to us as individuals than ourselves. We feel by depriving or having this option not on the table for people who face troubling and very personal life ending situations, they may resort to less compassionate and comfortable means to end their lives.

KRISTEN HANSON (Patients' Rights Action Fund):
I am here representing the Patients' Rights Action Fund in opposition of S.B. 165 and will read from my written testimony (Exhibit H).

SENATOR HAMMOND:
In your estimation, do you feel the safeguards we have in this legislation that patients can be referred out of the psychological evaluation are adequate?

MS. HANSON:
One of the reasons my husband felt so strongly he needed to speak out against assisted suicide was he saw patients as vulnerable as he was. You can experience depression at any point following your diagnosis, not just when you request the lethal medication. In Oregon, less than 4 percent of patients are referred out for psychological evaluation and we will never know how many of them are actually depressed when they take the medication.

DR. T. BRIAN CALLISTER (Compassion & Choices):
I am here representing Compassion & Choices in opposition to S.B. 165 and will comment on portions of my written testimony I have submitted (Exhibit I).

This is not about freedom, choice and autonomy. I am here as an interested physician as I have experienced this. I am a past President of the State Medical Association and the Governor-Elect of the American College of Physicians. I had no idea what this was about until this happened to me. My colleagues asked why I was so surprised, they did nothing illegal. They did not, but it is unethical in my mind.

Unending pain and suffering comes up time and again. In 20 years of Oregon data, 20 percent of patients refer to pain, or the future concern of pain, as the reason for requesting assisted suicide. I would also point out that the top reasons, burden to family, loss of enjoyment, usual activities and loss of autonomy are sad social issues. These are not a good reason to end your life prematurely, especially when the ability to predict life expectancy, giving a terminal diagnosis has an average error of 50 percent to 70 percent.

MARILYN GOLDEN (Disability Rights Education and Defense Fund):
I am here representing the Disability Rights Education and Defense Fund in opposition to S.B. 165. I will read from my written testimony and reference the handouts I have submitted (Exhibit J) and (Exhibit K).

CONCETTA TEDESCO (Catholic Daughters of the Americas):
I am here today in opposition to S.B. 165. What does it actually mean when a person requests physician-assisted suicide? It is not only the physical pain, it can mean other things such as loneliness or concern for being a burden to others. I have an issue with a statement Dr. Sandeen made about patients being referred to a psychiatrist or psychologist for competency only. I believe the bill should include the patient be referred to a psychiatrist or psychologist as soon as medical staff notices a patient is depressed and requesting physician-assisted suicide, not only for competency.

BELEN GABATO (Philippine Nurses Association of Nevada):
I am here representing the Philippine Nurses Association of Nevada in opposition to S.B. 165. Our members believe we become arbiters of life and death in the continuum of life. We do not know the unintended consequences of this bill. We practice by the old dictum in the Hippocratic Oath, "do no harm." We believe this is the ultimate harm done to the patient. Until the issues raised today are addressed, you should have a public hearing the next time so all issues are addressed. We cannot support this bill in its present form.

DR. WILLIAM FRANKELL:
If a person prior to becoming terminal has put in writing, such as in a will, their desire to no longer receive treatment and pass away, that should be honored.

After someone is sick or terminal their mental capacity has changed. Their thinking processes have altered. This issue is not addressed anywhere in S.B. 165.

I am a severely disabled person who is on numerous medications and am concerned if this bill passes there will be a financial issue with insurances, like Medicare and Medicaid, to slowly begin denying medications. I have had medications denied due to cost. No one should be denied medication due to cost, especially when they are terminal.

The thought process of those who are terminal can change. If someone prior to being sick has stated in a will their desire for assisted suicide, that desire should be honored. A will being written prior to one being sick should not be invalidated as stated in the bill.

I believe the actual cause of death must be included somewhere in the paperwork, not the underlying illness, but stating there was an assisted suicide.

KATHLEEN ROSSI:
I am opposed to S.B. 165 and will read from my written testimony (Exhibit L).

DR. KIRK BRONANDER:
I practice hospital medicine where I see patients on a daily basis and have conversations about end of life on at least a weekly basis. It is very difficult to give a patient a terminal diagnosis and predict the prognosis of an illness. We are often wrong in this prognosis. It is extremely difficult to give someone six months when you really do not know. It is a guess, and yet this law will make you eligible to terminate your life if a doctor says you have six months left to live. It is a total guess on most occasions. Even cancer, which is probably the easiest, is quite difficult.

It was stated in the law, we should depend on medicine to do well; we cannot always depend on this. I trust most of my colleagues. I do not trust every doctor in Nevada. You, as legislators, have had to deal with the opioid epidemic, as have we. Opioids are the most regulated medications we can prescribe; however, the medications prescribed for death with dignity are not regulated by the federal government. We will not know who is prescribing these medications, and it will not be stated on the death certificate.

It was also said patients need to seek hospice care. There are large parts of Nevada where there is no hospice care. I spoke with a provider today in Eureka, Nevada, and there is no hospice there. If we pass this law, they will not have hospice, but there will be the chance to kill yourself. I am in opposition to S.B. 165.

DR. TIMOTHY DOYLE:
I am a neurologist in Carson City and am opposed to S.B. 165 for several reasons. It certainly harms the practice of medicine itself. The American Medical Association states "physician-assisted suicide is fundamentally incompatible with the physician's role as a healer. It would be difficult or impossible to control and would pose societal risks."

Is it not ironic doctors who traditionally refuse to participate in the execution of convicted prisoners are not being recruited to help kill the innocent? This bill establishes a double standard of medical care for suicidal patients by targeting those who are most vulnerable with terminal illnesses.

The University of California, Irvine, Professor of Psychiatry Aaron Kheriaty reports that 80 percent to 90 percent of suicides are associated with depression or other treatable mental illnesses. Yet only 1 in 20 who have died by assisted suicide in Oregon were referred for psychiatric consultation before their deaths. "This lack of basic psychological evaluation and treatment constitutes medical negligence." In Nevada, medical license renewal for psychiatrists requires suicide prevention and awareness education. This bill promotes suicide; psychiatrists promote suicide prevention. The reason psychiatrists do not see these patients is because it would undermine the role of what this bill is promoting. It is promoting suicide.

ROWENA HARRISON:
I am a practicing hospice nurse in Washoe County and I oppose S.B. 165 and will read from my written testimony (Exhibit M).

For a patient to be put on hospice, there has to be two doctors agreeing on the terminal diagnosis of six months. They have to be recertified multiple times and have face to face visits by the physician, ensuring they are meeting criteria Medicare requires to maintain hospice care.

As was stated by Ms. Maynard's husband, there is terminal sedation available for patients that have any kind of intractable symptoms. They can be admitted to the hospital and receive acute care.

We are there for the patients. We are with patients and families when they are dying. We provide emotional, physical, spiritual and psychological support from social workers and chaplains as we are treating more than the patient; we are treating the family.

TOM BAKER:
I will read from my written testimony submitted in opposition to S.B. 165 (Exhibit N).

MARGARET DORE:
I am an attorney from Washington State where assisted suicide and euthanasia are legal under a similar law. I am in opposition to S.B. 165 and have submitted written testimony (Exhibit O).

The legislation you are considering allows euthanasia due to many reasons, one being the definition of self-administer. I want to make it clear we are talking about people who have years or decades to live. I have a friend who was talked out of assisted suicide 18 years ago. The definition of self-administer in S.B. 165 is not defined. It is defined in the Washington State bill as the act of ingesting. The preamble to the bill also refers to ingesting a lethal dose.

The death certificate creates the perfect crime. A person dies with a lethal dose, perhaps not voluntarily. They may be getting better and a family member knows the medication is available in the home in case the illness worsens and they decide to use the medication. The death certificate is going to show a natural death and the family inherits from the will. Senate Bill 165 is very explicit to allow insurance coverage in the event assisted suicide is the choice taken. This bill would allow legal murder. The death certificate is a get out of jail free card. There will be a complete lack of transparency.

DAVID WALKER:
I am here in opposition to S.B. 165. I believe the bill sends the wrong message. Nevada has a high teen suicide rate and I am afraid it degrades the dignity we should have for life and the sacredness of life.

I have not heard any breakdown on the assisted suicides for men versus women. I would suspect that it takes advantage of the vulnerable in our society, possibly elderly women. I would be disappointed if this bill would cause a disproportionate amount of women taking their lives.

I show the concern Nevada would, like in the past, become the divorce refuge of the Nation. I would not like to see people coming to Nevada making an industry out of it like we have a tendency to do throughout the Country. My overall concern is the dignity of living in Nevada and reducing the suicide rate and making people appreciate life and living, no matter how tough it gets.

CATHERINE O'MARA (Nevada State Medical Association):
I am here representing the Nevada State Medical Association. We are neutral on S.B. 165. Our neutral testimony should not reflect we have a divided disagreement in our membership. This is a very difficult issue for Nevada physicians to deal with primarily because it is against the American Medical Association (AMA) Code of Ethics. When we try to balance the autonomy of the patient with ethics that have been endorsed by our Association, it is difficult to marry those two, which is why we are neutral.

Physician-assisted suicide is fundamentally incompatible with the physician's role as healers. It would be difficult or impossible to control or would propose serious societal risks; this from the Code of Ethics. I am waiting for a letter from the AMA to allow me to introduce copyrighted material in order to submit it for the record.

Even though we are neutral, we have comments on issues brought up during the presentation. We would be opposed to any use of telemedicine in this regard, and would like to be involved in conversations on this topic. We had concerns about section 16 speaking to competency. Many physicians in Nevada believe they are tasked with capacity determinations, not competency determinations. For example, when someone is being designated as competent to stand trial, it is not only a psychiatrist, it is a super specialty within psychiatry. I alerted the proponents of the bill about this concern and we would be happy to work with them on the language. That does seem to differ from our current understanding of the physician's role relative to competency.

A comment was made stating this should follow the standard of care. It is not currently the standard of care. What you are doing is creating a new statutory structure to follow when patients are requesting physician-assisted suicide. We would not want this to become the standard of care for all patients who are struggling with terminal illness. We are neutral because this does not mandate physicians do this; it is up to the physician's individual choice. As I mentioned, it is unethical under the AMA Code of Ethics, which we have adopted. We would not want this to create a standard of care in the statute that later must apply to all physicians treating all terminal patients.

DR. PETER FENWICK:
As a physician and having practiced medicine for over 50 years, 40 in Nevada, I am opposed to S.B. 165. I have had many patients die from many ailments, including Lou Gehrig's disease. I have patients die in the intensive care unit, in the emergency room and I cannot live with the idea of actually killing a patient. I have never had to do that and have never let a patient suffer. I have gone to their homes, gone to see them in the hospital and I have never let a patient significantly suffer. I do not see why we should pass this legislation. We have hospice care, palliative care, and if we have good physician care, patients do not have to suffer. You treat the families as well; if a patient suffers, the families suffer.

I have never lied on a death certificate. If you do, that is a crime in my view. We are told we cannot show suicide on a death certificate. If a patient takes medication in order to die, they did not die of their underlying condition, they died of suicide which should be on the death certificate to keep the statistics correct.

HERB SANTOS, JR.:
I am here to testify in opposition to S.B. 165 and will read from my submitted written testimony (Exhibit P).

I hope there will not be a rush to vote on this, giving us the opportunity to provide you with information about the effects of insurance in other states in order to make an informed decision.

LISA BEDOTTO LAUGHLIN:
I am here to testify in opposition to S.B. 165, and have submitted written testimony (Exhibit Q).

THERESA DEGRAFFENREID:
I am here to testify in opposition to S.B. 165, and have submitted my written testimony (Exhibit R).

Section 38, subsection 3 of this bill seeks to go back in time and void provisions in life insurance contracts that may have been in place for many years. It is highly inappropriate for the government to interfere in existing business contracts.

BOB RUSSO:
I would like to put on the record that I oppose S.B. 165. In my opinion, this bill greatly diminishes the value that many of us have placed on human life. I have some concerns that once assisted suicide becomes a medical treatment option, insurance companies will favor this less costly option denying patients more expensive and potentially life-saving preferences. This is a hardship for many who cannot afford to purchase their own medical treatment choices. This could result in inequality in treatment.

I also fear this bill will easily target other vulnerable members of our community such as the elderly, disabled, the depressed and those with controllable terminal conditions such as diabetes. Our aging elders are particularly vulnerable due to their declining health and mental capacity to make clear personal decisions. Some may choose doctor-prescribed suicide out of emotion, such as guilt, or considering themselves a burden to others.

Lastly, to my knowledge, there are no provisions in this bill to ensure the patient is competent at the time the lethal drug is taken or that he or she knowingly and willfully took the drugs. Due to this lack of protection, the bill would put patients at an enormous risk.

MARY FECHNER:
The report from Oregon shows in 2017 there were 143 reported suicide deaths. Of those cases where a doctor was present, there were 24. The no provider present number was 6 and of those, where it was unknown whether a provider was present, was 89. The number of cases where the prescribing doctor was present at the time of death was 23. Other provider present was 19 and other care provider present was 101. We do not know who these other care providers were. The psychiatric evaluations in 2017 in Oregon were 3.5 percent.

JEAN SOKOL (Right to Life):
I am here to testify in opposition to S.B. 165. It is well spelled out to help a person take his or her own life. Would it not be a joy if there was a bill that spelled out the wonders of living life to its fullest until he or she is called home to God? I looked at the first few pages of the *Declaration of Independence* and the *Constitution of the United States*. As paraphrased here, all men are created equal, they are endowed by their Creator with certain rights; life, liberty and happiness. Everything I read was positive. Not so with S.B. 165, helping a person to take his or her life is not positive. This is not a good bill for us or our Nation.

LYNN CHAPMAN (American Independent Party):
I am representing the American Independent Party in opposition to S.B. 165. My mother died at home and her entire family was with her; she did not die alone. I cannot imagine her dying alone because she was in pain. I did search the internet and found an interesting item. There was a person with a sign stating "Suicide does not end the chances of life getting worse. Suicide eliminates the possibility of it ever getting better."

JANINE HANSEN (Nevada Families for Freedom):
I am here representing Nevada Families for Freedom in opposition to S.B. 165. This bill creates a culture of death, rather than one of compassion and care. We believe in the sanctity of human life. The Federalist Papers state:

> If angels were to govern men, neither external nor internal controls on government would be necessary. In framing a government which is to be administered by men over men, the great difficulty lies in this; you must first enable the government to control the governed; and in the next place oblige it to control itself.

This particular law will give, through government, an opportunity for abuse for those who are vulnerable. It will also create a culture of death.

When my father was dying in the hospital, I was in charge of making decisions for him. Every day I brought my children with me. It was one of the most valuable educations they could have. As he was in intensive care, I told him I loved him, and he said I love you, the last words I heard from my father as it took a couple of weeks for him to actually die. Those hours were very valuable to me and my children. Even though many are afraid of what happens in that process, it is an important process to learn with compassion, that we can still love and support and care about our loved one, even in these difficult circumstances.

DON NELSON (Pro-Life League of Nevada)
I represent the Pro-Life League of Nevada and we are in opposition to S.B. 165. We support life from conception to natural death.

I had a family member who attempted at 18. I remember how devastating that was. The medical people did everything they could to ensure that person would survive. We have all kinds of suicide prevention services in our Country because we believe people's lives are valuable.

Language in the bill that states, "those who have only six months to live," is most concerning to me. These people may have a terminal illness. We have to say they have lives worth living; we have to consent to that. We would not allow that to happen without providing resources if we did not believe this.

I believe the State has a duty to oppose a class of human beings who do not have a life worth living. It stigmatizes that class and I fear it will create a duty to die or a duty to help people die. We need to look at this from a civil rights perspective. This stigmatizes a certain class of people who have less than six months to live who may have a terminal illness, and that we think it is appropriate they would want to take their own lives.

MELISSA CLEMENT (Nevada Right to Life):
I have nothing to add to this incredible testimony. I would just like to register Nevada Right to Life is opposed to S.B. 165.

SENATOR PARKS:
This is not a partisan issue, it is an issue of personal choice for too many of our constituents when faced with few other options. This is an issue of compassion, love and personal options for those who want to have control of the last few months and moments of their lives.

There are several things I would like for you to remember as you consider this legislation. First, the patient is in control from the very first request, which the patient must make through the many steps and repeated requests up to the time when the patient must self-administer the drug. These safeguards ensure the patient is in charge and have been proven successful for more than two decades, ensuring the patient is not in any way forced into making this decision.

This law is not for everyone. The definition of terminal disease does not include those with disabilities or suffering from mental illness, nor individuals who are suicidal. The patient must be diagnosed within six months of death, which is the same standard of care used to qualify a patient for hospice care and one that is well known to physicians.

You have heard much about the evil insurance companies today. This law does not allow insurance companies to suggest this option in lieu of other treatment. They may not cancel, change or invalidate either health or life insurance policies. In most cases, they will not know the patient has chosen the option of assisted suicide. We have strict controls in the bill to ensure insurance companies are not involved in the process. No one is forced to participate. Doctors, pharmacists, hospital systems may all choose to opt out and never have this conversation with their patients.

I would like to leave you with one final thought. This legislation includes many safeguards, as well as the fact that medical aid in dying has been safely practiced in those states that have enacted this for a combination of 40 years. Not a single case of abuse or coercion, nor any criminal or disciplinary charges have ever been filed.

CHAIR RATTI:
We have testimony (Exhibit S) in support of S.B. 165 from Sandy Coyle. It is available on NELIS.

Seeing no further business, we are adjourned at 6:08 p.m.

Vickie Polzien,
Committee Secretary

APPROVED BY:

Senator Julia Ratti, Chair

DATE:

EXHIBIT SUMMARY

Bill	Exhibit / # of pages		Witness / Entity	Description
	A	1		Agenda
	B	18		Attendance Roster
S.B. 165	C	2	Dr. Robert Rabkin	Written Testimony
S.B. 165	D	2	Dr. Charles Held	Written Testimony
S.B. 165	E	12	Ashley Cardenas / Compassion & Choices	Written Testimony
S.B. 165	F	3	John Fudenberg / Office of the Coroner / Medical Examiner, Clark County	Proposed Amendment
S.B. 165	G	29	Jason Henkle / Nevada Death with Dignity Action Project	NV Death with Dignity Action Project
S.B. 165	H	1	Kristen Hanson / Patients' Rights Action Fund	Written Testimony
S.B. 165	I	2	T. Brian Callister / Compassion & Choices	Written Testimony
S.B. 165	J	3	Marilyn Golden / Disability Rights Education and Defense Fund	Written Testimony
S.B. 165	K	6	Marilyn Golden / Disability Rights Education and Defense Fund	Supplemental Testimony
S.B. 165	L	2	Kathleen Rossi	Written Testimony
S.B. 165	M	1	Rowena Harrison	Written Testimony
S.B. 165	N	2	Tom Baker	Written Testimony
S.B. 165	O	2	Margaret Dore	Written Testimony
S.B. 165	P	2	Herb Santos, Jr.	Written Testimony
S.B. 165	Q	2	Lisa Bedotto Laughlin	Written Testimony
S.B. 165	R	3	Theresa DeGraffenreid	Written Testimony
S.B. 165	S	1	Sandy Coyle	Written Testimony