MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-First Session
April 7, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:39 p.m. on Wednesday, April 7, 2021, Online. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/81st2021.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Rochelle T. Nguyen, Chair
Assemblywoman Sarah Peters, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Annie Black
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblyman Andy Matthews
Assemblyman David Orentlicher
Assemblywoman Shondra Summers-Armstrong
Assemblywoman Clara Thomas
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblywoman Jill Tolles, Assembly District No. 25
Assemblyman Edgar Flores, Assembly District No. 28

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Abigail Lee, Committee Manager
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Kim Callinan, President & CEO, Compassion & Choices
Peg Sandeen, Executive Director, Death with Dignity National Center
David Grube, M.D., Private Citizen, Philomath, Oregon
David Parks, Private Citizen, Las Vegas, Nevada
Susan Fisher, representing Death with Dignity National Center
Tess Opferman, representing Nevada Women's Lobby
Nick Shepack, representing ACLU of Nevada
Paul Klein, representing Compassion & Choices
Fred Voltz, Private Citizen, Carson City, Nevada
Kathleen Bohall, Private Citizen, Reno, Nevada
Dar Stone, Private Citizen, Las Vegas, Nevada
Kim Mazeres, Private Citizen, Reno, Nevada
Dan Diaz, Private Citizen, Alamo, California
Clare Johnson, M.D., Private Citizen, Reno, Nevada
Brianna Hammon, Private Citizen, Reno, Nevada
T. Brian Callister, M.D., Private Citizen, Reno, Nevada
Kathleen Rossi, Private Citizen, Reno, Nevada
Mary Fechner, Private Citizen, Reno, Nevada
John Kelly, Director, Second Thoughts Massachusetts
Felipe Avila, President, TeenProLifers
Peter Fenwick, M.D., Private Citizen, Reno, Nevada
Jamie Rodriguez, Government Affairs Manager, Washoe County
Melissa Clement, representing Nevada Right to Life

Chair Nguyen:
[Roll was taken.] I will go first to our work session and start with Assembly Bill 348. Patrick Ashton will summarize the bill and any amendments.

Assembly Bill 348: Revises provisions relating to the Patient Protection Commission. (BDR 40-497)

Patrick Ashton, Committee Policy Analyst:
As nonpartisan staff, I cannot advocate or oppose any measures you will consider today. We will begin the work session with Assembly Bill 348. [Patrick Ashton presented the work session document, Exhibit C]. We heard this bill on Monday, April 5, 2021. The bill transfers the Patient Protection Commission from the Office of the Governor to the Office of the Director of the Department of Health and Human Services (DHHS) and revises the membership of the Commission. The bill also requires the members of the Commission to comply with certain requirements regarding disclosure of conflicts of interest and abstention from voting when certain conflicts arise.

Assemblywoman Maggie Carlton proposes the following amendments to the bill, and see also the revised conceptual amendment [page 2, Exhibit C]:

1. Remove any provisions related to the establishment of a Patient Protection Commission Advisory Committee and an all-payer claims database.
2. Restore the existing duties of the Patient Protection Commission that are deleted by the introduced version of the bill.
3. Revise the membership composition of the Commission to provide that:
    a. One member who is a provider of health care must be experienced in running a health care for-profit business; and
    b. One member with expertise in health care information technology and patient access to medical records who must be either an employee or consultant from DHHS. Committee members, I would like to clarify that this amendment does not add any new members to the Commission but instead revises existing provisions in the bill related to membership composition. This amendment was revised after the bill hearing on Monday.
4. Authorize the Commission to establish any subcommittees or working groups as necessary.
5. Require the Commission to adopt bylaws governing its own operation.
6. Provide that the Commission members serve at the pleasure of the governor, thereby allowing the governor to remove members at will.

Chair Nguyen:
One of the significant amendments that came out at the conclusion of the hearing is that Assemblywoman Carlton took the suggestion of Assemblywoman Titus to include membership for a for-profit provider. Assemblywoman Carlton is here and available for questions. At this time, do any Committee members have any questions?

Assemblywoman Titus:
I absolutely appreciate Assemblywoman Carlton's addition of a for-profit person on the Commission. I think that is very helpful with getting appropriate data and input on this Commission and appreciate Assemblywoman Carlton listening to my suggestion. I wish that were the only issue I had with this bill; however, some health care folks whom I rely on are still having some angst with this. I want to let Assemblywoman Carlton and the other members of this Committee know that I am going to vote no on this, but if I can get reassurance from them after they have looked at the bill, I may change my vote on the floor. At this time, I am still going to be a no until I get other communications from these health care workers.

Chair Nguyen:
Are there any other questions from the Committee? [There were none.] Seeing none, I would entertain a motion at this time on Assembly Bill 348.

ASSEMBLYWOMAN PETERS MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 348.

ASSEMBLYWOMAN BENITEZ-THOMPSON SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMEN BLACK, HAFEN, KRASNER, MATTHEWS, AND TITUS VOTED NO.)

Chair Nguyen:
I will assign that floor statement to Assemblywoman Carlton. Next, we will move to Assembly Bill 287.

Assembly Bill 287: Providing for the licensing and regulating of freestanding birthing centers. (BDR 40-799)

Patrick Ashton, Committee Policy Analyst:
[Patrick Ashton presented the work session document, Exhibit D]. On March 31, 2021, we heard Assembly Bill 287. The bill provides for the licensure of freestanding birthing centers through the State Board of Health and requires the Board to adopt regulations necessary to provide for such licensure. Additionally, A.B. 287 requires such a birthing center to be located within 30 miles of a hospital that offers certain pregnancy-related services and prohibits a center from performing surgery. Finally, the bill makes various other changes related to freestanding birthing centers to ensure that they perform certain screenings and report certain information required to be performed or reported by other licensed facilities that provide health-related and pregnancy-related services.

Assemblywoman Daniele Monroe-Moreno proposes to amend the bill as follows; see also the attached "Proposed Amendment AB 287" [pages 3-7, Exhibit D]:

1. Revise Chapters 440, 442 and 449 of the *Nevada Revised Statutes* (NRS) to replace the term "mother" with the term "birthing person," and authorize the Legal Division of the Legislative Counsel Bureau (LCB) to make conforming changes throughout NRS, as necessary.
2. Add a certified professional midwife and a certified nurse midwife as providers of health care throughout the bill wherever midwife is mentioned, and authorize the Legal Division of LCB to make conforming changes throughout NRS, as necessary.
3. Revise Section 12, subsection 1(a) to require any regulations adopted for the licensure of freestanding birthing centers to be aligned with standards established by the American Association of Birth Centers and the accrediting body of the Commission for Accreditation of Birth Centers or any other approved national accreditation body.
4. Revise the requirement prescribed in subsection 2 to remove the requirement that a birthing center must be located within a certain distance of a hospital that offers obstetric and nursery services, and instead provide that a freestanding birthing center must be located within 30 miles of a hospital that offers obstetric and neonatal services relating to pregnancy.
5. Add a new subsection authorizing a freestanding birth center to serve as a supervised training facility for certain providers of health care.

Other amendments:

6. Revise provisions relating to the investigation of birthing centers.
7. Revise Section 22 to replace the term "gender transition" with "gender reaffirming surgery" in subsection 1 of NRS 449.102.
8. Revise Section 23 to replace "lesbian, gay, bisexual, transgender and questioning persons" with "sexual orientation or gender identity" in subsection 1(c) of NRS 449.103.

Chair Nguyen:
Are there any questions from Committee members? [There were none.] At this time, I will entertain a motion to amend and do pass Assembly Bill 287.

> ASSEMBLYWOMAN PETERS MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 287.
>
> ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

Now I will take any comments on the motion.

Assemblywoman Titus:
I am supportive of freestanding birthing centers. I appreciate the comment during the hearing from Assemblywoman Peters that women should have the right to choose where they birth a child. My biggest heartburn with this bill is the fact that they can be 30 miles away from an obstetrical center. As a family practitioner, I only delivered low-risk mothers, but having seen disasters that can happen in that group and knowing the importance of having assistance close by, I will have to be a no on this bill.

Chair Nguyen:
Are there any other comments from Committee members regarding A.B. 287? [There were none.]

> THE MOTION PASSED. (ASSEMBLYMEN BLACK, HAFEN, KRASNER, MATTHEWS, AND TITUS VOTED NO.)

I will assign the floor statement to Assemblywoman Monroe-Moreno.

I will move on to our next work session bill, Assembly Bill 256.

Assembly Bill 256: Provides for Medicaid coverage of doula services. (BDR 38-849)

Patrick Ashton, Committee Policy Analyst:
[Patrick Ashton presented the work session document, Exhibit E]. We heard Assembly Bill 256 on March 24, 2021. The bill requires a doula who desires to provide doula services for a Medicaid recipient to register with the Division of Health Care Financing

and Policy of the Department of Health and Human Services. The Director of the Department shall include in the State Plan of Medicaid a requirement that the state pay certain costs for doula services provided to Medicaid recipients to the extent authorized by federal law. The Department shall apply for a waiver of federal Medicaid requirements or request to amend the State Plan to receive federal funding to provide coverage of doula services.

Assemblywoman Summers-Armstrong proposes to amend subsections 3 and 4 of section 1; see also the attached amendment [page 2, Exhibit E]:

1. Remove the requirement that the Division adopt regulations prescribing the required training and qualifications for registration as a doula.
2. Revise requirements relating to persons who wish to receive reimbursement through the Medicaid program for doula services to:
    a. Require such persons to submit to the Division an application for enrollment in Medicaid and include with the application proof of certain training and qualifications; and
    b. Make conforming changes to the definition of "registered doula" to reflect that these persons are enrolled with Medicaid rather than registered by the Division.
3. Remove provisions authorizing the Division to charge a fee for registration of a doula, thereby removing the requirement that a two-thirds majority vote is required for the bill.

Chair Nguyen:
Do any Committee members have questions regarding the bill? [There were none.] At this time, I will accept a motion to amend and do pass.

> ASSEMBLYWOMAN GORELOW MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 256.
>
> ASSEMBLYWOMAN PETERS SECONDED THE MOTION.

Are there any comments on the motion? [There were none.]

> THE MOTION PASSED. (ASSEMBLYMEN BLACK, HAFEN, KRASNER, MATTHEWS, AND TITUS VOTED NO.)

I will assign that floor statement to Assemblywoman Summers-Armstrong.

Next, we will go to Assembly Bill 374.

Assembly Bill 374: Establishes requirements governing the expenditure of proceeds of litigation relating to opioids. (BDR 40-991)

Patrick Ashton, Committee Policy Analyst:
[Patrick Ashton presented the work session document, Exhibit F]. We heard Assembly Bill 374 last Monday, April 5, 2021. I will go straight to the summary of the proposed amendments:

1. Create the Nevada Statewide Substance Use Response Working Group within the Office of the Attorney General.
2. Require the attorney general, Senate majority and minority leaders, the speaker of the Assembly, and the Assembly minority leader to appoint members to this working group.
3. Prescribe the duties of the Nevada Statewide Substance Use Response Working Group, which must include requirements that the group:

    a. Leverage and expand current efforts to prevent and reduce substance use;
    b. Make certain recommendations relating to evidence-based prevention and intervention;
    c. Evaluate existing policies and programs relating to treatment and recovery for certain persons with substance use disorder;
    d. Analyze and evaluate access to treatment and recovery supports for persons with substance use disorders in Nevada;
    e. Make certain recommendations relating to opioid prescription and persons who are in recovery from opioid use disorders;
    f. Analyze qualitative and quantitative data relating to substance use and addiction in this state;
    g. Make certain recommendations relating to drug overdoses;
    h. Make recommendations relating to the sharing of certain information between local, state, and federal agencies relating to certain substances, including heroin, opioids, and stimulants;
    i. Analyze the manner in which substance abuse impacts the criminal justice system and the economy;
    j. Study the effectiveness of criminal and civil penalties in preventing substance abuse and the manufacture, trafficking, and sale of commonly abused substances; and
    k. Submit certain reports to the Department of Health and Human Services, the governor, the attorney general, the Advisory Commission on the Administration of Justice, and the Legislature.

Chair Nguyen:
Are there any comments or questions at this time about the bill? Assemblywoman Tolles is on this call. I believe there is a further amendment that did not make its way into the work session document. I will allow her to make that orally at this time.

Assemblywoman Jill Tolles, Assembly District No. 25:
Thank you again, Committee, for hearing this bill and for the support. There were some individuals who wanted to add on as cosponsors, and I apologize that the information did not

get into the work session document. Senator Ratti, Assemblywomen Thomas and Peters, Chair Nguyen, and Assemblymen Hafen and Orentlicher all wanted to be added on as cosponsors. Of course, if anyone else would like to, I would welcome them as well.

Chair Nguyen:
Are there any further questions? [There were none.] At this time, I will entertain a motion to amend and do pass with the additional amendment of the listed cosponsors.

> ASSEMBLYWOMAN PETERS MADE A MOTION TO AMEND AND DO PASS ASSEMBLY BILL 374.
>
> ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

Are there any comments from Committee members before we move on?

Assemblywoman Summers-Armstrong:
If I want to be added on as a cosponsor, should I have done it before the motion?

Chair Nguyen:
I am sure we can add your name during the amendment process. I would encourage anyone else who wishes to be added during the next few days to reach out to Assemblywoman Tolles and she will make sure you are included. Are there further comments on the bill? [There were none.]

> THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman Tolles.

Patrick Ashton:
Would you like Assemblywoman Summers-Armstrong included in the motion right now to be added as a cosponsor to the bill?

Chair Nguyen:
Let us do that. Assemblywoman Peters made the motion. Do you have any problem including Assemblywoman Summers-Armstrong in the motion to amend and do pass?

Assemblywoman Peters:
I intended to include the addition of Assemblywoman Summers-Armstrong as a cosponsor in that motion.

Chair Nguyen:
Do we have a second, Assemblywoman Gorelow?

Assemblywoman Tolles:
Assemblywoman Gorelow just asked if she could join as well, so could we add both Assemblywomen Summers-Armstrong and Gorelow in the same motion?

Chair Nguyen:
We will do that right now. If there are other people, I will ask that they be added as a personal amendment on the floor. Assemblywoman Peters, are you okay with amending with both those individuals; and Assemblywoman Gorelow, would you second that?

Assemblywoman Gorelow:
Yes, I will.

Chair Nguyen:
Since I know we have unanimous support, all those in favor, please say "Aye." Anyone opposed say "Nay." That motion passes unanimously.

With that, I will end our work session and we will move into our one bill presentation. I will now open the hearing on Assembly Bill 351. We have Assemblyman Flores with us to present A.B. 351.

Assembly Bill 351: Establishes provisions governing the prescribing, dispensing and administering of medication designed to end the life of a patient. (BDR 40-882)

Assemblyman Edgar Flores, Assembly District No. 28:
I am here today to engage in what I hope will be a very thoughtful dialogue and at the same time, one that I recognize to be a difficult dialogue, in presenting Assembly Bill 351. First, I would like to give some context as to how I landed in what I believe is a responsibility to move forward and push for this legislation. There are two amendments posted on the Nevada Electronic Legislative Information System (NELIS). There is a mock-up [Exhibit G] and then there is a second amendment by Washoe County [Exhibit H]. Both are friendly amendments. So as not to jump back and forth between documents, I am going to focus on the original document as introduced, and I will reference page numbers to that. When I hand over the presentation to my copresenters, I will let them go through the amendments to explain why we have them and what their objective is.

I am incredibly grateful for the work of David Parks who, on three separate occasions, came forth on behalf of many Nevadans to be a voice for them in presenting similar measures in the past. I hope to be able to continue the work he laid down for Nevadans and that we can deliver this for Nevadans. I do so in respect and honor to his work.

I do not think I would have engaged in this conversation years back. Maybe it is because I grew up in a traditional Latino Catholic household where we talked about death, but the conversation about death was always within very specific parameters. Or maybe it was because my age had not allowed me to experience enough of what death means in my family and how it impacts those around us. As I get older, I am constantly reminded of my own mortality, but more important, how limited the time is with those around me—those I love and care about.

In coming forward with this bill, what really sent it home for me was with a particular family member. I remember when he was diagnosed with his terminal illness. It was very devastating and incredibly difficult, but more important, he fought every second. I, in a very selfish way, applauded him. I think the reason I did was because for a long time, death was always associated with how it related to me. I realized I needed to go on the other side of that conversation. It hit me then: It is not about me, it is not about you, it is not about the family member, it is not about how everybody in that room feels, but rather, it is about that individual who suffered every second, whom we selfishly applaud as we sit there. We saw it as an act of valor to say, You are doing that for us; but what about your pain? That delivered it home for me; and I said, "Understood. I have a responsibility." Even if this bill had existed, that person could very well have made that exact choice because this does not force anybody to do anything. But it gives them the power at that very painful reality to say they have a choice about whether they are going to continue suffering or whether they can endure another second of that terminal illness. So I am here. I think the pandemic also put so much into perspective for me. I realize we have a responsibility to engage in very difficult convos. In respect and honor of them, I said, "Let's do it," so I present this now. I needed you to see me getting to why I wanted to engage. Now that we have an understanding there, I would like to speak broadly as to the actual language and what we are doing.

I have had an opportunity to speak to numerous Nevadans in every corner of Nevada. I am so grateful to those wonderful convos I have had with so many folk reaching out, in such painful stages that they may find themselves in, or their families, to speak up and say, "We need to have this very real conversation about what it means to have a bill like this." Some of these folk are very healthy Nevadans. They have broken it down to me, saying that they just want to know that if they are ever diagnosed with a terminal illness, and that after exploring every single traditional option, they know a legal, safe, and peaceful option is available to them to take control of the end of their life and they do it on their own terms. This goes to the very core of our individual rights to be able to say, "I no longer wish to suffer anymore."

I do not want this conversation to be hijacked into something that is not real. This is not a question about choosing between living and dying. This bill is about having control and a choice at the moment of dying. This legislation allows a terminally ill, mentally capable adult who is a resident of Nevada with a prognosis of six months or less to live, to have the option to request, obtain, and take medications, should they choose, to die peacefully in their sleep if their suffering becomes unbearable. This is not something new. This bill is modeled after the Oregon Death with Dignity Act, which has been in practice for more than 20 years, and there has not been a single instance of abuse or coercion in that state. Now, collectively, we have more than 40 years of evidence and cumulative data with medical aid in dying in Oregon and nine other authorized jurisdictions. One in every five Americans—about 22 percent—now have access to this compassionate, end-of-life care option because nine states have authorized something similar: California, Colorado, Hawaii, Maine, Montana, New Jersey, Oregon, Vermont, and Washington; and Washington, D.C. In addition, New Mexico passed legislation in March, and the governor is scheduled to sign a bill tomorrow, April 8, to enact it into law.

We cannot forget that only the dying person can determine how much pain and suffering is too much. This law puts the decision in the hands of the dying person, in consultation with their doctor and their loved ones—or it should be for such a deeply personal health care decision. This is their deciding that. They should have the opportunity to talk with everybody, get all the medical professionals involved, speak with all the family, make their peace with whomever. But at the very end, they should have the choice.

Rather than walk you through the original bill line by line, I will reference sections and walk you through the page numbers those sections fall in. On page 5, a new section is being created in *Nevada Revised Statutes* (NRS) Chapter 440. Section 1 talks about and specifies that a coroner, coroner's deputy, or local health officer is not required to certify the cause of death resulting from the self-administration of medication that is designed to end the life of a patient pursuant to this bill.

Section 2, which falls between pages 5 and 6, requires a death certificate to list the terminal condition of the patient as a cause of death of a patient and must not mention that the patient self-administered such medication. Section 3, page 6, prohibits a coroner, coroner's deputy, or local health officer from investigating such a death under certain circumstances and specifies the cause of death is not required to be certified. Sections 4 through 30, which fall on pages 6 through 18, you will see a whole host of different definitions. Specifically, you will read in section 6 the definition of "attending physician"; in section 7, the definition of "competent"; in section 8, "consulting physician"; in section 9, the definition of "Division"; in section 10, the definition of "health care facility"; in section 11, the definition of "person professionally qualified in the field of psychiatric mental health"; and section 12 defines "terminal condition."

Section 13 on page 7 talks about the requirements in order to authorize a patient to request that his or her physician prescribe such a medication if a patient:

1. Is at least 18 years of age;
2. Has been diagnosed with a terminal condition by at least two physicians;
3. Is a Nevada resident;
4. Has made an informed and voluntary decision to end his or her own life;
5. Is competent; and
6. Is requesting the medication and is not doing it because of coercion or undue influence.

It is incredibly important to make sure these are the parameters. Again, we want to remind everybody that no one is obligated to do anything. In fact, you will hear our copresenters talk about how many folks, while in this situation, have decided to utilize this option, and you will realize it is not as many as you think.

Next, in section 14 on pages 7 and 8, it requires that to fulfill certain requirements to request such a medication, the patient must make two verbal requests and one written request for the medication, and that the written request for the medication must be signed by a witness.

Section 15, which falls on pages 8 and 9, prescribes the form a patient must complete to request such a medication. Section 16, pages 9 and 10, imposes certain requirements before a physician is allowed to prescribe such a medication, including that the physician must:

1. Inform the patient of his or her right to revoke a request for medication at any time;
2. Determine and verify that the patient meets the requirements for making such a request;
3. Discuss certain relevant factors with the patient, including the diagnosis and prognosis of the patient and alternative options for care;
4. Refer the patient to a consulting physician who can confirm diagnosis, prognosis, and competence of the patient, and that the patient has not been coerced or unduly influenced;
5. Instruct the patient against self-administering the medication in public.

In the mock-up amendment [Exhibit G], you will see an amendment in section 16. We are adding something else to that list and will explain later.

Section 17 on page 10 requires a physician to refer a patient to a qualified mental health professional and to receive confirmation about the patient's competence, if the physician determines that a patient who has requested a prescription for such a medication may not be competent. This is important because all of this goes to the heart of the conversation I have had with some of you and that I have heard a lot of concern about, which is, how do we ensure that an individual understands what they are doing? I agree 100 percent wholeheartedly. All those other states that have engaged in this agree with you wholeheartedly. The 22-plus years of working in this area by many medical physicians will tell you that is very important to them and that is why we built these safeguards in place—to ensure that folk understand exactly what they are doing.

Sections 18 through 19 on page 11 prescribe certain procedures for the issuance of a prescription for such a medication and provide that only an attending physician or pharmacist may dispense such a medication. Section 19 prohibits an attending physician from prescribing such a medication based solely on the age or disability of the patient. Section 20 requires certain health care providers to include certain information concerning requested prescriptions for, and the dispensing of, such a medication in the patient's medical record, and requires that the physician or health care facility that previously provided care to a patient transfer the medical records to a new physician or health care facility.

Section 21 allows a patient to revoke a request for such a medication at any time. Again, if you request it and later change your mind, that is perfectly okay and allowable. Section 22 on page 12 provides that only the patient to whom such a medication is prescribed may administer the medication. You will see an amendment in that section that our copresenters will briefly touch upon.

Pages 12 through 13 address section 23, which describes certain information that must be reported to the Division of Public and Behavioral Health (DPBH) in the Department of Health and Human Services relating to the patient who has been prescribed or self-administered such a medication; makes such information confidential with certain exceptions; and requires DPBH to complete an annual review of a sample of the reports. Section 24 requires DPBH to compile an annual report concerning the implementation of the bill. Section 25 on pages 13 and 14 provides that the death resulting from a patient self-administering such a medication in accordance with this bill does not constitute suicide or homicide. This goes to ensure it is noted that it is the underlying illness that is the cause of death. Section 26 on page 14 prohibits a person from preventing a patient from making or revoking or requiring a patient to make or revoke a request for medication that is designed to end the life of a patient as a condition of receiving health care.

Section 27 makes it a category A felony to engage in certain fraudulent or coercive acts intended to cause a person to self-administer such a medication. Section 28 clarifies that a physician is not required to prescribe such a medication, but that the physician must provide information concerning the prescription and self-administration of such a medication or refer that patient to another health care provider. It also provides that a pharmacist is not required to fill a prescription for or dispense such a medication. Pages 15 and 16 address section 29, which allows the owner or operator of a health care facility to prohibit an employee or independent contractor of a health care facility or any person who provides services on the premises of the health care facility from providing any services relating to prescribing a medication that is designed to end the life of a patient while acting within the scope of his or her employment or contract with the facility or while on the premises of the facility.

Section 29 is important because it is important to make it abundantly clear that no health care facility has to engage in any particular conversation that we are engaging in this bill. If there is a health care facility that wishes not to engage, that is something that can occur. I want that to be abundantly clear because I know there were a lot of concerns and questions around that issue. Section 30 prohibits a health care facility, provider of health care, or professional association from taking certain actions against an employee, independent contractor, or member who provides accurate information concerning end-of-life care to a patient within or outside the scope of employment, contract, membership as applicable, or facilitates the prescription or self-administration of medication that is designed to end the life of the patient outside the scope of the employment, contract, or membership, as applicable.

Section 30, pages 16 through 18, is also important because there has been concern nationwide as to how accurate the information is that is being disseminated in some of these facilities. It is imperative that we recognize we are giving clear and accurate information, and that is what this section seeks to address. Section 31, page 18, addresses NRS 453.256 specifically to prescriptions. It makes conforming changes by including the dispensing of a medication that is designed to end the life of a patient and the definition of "medical treatment." Section 32 addresses NRS 453.375, which is the authority to possess and administer controlled substances. Section 32 makes conforming changes by excluding a patient requesting such a medication from the list of persons who may possess and administer a controlled substance.

Section 33, pages 20 through 23, addresses NRS 454.213, which is the authority to possess and administer a dangerous drug, and makes conforming changes by excluding a patient requesting such a medication from the list of persons who may possess and administer a dangerous drug. Section 34 addresses NRS 454.215 and is the authority to dispense dangerous drugs. It makes conforming changes by excluding a patient requesting such a medication from the list of persons who may possess and dispense a dangerous drug. Section 35 addresses NRS 133.065, which talks about conditional device and appointment. Section 35 also prohibits a person from preventing a patient from making or revoking, or requiring a patient to make or revoke a request for medication that is designed to end the life of the patient as a condition in an agreement, contract, or will.

Section 36, page 24, addresses NRS 159.054. It provides that a proposed protected person should not be deemed to be in need of a general or special guardian solely because the proposed protected person requested a medication that is designed to end his or her life or revoke such as request. Section 37 addresses NRS 239.010 and addresses confidential information in public books and records and makes conforming changes to ensure certain information is confidential. Section 38 on pages 27 and 28 addresses NRS 598.0923, deceptive trade practices. It makes it a deceptive trade practice for a health care provider or an owner, officer, employee, or independent contractor of a health care facility to knowingly engage in any false, misleading, or deceptive conduct concerning the willingness of the provider or health care facility to take certain action relating to the prescription and self-administration of a medication that is designed to end the life of the patient.

Section 39, pages 28 and 29, address NRS 639.1375 and clarify that an advanced practice registered nurse is not authorized to prescribe a medication that is designed to end the life of a patient. Section 40 addresses NRS 639.2351 and makes conforming changes to clarify that an advanced practice registered nurse is not authorized to prescribe a medication that is designed to end the life of a patient. Section 41 addresses NRS 639.238, which is in regard to prescriptions not being public records, and makes conforming changes to ensure some information is confidential. Sections 42 and 43 address NRS Chapter 688A and Chapter 688B. These are new sections that prohibit insurers from refusing to sell, provide, or issue a policy of life insurance or group life insurance or annuity contract, or charging a higher rate because a person makes or revokes a request for a medication that is designed to end the life of the person who self-administers such a medication, or conditioning life insurance benefits, group life insurance benefits, or the payment of claims on whether the insured makes, fails to make, or revokes a request for a medication that is designed to end the life of the insured or self-administers such a medication. Section 44 addresses NRS 688B.040 and makes conforming changes reflecting the prohibitions in sections 42 and 43 on the policy of group life insurance. Section 45 on page 33 requires DPBH, to make the

prescribing forms in the bill available not later than 45 days after the effective date of the bill. Last, section 46 specifies that this bill becomes effective upon passage and approval.
I will now hand the presentation over to Kim Callinan.

Kim Callinan, President & CEO, Compassion & Choices:
[Kim Callinan submitted written testimony, Exhibit I, and supplemental information after the hearing, Exhibit J]. I am the president and CEO of Compassion & Choices action network. As Assemblyman Flores noted, the legislation is modeled after the Oregon Death with Dignity Act. We have more than 20 years' experience in Oregon, and we have a combined 60 years of experience across the other nine states and Washington, D.C. This bill includes the same strict eligibility criteria and core safeguards that are in all the other bills that have been proven to find that balance between ensuring that vulnerable populations are protected but also making sure that this compassionate option is available to those who want it.

It is entirely optional for everybody, for the doctor, for the patient, for the health care facility. Nobody is forced to participate, and the availability of the option brings people comfort during a very difficult time. As Assemblyman Flores noted, this is for a really small group of people. A person has to be an adult, mentally capable, terminally ill, have a prognosis of six months or less to live. That is very important. It is tied to the prognosis in hospice, so people are not choosing between death and care. They do have hospice care available to them if this is an option that they do not want to afford themselves. One key criterion is that the person must be able to self-ingest the medication so that they are always maintaining decision-making authority and are capable and able to change their minds at any point.

One amendment Assemblyman Flores mentioned will strengthen the language being used around self-administration to make it very clear that only the qualified patient is able to self-administer the medication and that it can only go through ingestible means. This amendment will align your bill more directly with the other authorized states and is a very important safety feature. The law also has more than two dozen additional regulatory requirements. When you look at that bill, there are a lot of steps that a patient has to go through. Two doctors have to certify that the person meets the requirements. The person makes three separate requests: two oral and one written. There are two witnesses who have to confirm that the person is making this request voluntarily. There is a 15-day waiting period and there is mandatory reporting by doctors.

All the provisions in this bill are on top of all the other regulations that govern the practice of medicine, so one of the things that is important with this legislation is you want to have enough safeguards in play that it ensures that vulnerable populations are protected. You also want to be sure you are giving your medical providers the ability to actually support their patients. You are really striking a fine line, and this legislation helps ensure that a small number of people will be able to access it. It also includes a requirement for a lot of education of the patient before they afford themselves of this option. The attending physician must discuss with the patient the importance of having another person present when the patient self-administers the medication and they must review the benefits of notifying the patient's next of kin of his or her decision to request a prescription for medication that is designed to end the patient's life.

An additional proposed amendment for your consideration which we are in support of is that the doctor should also counsel the patient about the benefits of discussing their decision to request the medication with their religious, faith, spiritual, or support leader. That is another provision being recommended and this would be the only bill in the nation that includes that provision, but it is a good addition to the legislation.

As I mentioned, on top of all the provisions of this bill, you also have the practice of medicine that governs this and the standard of care that has been developed. Your own Assemblyman, Dr. David Orentlicher, is the lead author for a peer-reviewed *Journal of Palliative Medicine* article that was published in 2016 which outlines the clinical criteria around medical aid in dying.

Assemblyman Flores spoke about how you will be surprised that very few people choose to use the law, and this is really important. Across all the authorized jurisdictions, across all 50 or 60 years of data, there have only been about 4,300 people who have chosen to use the law. It is a really, really small number, so the concern that large numbers of people are going to use this law—that is not the reality in practice. It has not been in any of the authorized states. It is far fewer than 1 percent of people.

Of course, then the question becomes, if so few people are choosing to use the law, then why spend all this time authorizing this as an option? It is not just about the small number of people who choose to use the law, it is about all the people who get the peace of mind of knowing that, should their suffering become too great, they have an option. We also know that when the law gets implemented, what the evidence and data show—and there is a *Journal of Medical Ethics* report that showed this—is that there is no concern about abuse, coercion, or misuse. The report concluded that assisted dying did not pose any heightened risk for any population, including vulnerable populations such as the elderly, the uninsured, and those who are physically disabled.

This law provides profound peace of mind to those who choose the law. A third of the people who get the prescription will never take it, but they get profound peace of mind simply knowing the medication is there and they have the option should they need it. Research from a *Journal of Palliative Medicine* article demonstrated that medical aid in dying also improves end-of-life care generally by contributing to more candid conversations between doctors and patients, higher hospice usage rates, and improved palliative care training for physicians.

Because we now have so much evidence and data, we also are seeing this movement grow across the country. Tomorrow, as Assemblyman Flores mentioned, the governor of New Mexico is planning on signing legislation to make that the tenth state, eleventh jurisdiction, to authorize medical aid in dying. What is key is that seven of those jurisdictions have taken place in the last six years. Polling data which was just completed in your state last month shows that Nevada voters want this compassionate option; three out of four residents support passage of medical aid in dying, including widespread support across all demographic groups. We have seen that over the past six years, 30 national and state medical professional associations have endorsed or dropped their opposition to medical aid in dying in support of the growing reality that this is something the American public wants. The Nevada State Medical Association has taken a neutral position on medical aid in dying.

We no longer have to hypothesize about what is going to happen when this law gets implemented. The evidence is very clear: medical aid in dying protects vulnerable populations; it affords dying people autonomy and compassion during the most difficult time; it improves end-of-life care generally by resulting in more conversations about hospice care and improved palliative care training; and it costs almost nothing to implement. The cost of inaction, however, is truly immense. Without the option of medical aid in dying, terminally ill individuals may not try that one last miracle treatment because often it is the treatment itself that causes the most amount of suffering. They are afraid to try that one last treatment without knowing that they have this option available. They may also choose violent means to end their suffering, and they could experience needless agony when they die while families and doctors remain powerless with no legal way to respond to their pleas for help.

Terminally ill residents do not have the luxury of endless deliberations. They need the relief this law affords them right now. Not a single additional person will die if you authorize medical aid in dying, but far fewer will suffer. On behalf of our thousands of supporters across the state, supporters like Hannah Olivas who need this option right now, I urge you to let the evidence, the data, the strong public support for this end-of-life care option guide your policy making, and pass this bill this session.

Peg Sandeen, Executive Director, Death with Dignity National Center:
I am a social worker and live in Portland, Oregon. I have been working on death with dignity for 16 years. I am pleased to be able to share my experience with you. As a social worker who has built a career caring for and working with people who are dying, I want to reflect on the vulnerability and honesty with which Assemblyman Flores shared his story with us today. I hear stories like this every day—about people who are dying; people who would qualify for Oregon's Death with Dignity Act or people who do not. One thing that it is important to remember is that we all get one death and we all deserve an option like death with dignity.

One of the most difficult things for a terminally ill individual is the silence—the silence surrounding the dying experience—and the silence arises out of society's unwillingness to face death directly. I know at least one family in the state of Nevada tonight will have a difficult conversation about dying, last wishes, and advanced directives because they were somehow engaged with or heard about this hearing today. That is meaningful. What is also meaningful is the care with which this bill before you has been constructed. We have ten other jurisdictions with death with dignity bills. What I know is that this bill in front of you represents the best of all those pieces of legislation. It provides strong, time-proven safeguards which have been well covered by Assemblyman Flores. These safeguards protect vulnerable individuals from coercion and at the same time, these safeguards do not act as barriers to access for those who need it. This bill strikes a tension between protection and access and this tension is difficult to strike, and our team in Nevada has worked with all the necessary stakeholders to get this bill just right.

The proposed law you are considering today is at its core a medical standard of care, so when you go through section by section, you can see what a physician has to do in order to prescribe medication to a patient who requests a hastened death. By enacting this law, the Nevada Legislature will send a strong message that a compassionate response to suffering is available in the state through medical aid in dying, but that health care providers must follow the carefully regulated safeguards you are considering today. Assembly Bill 351 puts decisions about easing suffering in the hands of terminally ill patients, allowing them to engage their family members, their physicians, clergy members, and anyone else they choose—if they so choose. It sets aside outdated and archaic government bans on a medical practice that is currently legal for 72 million Americans, a practice that is validated, researched, effective, and full of safeguards to protect vulnerable populations.

Nevada has considered similar legislation in the past, and those of you who have engaged in this debate in prior sessions know you will hear a lot of negative accusations about this bill. For more than two decades now, we have heard these same slippery slope arguments—the statement that this law will target individuals who are poor, living with disabilities, the elderly—statements suggesting that those without medical care or access to health care resources will be forced to end their lives using medical aid in dying because it is cheaper than treating cancer. These slippery slope arguments are just not true. Independent researchers have concluded that the results are quite the opposite.

One group of researchers explored data out of Oregon to determine if there was a disproportionate impact on ten groups of potentially vulnerable patients. The data led the researchers to conclude, and I quote, "There is no current factual support for so-called slippery slope concerns about the risks of legalization of assisted dying. These patients are not at risk." I have already read letters to the editor published in Nevada suggesting that death with dignity will undermine hospice and palliative care services, and the researchers are clear on this point also. In a study published in the *Journal of Palliative Medicine*, research concluded, and I quote, "Another concern regarding the legalization of physician-aided dying is that physician-aided dying would become a substitute for quality end-of-life care. This study adds to the evidence that the choice to pursue physician-aided dying does not appear to be due to or a reflection of poor end-of-life care."

What we do know for the states that have enacted death with dignity laws, the point is that people have access to death with dignity and hospice care. It is not one or the other. The data demonstrate that they come together in all the jurisdictions that have enacted death-with-dignity legislation. A lot of people want to speak against the Oregon experience, and you will probably hear that today, but in almost every legislative hearing I have attended, these people are not from Oregon. I have worked in this state; I am an Oregonian and I have worked with people who have used this law for almost 20 years. Oregon's law works as intended—to give dying and suffering patients more options at the end of life. I very much appreciate Assemblyman Flores and all the work he and countless others from Nevada have contributed to bring this important bill to you today, and my organization and I as a social worker stand ready to help Nevada enact and implement this critical piece of end-of-life care legislation, should our support be necessary.

Chair Nguyen:
We do have questions, and we will start with Assemblyman Matthews.

Assemblyman Matthews:
It has been noted that this bill has been modeled with Oregon's Death with Dignity Act, and I also know the stated intent of this bill is to provide options to those who are suffering and those who are experiencing unbearable pain. The Oregon Health Authority's own data summary on that state's Death with Dignity Act notes that in most cases, current pain or even concern about future pain is not cited by patients as a reason for obtaining these drugs. But rather, the number one reason listed by patients to die from assisted suicide is being a burden to family and friends and loss of enjoyment in the usual activities. Given the intent of this bill, what safeguards, if any, are in place to ensure we do not see the same thing happen here in Nevada?

Kim Callinan:
It is important to remember that Oregon data is coming from a doctor filling out a form about their perception of why the patient is choosing to use the option. It is not the patient's self-reported reason for choosing the option. Also, when you are talking to a patient who is at the end of life, it is not just about pain, but it is about all the pain and suffering they are experiencing. Assemblyman Flores spoke to it so beautifully in the beginning when he talked about his own personal experience watching his loved one who was going through this. A person who is at the end of their life, they are going through a whole host of things. It is the totality of that experience that determines whether they are suffering too much. Really, only the dying person can decide how much suffering is too much. I do not see the Oregon data as a problem. It is a very small number of people who choose the option. They are getting peace of mind in knowing that they do not have to suffer from whatever their definition of suffering is. Again, they are terminally ill; they are already going to die; the question is how they die and not if they are going to die.

Assemblywoman Thomas:
My question has to do with our Black, Brown, and people of color who at times have had a discouraging experience with health care personnel. Is there any data showing that people who are in a minority have experienced a reception of the same outcome as with dignity when they decided that life was enough for them? Are they discouraged when it comes to accepting this as a final episode in their life's journey?

Kim Callinan:
We share your commitment to health equity at life's end and have an initiative going with our African-American and Latino leadership councils to try to address the systemic inequities that exist in end-of-life care broadly because they are pretty profound and it is across the

entire end-of-life care spectrum—hospice, palliative care, pain management. Unfortunately, Black and Brown Americans are less likely to enroll in hospice care and get adequate pain management and all the things you are referencing. That is a huge commitment and priority for the organization. In terms of this bill, what ends up existing, if you look at the data, is that very few minorities take advantage of the option. One of the things that is positive and good about the initiative is that everything is self-directed. The person has to make the request; they are in charge of the process from start to finish. With this end-of-life option, there is not a chance that a person is going to be coerced into using the option because it is entirely self-directed. What we see is that a lot of public education is needed in order to ensure that African Americans, Latinos, other minority populations are aware of and taking advantage of all end-of-life care options that are available to them so they are able to make the best decisions they can for themselves.

The bill has the potential to help ignite that because, as Peg Sandeen said in her opening remarks, what we see happen is this legislation opens the door to people finally having a conversation that they otherwise avoid. It might open up because there is a bill hearing; it might open up because they see a media article; it might open up because now they ask their doctor. That is why we see increased enrollment into hospice care after the legislation is implemented into a state. A patient goes in and says, "I want to be in control of my end." It opens up the door for that conversation and then you have doctors and patients finally having a conversation about what kind of end-of-life care options you have. It ends up improving end-of-life care across the board.

As an organization, we are very committed to addressing the inequities that exist across all end-of-life care. This bill does work to ensure that no one will be pushed into this as an option in its current form.

Assemblywoman Titus:
Thank you, Assemblyman Flores, for sharing your story. You should never apologize for being human and having emotions. I am honored to hear your story today. These are emotional issues. As a physician, I have been involved with hundreds of patients at the time of their deaths, understanding their fears and concerns. I have had patients ask me not to let them suffer, saying that they are worried about pain. That is always my question to them, "What are you afraid of?" I was there for them and actively involved, making sure we had palliative care and making sure we had hospice care. That concern about death with dignity and making sure they do not suffer—usually I can solve that for them and make sure that does not happen, but I never actively engaged in ending their life.

I would like to focus on the bill; the rest is all about emotion. I have some concerns—which is one of several reasons why in the past this bill has not been passed. First and foremost, there was testimony that there was no abuse of this in Oregon; however, in section 1, it is forbidden for a coroner to investigate the case. When someone has a prescription, how would we know if the case was abuse or not when the coroner is forbidden to investigate? How do we know there is not abuse when you cannot investigate it?

Kim Callinan:
The intention of the language in section 1 is that if the person has chosen this as an option, there is nothing to investigate because you know they are going to take the prescription medication. If there was some reason or suspicion of foul play, of course the coroner would be able to investigate. It is not stopping an investigation if there is foul play, but if a person has chosen this as an option and has gone through the process, there is not a reason to investigate because the investigation is going to show that they have taken a prescription to end their suffering.

Assemblywoman Titus:
I disagree with that. Just because they got the prescription does not mean they are ever going to use it. You have testified that many people apply for this and then do not use it. Does the fact they have applied for the prescription negate any other studies or investigations? I have to disagree with you there.

Next are sections 3 and 25. I, as a doctor of 36 years, have signed many death certificates. In that death certificate are categories: immediate cause of death, associated cause of death, up to five lines on underlying causes of death. In your bill, it mandates that we have to sign what the diagnosis was that allowed them to obtain this medication—that six-month diagnosis. We all know, and you have to know, that just because a doctor says someone is going to die within six months—I have had patients die in a week, and I have had patients die many years later. The diagnosis of six months does not mean that is inevitable. I believe there is a power greater than me, and to say someone is going to be dead in six months, frequently that does not happen.

My concern is by not being able to sign that the person did indeed take an assisted suicide drug. Say they took it within a day of getting that suicide drug and their diagnosis was pancreatic cancer. The average lifespan of someone with pancreatic cancer is six months, but now this person has died in two weeks and not from pancreatic cancer but from taking this medication. That skews the data on what the average lifespan is for a person with X disease. We are looking at terminal diseases here. Not being allowed to say, "No, they took this medication," but with the caveat of having a terminal disease. By saying they died of pancreatic cancer, which is absolutely not true—they died from the medication, because I would write down as the immediate cause of death, respiratory distress, heart attack. Why is that any different? The underlying cause would still be pancreatic cancer; it does not take away the fact that they had that disease. But why the push for not giving the truth—the fact that they died from an overdose of medication?

Kim Callinan:
Dr. Grube is on the line, and I think he can respond to this one.

David Grube, M.D., Private Citizen, Philomath, Oregon:
I am a retired family physician in Oregon, and I did respond to patient requests regarding aid in dying. I appreciate your question because I have heard this many times and we have had many conversations with other physicians about this. From my perspective, and possibly the

perspective of the bill, there are two reasons for the death certificate. One is to establish the legal parameters of the estate and the other is the epidemiology of the disease that you talked about. The latter will be covered by the reporting requirements that you will have in Nevada and that we have in Oregon. That data will be coming to the state for epidemiological concerns. The death certificate, however, is a public document and discoverable by anybody. When Death with Dignity or Medical Aid in Dying—the name of the bill—is on the death certificate, that has implications publicly for the family, for intimacy, for HIPAA [Health Insurance Portability and Accountability Act] violations, et cetera. I think your concerns are addressed by the reporting requirements your State of Nevada requires.

Assemblywoman Titus:
I respectfully disagree. In section 28, I am mandated to refer to another physician. Is there a timeline in the bill that says how much time I have to make that referral? Is there going to be a list published somewhere so that I, as a provider, have a list of other providers who are willing to do this? How does that work?

Kim Callinan:
There is not a time frame in the bill. It is expected that, in the same way you would refer someone in a timely manner to any other provider, you would do the same with medical aid in dying. It is asking you to follow the normal practice of medicine and refer the patient out. There is also the option of referring the person for information. It does not mandate that it has to be to another provider who will practice medical aid in dying. It could also be to a general information source.

Assemblywoman Titus:
Who pays for the medication? You get this prescription, you go to the pharmacist, and section 29 mandates that the pharmacist fill it. What is the average cost and what if they cannot pay? Does the pharmacy have to dispense the medication?

Kim Callinan:
Most of the time the person is paying for the medication themselves, or some of the states that have medical aid in dying have allowed for the medication to be paid for through their state Medicaid program. Also, private insurance often does cover the medication. It runs about $550 to $600.

Assemblywoman Titus:
And there is no shortage of supply.

David Grube:
There is no shortage of supply at the present time. The prescription is a compounded prescription of currently available medications.

Assemblywoman Titus:
Sections 42 and 43 mandate that insurance companies cannot deny someone insurance coverage even though they have noted that they are going to take this medication. For me,

the person can get a terminal illness, say, "I am going to get this medication and then apply for life insurance." From a business standpoint, it seems as though you are putting a huge burden on the insurance companies. How does that work in Oregon? Can they still issue a life insurance policy, yet the person knows he or she has a terminal illness?

David Grube:
These people are about to die. Not one of them would be available for life insurance if they recovered. In Oregon, 95 percent of them are already enrolled in hospice, so they are covered in that way. There is no possibility that this group of people would be eligible for life insurance.

Assemblywoman Titus:
Why is it in the bill that you cannot refuse life insurance? Section 43 says that specifically: you cannot deny under a group policy, cancel a policy, or refuse to issue an insurance policy if you apply. To me, they could apply once they get the diagnosis.

David Grube:
We do not have that as part of our Death with Dignity Act in Oregon.

Assemblywoman Titus:
Section 43, subsection 1, paragraph (b), you cannot "Refuse to sell, provide, or issue . . . life insurance" to someone who applies for this.

Kim Callinan:
That was not the intention. It could have been that something got reworded in bill drafting. That is certainly something I am sure we can look at with Assemblyman Flores. If your conclusion is correct, we would be supportive of an amendment if he was.

Assemblywoman Titus:
Thank you all for your presentation. Thank you, Madam Chair, for your tolerance of my line of questioning, but I just felt these questions needed to be asked.

Chair Nguyen:
Assemblywoman Titus, if you have additional questions, please ask them. Do you have further questions?

Assemblywoman Titus:
Madam Chair, I have a bunch more, but I know other folks have questions, so thank you.

Assemblywoman Krasner:
I would like to say thank you to Assemblyman Flores for sharing his personal story with us. My question is for Ms. Callinan. In preparing for this hearing today, I did a lot of reading and read several articles on the topic. I am glad she talked about protecting vulnerable populations. In some articles I was reading about the limitations on safeguards for vulnerable populations. Is there anywhere in the bill where there are safeguards preventing

an insurance company from delaying or denying expensive treatments—for say, cancer—causing the person to suffer, almost pushing or encouraging someone to choose end-of-life prescriptions? This is something I saw on the National Council on Disability, which said that when assisted suicide is legalized, it immediately becomes the cheapest treatment; "direct coercion is not necessary." If insurers deny or even simply delay approval of expensive life-sustaining treatment, patients can be steered toward hastening their death. Could you comment on that?

Kim Callinan:
The decisions an insurance company makes about whether to provide care have nothing to do with the medical aid-in-dying laws being in a state or not. Insurance companies look to see whether a treatment meets their criteria and that is what determines whether they do that. The bill does not allow for an insurance company to deny treatment and then offer medical aid in dying as an option. If that was really happening, if that was the way it worked across the states, we would not have 4,300 people utilizing the law across the combined 50 years of experience. The law requires that the person be the one who is making the request and asking for the option. While I understand that is a concern, the legislation does address that concern.

David Grube:
That is a concern I have heard before, but it is not a reality. The experience in Oregon does not show that has ever happened. This group of people are near death, and have been through all the kinds of treatment. It is not as though they are being denied a last treatment. This is a group of hospice patients for the most part, so that is not something we have ever seen happening in Oregon.

Assemblywoman Gorelow:
You mentioned that 43 people have chosen this. Was this just in Oregon or is that a total number?

Kim Callinan:
It is 43,000 people across all the authorized states that collect data, which is about nine states over 50 years.

Assemblywoman Gorelow:
In section 22, it says that the patient must be able to ingest the medication themself. Is this in pill form or a liquid?

David Grube:
The current protocol is a liquid of about four ounces, or half a glass of water, that is drunk. The individual will fall asleep in about ten minutes and die very peacefully in less than an hour. It can sometimes come as a powder that the family would mix with a liquid, so it could be a powder or a liquid form, but it is not a pill.

Assemblywoman Gorelow:
My last question concerns section 28, which states that a pharmacy does not have to dispense such medication. Has that been a barrier in other states?

David Grube:
I had a woman who went four miles in her electric wheelchair, as she was dying of breast cancer, to get a prescription. I live in a small town, and the pharmacist that day did not believe in death with dignity and would not dispense the medication that was sitting on the shelf. She went all the way back to her residence and had to return another day, so this is a thing that can happen.

Kim Callinan:
David Grube is right; this is something that can happen. The good news is that we have more pharmacies participating, and with the ability to mail, we have been able to mitigate this as an issue, but it is a challenge that we have to work through after the law gets implemented.

Assemblywoman Gorelow:
You mentioned it can be mailed to a patient as well.

Assemblyman Flores:
Madam Chair, could I go back to the question posed by Assemblywoman Titus?

Chair Nguyen:
Go ahead, and I know Karly O'Krent with the LCB [Legislative Counsel Bureau] Legal Division can also assist.

Assemblyman Flores:
Referring to section 42, page 31, lines 42 through 45, you posed a question as to whether we were somehow tying the hands of an insurance provider by including that section. I wanted to clarify that an insurance company now can still refuse based on someone having a terminal disease or illness. They can still do that. What this section is clarifying is that they cannot say they are not going to, based on the fact that the medication has been requested. We wanted to specifically delineate that so we are not sending mixed messages. The insurance company, as they do now, would be allowed to refuse based on the fact that someone has a terminal illness. That does not change; this is just specifically denying on the basis of the actual request for the medication.

Assemblywoman Titus:
Thank you for that clarification. I will follow up offline because I still have some concerns about that provision being in there. It may be the only thing they know about the patient.

Chair Nguyen:
I would encourage Assemblywoman Titus to reach out to Ms. O'Krent. I know she provided a similar answer.

Assemblyman Hafen:
I want to thank Assemblyman Flores for bringing this bill forward. It has made me do some soul-searching and made me do some research in the Bible, because this is a very tough conversation for us to be having today. In some research in the other states that have had the assisted suicide path, we have seen a direct correlation with increased suicides. My concern is that with the recent pandemic and lockdown, we have seen a dramatic increase in suicide attempts. Is there an explanation about why we are seeing a direct correlation with states that have passed assisted suicide—specifically Oregon—and the increase in suicide?

David Grube:
I will send you an article that recognizes there is not a correlation between increased suicides in Oregon and our Death with Dignity Act. It is probably based more on the fact that our population has increased and other situations and stressors. Suicide in America is a huge problem that we in medicine and in all parts of our society need to address genuinely. However, it is not true that there is a direct correlation between the passage of the Death with Dignity Act in Oregon and suicides in our state.

Peg Sandeen:
I echo what Dr. Grube said. There is not a direct correlation and there is statistical evidence that there is not a direct correlation between suicide and enactment of the Oregon Death with Dignity Act. Suicide patterns are different across the United States. Some states have higher levels; some states have lower levels, but it is not related to the existence of any of the death with dignity acts.

Assemblyman Hafen:
I would appreciate looking at the data because the data I looked at is showing that Oregon's suicide rate is 41 percent higher than the national average. If I understand it, the problem is not the assisted suicide but the increase in population; however, I am confused about why an increase in population would be the rationale for a percentage increase. I could see the number increase, but not a percentage increase over the national average being caused by population. Could you clarify that?

David Grube:
I did not mean that it was an increase in the percentage. That is not part of the argument that shows there is no correlation, and I will send you that study so you can read that. You are correct.

Chair Nguyen:
Committee members have been inundated with emails in support and in opposition to A.B. 351. With reference to high suicide rates in Oregon since 1999, do we have any indication what the suicide rates were in Oregon prior to this? Is it too hard to make a specific correlation between their law and those rates without taking into consideration other factors like COVID-19, other forms of isolation, weather, or any of those things?

Kim Callinan:
When you look at the studies looking at suicide rates, there is no correlation. There are so many different factors, as you noted, that could lead to suicide. The thing that actually shows is that the Western states that have laxer gun laws are the ones that have higher suicide rates. That is where the correlation exists. If you look at the states that have enacted medical aid-in-dying laws that are on the East Coast, there are lower suicide rates there. There is no correlation, there is no causation; they are very independent.

Chair Nguyen:
I do not see any other questions. Assemblywoman Titus, would you like me to go back to you for additional questions?

Assemblywoman Titus:
I have a question about being a Nevada resident. A lot of people became Nevada residents because of our divorce laws many years ago, as in other states it took a long time to get divorced. Numerous places in northern and southern Nevada were established because people could get divorces here. When you say "Nevada resident," there is no limitation that you have to be here for, say, six months. What is the definition of a Nevada resident? Could they be here just a week and be considered a Nevada resident?

Kim Callinan:
There is no time frame for how long someone has to be within the state. It is really about whether you have a government ID, voter registration, all the normal ways you would establish residency. However, there are two important things to keep in mind. Your bordering states of Oregon and California already have this as an option, so the idea that Nevada would become a suicide mecca for this is highly unlikely both because you are seeing so many other states adopt this as an option. But in addition to that, people at the end of their lives do not have the wherewithal, the means, the physical ability to pick up and move. People choose this option because they want to be able to die at home surrounded by their loved ones. Very few people have the wherewithal and are able to just pick up at the end of their lives after getting a terminal diagnosis, be able to reestablish residency someplace, and be able to go through the 13-step process in order to access the law. In the history of it being authorized in all the states, there are a couple of examples where people have successfully moved to a state in order to access the option, but those are few and far between.

Assemblywoman Titus:
In choosing the age of 18 instead of, say, 21, have you seen an age difference in who requests this medication?

Kim Callinan:
When you look at the data across all the authorized states, generally speaking, you see that older people are accessing the option.

David Grube:
The average age has always been over 70. The exceptions are generally the neurodegenerative diseases like ALS [amyotrophic lateral sclerosis].

Chair Nguyen:
Are there any other questions from Committee members? [There were none.] I will begin testimony in support.

David Parks, Private Citizen, Las Vegas, Nevada:
I support the passage of A.B. 351 sponsored by Assemblyman Edgar Flores. For the last three legislative sessions, I requested legislation on the issue of medical aid in dying. I brought legislation forward as a promise to a dear friend, who at the end of her life pleaded with me to introduce a bill that would mirror Oregon's Death with Dignity Act. She would have relocated to Oregon to avail herself of this legislation had her health allowed her to make the move.

During the time I pursued this legislation, I have been asked by people from across Nevada, from many different legislative districts, to pass this legislation. Some were cancer patients who wanted to have the peace of mind of knowing they could control their final days. Others wanted the assurance that, after exploring all traditional options, a legal, safe, and peaceful option would be available to them to control the end of their lives on their own terms. Please support A.B. 351.

Chair Nguyen:
Thank you, Senator Parks. It is a pleasure to see you back here in the virtual legislative building. Now I will turn this over to callers on the line in support of A.B. 351. It is necessary to limit your testimony to two minutes, but again, I would encourage everyone to reach out within 48 hours if you have additional written comments you would like to provide to the Committee for consideration either in support or opposition of A.B. 351. I know that one of our own Committee members, Assemblywoman Black, has received a lot of constituent outreach regarding A.B. 351. I would encourage those people who have participated with her outreach to directly reach out to the legislative website to submit that documentation.

Susan Fisher, representing Death with Dignity National Center:
I am speaking today on behalf of a friend, and I thank Assemblyman Flores for picking up the torch on this important issue and for introducing A.B. 351. During the 2015 Session, I was working on Senate Bill 336 of the 78th Session, which was a bill similar to what you have before you today. In the course of the session, I met a woman who lives right here in Carson City who has been suffering with cancer for many years. Her name is Debbie Black, and in the exhibits you will find a guest column recently written by Debbie [Exhibit K] and printed in the *Reno Gazette Journal*. She has the best attitude toward life and has an amazing sense of humor. I rarely see her without a smile on her face. Debbie could not join us today because she is spending what will probably be her last visit with her three sisters who all live

in different states. Debbie asked that I relate her story and urge you to support A.B. 351 for her. She is not in a hurry to die.

She was first diagnosed with breast cancer 29 years ago when her son was just 6 months old. She fought it then—surgery, radiation, chemotherapy—and she did pretty well for the next 20 years until she was diagnosed with brain cancer. That tumor was removed, but she lost most of the use of one side of her body. Lots more rounds of chemotherapy, years of physical therapy, and she regained both the use of her arm and leg for the most part and, more important, gained more years of hope. This past August, she had a craniotomy to get to a new mass in her head. It was a metastatic brain tumor. They were not able to remove it. She could not have visitors due to COVID-19, so she sent me photos of the huge swath of bare scalp covered with metal staples and the dent in her skull where the bones had been removed. It was estimated in early September that she had 10 to 12 months to live. She asked me then if we could hurry up and get this bill passed within that time so she could control the end game. I told her I did not think we could get it done that fast, but we would try.

Her son and granddaughter live with her in Carson City. She does not want to leave them, but she will leave this world anyway—one way or the other. She has considered setting up residency at a friend's home in California where the Death with Dignity Act has been in place since 2016, and she has asked me to be there with her—to help make her laugh right up to the end. She told me just last week that her doctors think there is a new mass in her brain. They do not know what it is yet, but they think it may be necrosis—dead brain tissue. Debbie Black does not know if she would actually use this act and the medication to end her life, but she wants this option because her other options have all been taken away, including the option of living. I thank you, and Debbie thanks you for your time and consideration of A.B. 351.

Tess Opferman, representing Nevada Women's Lobby:
We appreciate the emotional testimony that has been presented today. End-of-life care decisions are difficult for everyone involved—family, children, parents—and these decisions are even more difficult when someone is dealing with unbearable pain and suffering. Assembly Bill 351 gives the option for compassionate end-of-life care allowing someone with six or fewer months to live the opportunity to make informed decisions with their family and friends to escape pain and suffering. This is about human dignity. The Nevada Women's Lobby is in full support of this bill, and sincerely thanks Assemblyman Flores for his compassion in dealing with this challenging topic. We urge the Committee to pass A.B. 351, giving Nevadans the option to choose.

Nick Shepack, representing ACLU of Nevada:
I want to thank Assemblyman Flores for his impassioned and very real testimony. I feel you. We recently lost my aunt to pancreatic cancer, and it was one of the most brutal and violent and aggressive things I have ever had the misfortune of witnessing. The fact she lived in a state where she had access to this type of end-of-life medication brought comfort to her, to

my grandmother, and to my family that she would not have had at that point. She did not choose to use the medicine, but the option made all the difference.

The right to individual autonomy protects people's constitutional right to control their bodies and to make end-of-life decisions. There is value in having aid in dying that is legal and transparent. States with bans have tolerated gray markets where people with resources can find sympathetic doctors to give them medication, but those with limited resources often use self-induced means that fail. When a process is open and transparent, it can be regulated and keep people safe and keep track of the process. End-of-life choices are already recognized and accepted legal practice. Competent adults' unqualified legal right to decline medical care is accepted when clear and convincing evidence exists that the patient wishes to end life support through advanced directives.

Finally, aid-in-dying laws open communications between doctors and their patients to promote the right of the person to choose to keep living. The statistics from the Disability Rights Project show that 1 in 25 patients who ask a physician about aid in dying actually request the medication. Because patients and their physicians can speak openly about end-of-life options without fear of criminal liability, those patients are free to discuss their fears more openly and seek alternative options. For these reasons, we strongly support this bill. We encourage you to vote yes and, again, we thank you for bringing this bill on behalf of anyone who has watched someone struggle through the end of life.

Paul Klein, representing Compassion & Choices:
[Paul Klein submitted the results of a poll, Exhibit L]. Assemblyman Flores, I truly felt your passion, conviction, and values today. I feel incredibly lucky to have your representation at the Nevada Legislature. Committee members, we really appreciate your consideration of this bill today and the thoughtful questions you asked thus far. While you continue to evaluate this bill, I want to point your attention to a poll conducted just a few days ago that resulted in 72 percent of Nevadans supporting this legislation. That is nearly three in four Nevadans; most notably in this poll from political party affiliation to religious affiliation, to age, race, gender, and more, every demographic group supports this legislation. Therefore, if you are content with the criteria, if you are content with the safeguards of the bill, but your personal view is unsure, please know that the Nevada electorate—your electorate—by a vast majority supports this bill.

Fred Voltz, Private Citizen, Carson City, Nevada:
Several of this Committee's members are either lawyers, medical doctors, work in the helping professions, or have science training in their backgrounds. They are oriented toward problem-solving. Unfortunately, an incurable disease does not have a solution. Worth noting, most of this Committee's members are of a younger age where they probably have not personally experienced the horrific illnesses family, friends, and colleagues face, typically in the later years of life. Just as each one of us holds varying views about religion, any single religion's beliefs should not be imposed upon the individual or society at large when facing an existential decision about a personal illness where there is no hope of recovery.

Machines, drugs, therapies, and other technology can keep someone alive in the technical sense for a considerable amount of time despite the human body being ravaged by disease, pain, or a hopeless medical condition. Taken in its totality, this legislation offers multiple safeguards against abuse of its provisions; however, one area needing clarifying language is in the life insurance realm of sections 42 and 43, as Assemblywoman Titus brought up. It is concerning that someone could purchase life insurance that might not require underwriting just before taking the death-inducing substance in a last-ditch attempt to financially benefit their family, heirs, or charities. Insurance companies would likely hike premium requirements on everyone else insured by the company to recover the prospective losses of too few premiums and too many benefits paid out.

Kathleen Bohall, Private Citizen, Reno, Nevada:
I am in support of A.B. 351. The Nevada end-of-life options act is not murder, nor is it suicide. It is a plan for the eventuality of death, which we all face. We do not wait until the moment of birth of a child to plan for it. We spend nine months, sometimes years, preparing for that event. I am not afraid of death, but I am afraid of the dying process. I have twin aunts who lived in California. One aunt died of congestive heart failure at the age of 90 in 2017. Her twin sister was at her side and had to watch her agonizing death. Three years later, my surviving aunt was dying of the same diagnosis. She chose to utilize the California end-of-life options act. The relief and joy she experienced once she was authorized to use this option was remarkable. I shared that relief, all the while dreading her death.

I moved to Nevada in 1962, almost 60 years ago. Nevada is my home and I want to die in Nevada. But I plan to move to a state which allows end-of-life options if and when I am diagnosed with a terminal illness. I urge all lawmakers to research the process of a death from congestive heart failure before you deny this alternative. Every mentally capable adult with six months or less to live should have the choice to request from their doctor a prescription they can take to avoid unbearable suffering and die peacefully. Please support A.B. 351.

[Assemblywoman Peters assumed the Chair.]

Vice Chair Peters:
May we have the next caller, please.

Dar Stone, Private Citizen, Las Vegas, Nevada:
I live in Assembly District 41. I appreciate being allowed to come before you to speak in favor of A.B. 351 today. I have been a physician assistant for 38 years with the last 27 years being here in southern Nevada. Before that I was a registered nurse and commissioned officer in the United States Public Health Service. I have attended the bedside of patients and their families at the end of life and it has all too often been fraught with pain, suffering, and intense anxiety for the patient and their families.

Medical aid in dying is not assisted suicide. It is not out of depression that a terminally ill patient may want to end their life. They simply want the option to die peacefully. It is not for everyone, but it is a choice. For those concerned that this decision may be impulsive or coerced, those concerns have not been borne out of the evidence gathered over the last two decades in states where this has been legalized. There are strong safeguards in place in this bill to prevent abuse, coercion, and impulsivity. None of us who work in health care question a patient's right to informed consent. It is the backbone of our virtually unanimous belief in patient autonomy—the right to elect or forego a medical intervention. This logic should extend to the rights of a patient to control the circumstances of their death. It is simply humane and compassionate when suffering is refractory, when hospice care has done all it can do for a person suffering from an irreversible terminal illness, that the patient be allowed to ingest a lethal medication to end their suffering if that is what they choose. I urge you to vote in favor of A.B. 351.

Vice Chair Peters:
Are there more callers in support?

Kim Mazeres, Private Citizen, Reno, Nevada:
[Kim Mazeres submitted written testimony, Exhibit M]. I am speaking today in support of A.B. 351. My husband was cognizant until his very last hours. He knew he wanted the option to decide for himself when enough was enough. Steve passed away in June of last year after suffering chronic rejection due to a lung transplant; however, he and I had many conversations about his wishes and those included potential relocation to Oregon in order for him to control the end of his life. He suffered from COPD, chronic obstructive pulmonary disease, and we discussed medical aid in dying both before his transplant and after. My husband and I spent more than 30 wonderful years together, a veteran who late in life became an attorney employed by the district attorney's office. Steve was diagnosed with COPD when he was in his 50s. After an exacerbation and a failed surgery, doing nothing or having a transplant were his only options. Steve brought up the idea of moving to Oregon so he could utilize their medical aid-in-dying law. I was mad, mad that we might have to uproot ourselves to establish residency in a state where we have no family, a place that was not home to either of us.

Steve ultimately opted for the transplant, and he did really well for a year, but something kicked off chronic lung rejection. He opted for treatment of the rejection, but it did not work for him. Steve's last 24 hours were horrific. He was in a tremendous amount of pain, and I scrambled to get him enrolled in hospice. As it turned out, assistance from hospice was perfect. Steve passed only five hours after starting on service with them, but what would have happened if it had been a weekend with no hospice intake staff available or had I been unable to make that happen for us? If we had the option of medical aid in dying in Nevada, my husband could have chosen whether he wanted to avail himself of that option. Terminally ill adults should have [unintelligible] at the end of life. I urge you to pass A.B. 351 to give all Nevadans this choice.

[Assemblywoman Nguyen reassumed the Chair.]

Chair Nguyen:
I will go to our next caller in support.

Dan Diaz, Private Citizen, Alamo, California:
I am Brittany Maynard's husband. Brittany died on November 1, 2014. She was only 29 years old. Brittany experienced a gentle dying process only because of the option of medical aid in dying. Yes, my wife utilized the very program we are discussing here today. I am testifying in support of A.B. 351. Brittany was determined to live as long as possible. She endured an eight-hour brain surgery. We researched every treatment option that was available. Unfortunately, the cancer was growing aggressively. This program allowed her to truly live the time she had left and then experience a gentle death. Brittany's case received significant attention because at the time we had to move from our home in California so she could access Oregon's law. Had we stayed in California, the brain tumor would have continued to torture her to death.

People in Nevada deserve better than that. No one should ever have to leave their home like we did. With 72 percent of Nevadans agreeing with Brittany that a terminally ill individual should have this option at end of life, I hope this Health and Human Services Committee reflects that support from your constituents as you vote in favor of this bill. Furthermore, as a Catholic and as a Latino, I take great pride in the fact that 70 percent of Catholics nationwide also agree that this option should be available to terminally ill individuals who qualify.

I have spoken with several of you personally. Please keep in mind that Brittany simply took control back from that cancer so she would not have to suffer. The opponents' campaign is based on fear. They use inflammatory words like "suicide" and "euthanasia" in their attempt to scare legislators and the public. To be very clear on this, this very protective option for terminally ill individuals does not result in more people dying. It simply results in fewer people suffering.

Clare Johnson, M.D., Private Citizen, Reno, Nevada:
[Clare Johnson submitted written testimony, Exhibit N]. I am an emergency medicine physician living in Reno. As an emergency room (ER) doctor, I see patients at the peak of their suffering, often in the last six months of life. I have seen patients lose the ability to eat as stomach cancer has progressed. I have seen 6-foot-2-inch men at only 130 pounds at the end of months of chemotherapy. It has become evident to me with great medical advances, we have created great suffering. I believe it is our moral imperative as a society to give options that alleviate this suffering.

I started my career in a state without medical aid in dying, Georgia, and later worked in a state with medical aid in dying, California. A coworker in California recently lost a family member after a three-year battle with metastatic cancer. This family member opted for medical aid in dying at the end of her life. She had control over the end of her life and was able to die in the comfort of her own home with multiple family members present. She was one of the 405 terminally ill people in California in 2019 who chose this option. Many of you here today may not want to exercise this option or this option may go against your personal belief system. I respect that and celebrate that we have different views; however, we owe it to our diverse state to provide people with diverse options at the end of life. I strongly support A.B. 351.

[Exhibit O, Exhibit P, Exhibit Q, Exhibit R, Exhibit S, Exhibit T, and Exhibit U in support were submitted but not discussed and will become part of the record.]

Chair Nguyen:
That was the last caller we had on the line in support of A.B. 351. We took 23 minutes of testimony in support, and at this time I will take testimony in opposition to A.B. 351. I have some individuals on Zoom and will start with them. I will ask you to limit your testimony to four minutes today, please.

Brianna Hammon, Private Citizen, Reno, Nevada:
I am an international disability advocate born and raised here in Nevada speaking in opposition. Please note, I have an incurable and irreversible condition that cannot be cured or modified by any known current medical therapy or treatment. In fact, I have several. They are called disabilities. Even though the bill cleverly does not say the word "disability," there I am. All you need is an opinionated doctor to make a subjective pronouncement of my imminent death, which many would be very willing to do, and I meet the definition of terminally ill. I am amazingly healthy, but I am at risk here. All ideas, including assisted suicide, are utopian, full of safeguards and happy, rich white people who are used to having control over their health care. But reality is chaotically haphazard and even violent especially for people with disabilities and the elderly who live in poverty and even middle incomes. People with disabilities very often do not even receive suicide prevention counseling for depression, did you know that? We show signs of wanting to give up or have suicidal thoughts. Attitudes and access barriers can make us lonely, but no one tells us about counseling. They tell us about death. What kind of message is that? Disability you are born with; it is just who you are. I do not want to be you; I want to be me—disability and all. And for people who acquire disabilities, we are talking about conscious, sentient human beings who need time to adjust to limitations and overcome obstacles. Assisted suicide's push fails to allow that time.

I need you to understand that as the only alternative to death that those in power offer to people who require assistance is poverty and segregation in nursing homes, then it makes no sense to talk about assisted suicide as a choice because according to the Oregon statistics, the number one reason that people choose assisted suicide is not wanting to be a burden. No one even tells them about attendant supports and all the other myriad of supports that help us stay connected to communities.

I think it may be hard for you to imagine what it is like to seek medical services as a person with a disability. I have a very hard time getting many medical professionals to listen to me. It is like they have a script in their head about the poor disabled girl and they assume they need to make decisions for me. I explained to the doctor that I have a significant gag reflex and would need sedation for a procedure, but he kept ignoring me and assuring my mother I was not a behavior problem. Many professionals are as uncomfortable around me as the general public because I have the "Stevie Wonder" head bob; people prefer to talk to the people I am with who have an easier time making eye contact.

Family members have so much influence in the medical field and not all of them want what you want. Well-meaning doctors look at me and think I would be better off dead. They will think it is a favor to just offer suicide to me. Over and over again, I will be educated about my right to die. Do you know what it is like to be told you should suicide? You should fill out paperwork to end treatment? You should have a DNR [do not resuscitate]? Everyone wants to educate me; no one wants to tell me my life is worth living. If you pass this bill, you make it law. You make it worse.

T. Brian Callister, M.D., Private Citizen, Reno, Nevada:
I appreciate being here. This is such an emotional, tough subject. My heart goes out to Assemblyman Flores and all of you who have had to experience this. I am here to let you know that there are perverse, negative consequences you need to consider with this legislation. It sounds like everything is going swimmingly well in Oregon. That is not exactly genuine or legitimate.

I got involved with this a few years ago when I had two patients—Nevadans—in our hospital. One was visiting and then going back to Oregon and one was going to California. They both had serious illnesses that would be terminal without treatment. Both patients had a potential for a cure, a significant chance of cure with a standardized medical regimen. I referred one of these patients to Oregon and one to California. When this came up, in both cases the insurance medical director—not in writing but on the phone—said to me, "Brian, we are not going to cover the treatment or the transfer, but by the way, did you talk about assisted suicide? Did you bring it up?" I was stunned; I could not believe it. Of course, when I called them out on that, their response was, "Oh, there is no correlation," and you heard some of that today. No correlation. They deny treatments all the time, they approve treatments all the time, and they just happened to deny a lifesaving, standardized treatment, and asked if we had offered this alternative. That is what got me involved in this.

In fact, when you talk about the potential for coercion and abuse, you have to understand that as physicians, we are very poor at predicting life expectancy with a terminal diagnosis. It sounds all so precise: Oh, I am a doctor, and you have six months to live. Our average error in the medical literature in predicting how long you have is 50 to 70 percent off. So, we are very good at giving you a diagnosis. We are very bad at predicting how long you have and, most important, how good a quality of time you may have left. Once you get to the end, yes, we need more effort in palliative care, in hospice, and they are working well in other states. This falls in the category of throwing out the baby with the bath water.

To address Assemblywoman Thomas's concern, especially with communities that have limited access to health care—that have been marginalized, disenfranchised, people of color, people in poor neighborhoods—how do you know people are not being denied standard medical treatments because this is now called a "medical treatment." Killing someone with a prescription is called a "medical treatment" and it gives the insurance companies the cheapest option. The chance to offer that up instead of a standardized treatment, and it has happened to me twice.

People have said in the past, "There is no proof of that." Let me get rid of that right now. My senior resident at the time backs this up and you can look at the *Washington Free Beacon*, June 5, 2017, because there is an article corroborating this story. You get to the fact that there is a suicide contagion. In answer to the question about suicide rates, in the first 15 years since the Oregon assisted suicide law was passed, the national rate of suicide went up by 23 percent, and that is sad. The Oregon rate of increase in general suicide was 48 percent. Because there is no witness required at the very end, what is to keep granny, who is being told by her freeloading grandson and girlfriend, "Your life isn't worth living," to go get the prescription and go home. Who knows if the pill was forced on granny? They say there is no evidence of abuse, but there is no requirement for investigation.

Chair Nguyen:
Dr. Callister, you are right at four minutes. Can I get you to wrap up?

Brian Callister:
The real story here is, when does your right to die become some other person's duty to die? This is not a medical treatment. This is assisted death. Let us make that very clear.

Chair Nguyen:
Let us go now to the phone lines and begin testimony in opposition to A.B. 351. As a reminder, if you are not able to testify in support, opposition, or neutral today, you have 48 hours to submit written comments.

Kathleen Rossi, Private Citizen, Reno, Nevada:
I am a registered nurse who has worked in Nevada for over 34 years, and I have a lot of experience in end-of-life care. I am opposed to this legislation because it is rife with flaws and it will bring unintended consequences. The phrase that "hard cases make bad law" could never be truer than here. It will change the standard of care when it makes assisted suicide quote, "medical treatment," unquote. Suicide has never been a medical treatment and one certainly does not need a physician to overdose with pills. To act like assisted suicide does not change attitudes of physicians toward medical care options is naïve. I would like to quote Wesley Smith, a bioethicist, when he says, "Advocacy for legalizing assisted suicide is always couched in terms that would limit access to those who are terminally ill. But given the philosophical and ideological principles that underlie the assisted suicide movement that autonomy is paramount and ending life is a valid answer to human suffering, restricting assisted suicide to the dying becomes utterly illogical. After all, many people experience far greater suffering and for a longer period of time than people who are terminally ill. Thus, should the two seminal premises of assisted suicide become generally accepted by a broad swath of medical professions and among the public, there is little chance that this permitted suicide would remain limited to the terminally ill."

We do see this in the Netherlands and in the documented cases of suicide contagion. I see that almost every state that has passed assisted suicide goes on to expand and progress those laws in future years. As a nurse, I have also noticed that it often is not the patient that cannot handle the terminal suffering, it is the family that does not understand the dying process in general. I also note that many end-of-life dying processes like heavy breathing that occur normally are not evidence of pain but are extremely distressing to family members. We need to do more education about hospice and end of life with family members. We have gotten so much better at end-of-life care since I started in nursing.

Chair Nguyen:
You are right at two minutes. Can I get you to wrap up and please submit any written comments you might have to supplement your testimony today.

Kathleen Rossi:
This will change medical options by making this "medical treatment." Research should be put into continuing the improvement we see in hospice care and not in allowing assisted suicide.

Mary Fechner, Private Citizen, Reno, Nevada:
[Mary Fechner supplied additional information, Exhibit V]. I represent myself and I urge you to vote no on A.B. 351. Physician-assisted suicide is an extremely complex subject. It demands careful thought and consideration of the many issues at stake. I am currently holding a copy of the proceedings of a two-day workshop hosted by the National Academy of Sciences, Engineering and Medicine in Washington, D.C., in 2018. The workshop entitled "Physician-Assisted Death: Scanning the Landscape" included 40 experts in the fields of palliative medicine, aging, end of life, bioethics, hospice care, law, veterans affairs, serious illness care, theology, epidemiology, medical ethics, health policy, special needs, Medicare, Medicaid plans, employee health programs, clinical psychiatry, philosophy, medical doctors and practitioners. These experts presented their findings based on their research and experience. They published a 165-page summary of their findings. Rather than a cursory consideration of public testimony—which I have found there are some inaccuracies and some lack of basic general knowledge about how this bill works in Oregon, which is very concerning—I urge you to research this very complex issue and its ramifications before making your decision. Rather than concentrating your efforts and our tax dollars on ending the lives of our citizens, please direct them toward preserving life and providing loving, palliative care at its end. Nevada citizens will thank you for it.

Chair Nguyen:
You are at two minutes now; can I get you to wrap it up? If you have additional comments, please submit those in writing.

Mary Fechner:
I wanted to say that Ms. Callinan has been quoted in 2019 as saying, "If lawmakers want to improve medical aid-in-dying laws, then let's address the real problem: There are too many regulatory roadblocks."

John Kelly, Director, Second Thoughts Massachusetts:
I am the director of Second Thoughts Massachusetts, disability rights advocates against assisted suicide. I agree with everything Brianna Hammon said. Bills like these promote prejudice against our lives because we depend on others for our care. The messages that our lives are worthless are endless, and this bill promotes that prejudice. Assembly Bill 351, like all assisted suicide bills, takes away individual choice and gives it to insurers who care more about money than people. Doctor Callister speaks the truth. We cannot trust insurers to do the right thing rather than the cheapest thing.

Proponents say there has never been a case of abuse, but that is absolutely false. Please do a search for Wendy Melcher, a very ill transwoman who had not applied for assisted suicide. Two nurses tried to kill her with massive amounts of morphine, and she died a few days later. There was no criminal referral to authorities, the Oregon Nursing Board dealt with the matter in secret, and the nurses received light discipline. There are many other cases that have been documented.

I thank Dr. Titus for bringing up the impossibility of accurate prognoses. As she said, people can live years longer than six months, like the 12 to 15 percent of people admitted to hospice who outlive their prognoses. What about those people? Do we care about them? Please do a search for Jeanette Hall who has been alive for 20 years after she sought assisted suicide. She was persuaded to try more treatment and now she is active against these bills. Assisted suicide means that people who would otherwise be happily alive are now dead. Assisted suicide is just too dangerous. Please vote no. No matter what they say about safeguards, the public health department has no authority or resources to investigate.

Chair Nguyen:
You are at two minutes now. Will you wrap up and please submit your testimony if you have additional comments.

John Kelly:
Assisted suicide says that some people have dignity and some people do not. It is divisive and must be defeated.

Felipe Avila, President, TeenProLifers:
TeenProLifers is an international youth organization composed of exceptional high school and university students working to advance the pro-life cause worldwide. It is truly astounding to hear Assemblyman Flores advocate for ending human life in such a casual forum. Assisted suicide gives insurance companies and governments the ability to save money by pushing lethal drugs that are less expensive than treatment. No trained medical personnel are required to be present at the time the lethal drugs are taken or at the time of death, creating the opportunity for an error or abusive caregiver to coerce the patient to take the deadly drugs or put them in the patient's food without the patient's knowledge or consent. There is no requirement in the bill that the patient, in order to receive lethal drugs, be facing a terminal disease that would take their life in six months. For those in difficult circumstances, the correct responses are encouragement and assistance and not strong arguments in favor of

their death. People dealing with depression in the face of illness, injury, or impairment need those around them to affirm their value rather than advocating for a quick end.

People targeted for assisted suicide are often people of color like me who often lack the resources to pay for medical care. This discriminatory bill will result in a bigger inequity gap between income levels in the state, favoring the wealthier who are able to afford such treatment. As people near the end of their lives, realistic, humane treatments and compassionate care are essential. We can and should explore options such as hospice and other measures that help provide comfort to people in their last days. However, intentionally killing someone can never be compatible with an ethical world view. Please vote no on Assembly Bill 351.

Peter Fenwick, M.D., Private Citizen, Reno, Nevada:
I am a family practice physician of over 50 years and at present a professor at the University of Nevada, Reno medical school seeing patients and teaching students. I practiced at times in four countries—England, Scotland, and Anguilla, where I was the only physician, and the U.S.A. I oppose A.B. 351 for several reasons. I took the Hippocratic oath, which categorically states that I will give no deadly medicine to anyone if asked or suggested. As a family practitioner, my patients have become my family. I have treated literally thousands of patients and hundreds of patients with terminal illnesses and never needed to subject anyone to a form of assisted suicide. I also have never let anyone suffer, as I have always been able to treat any untoward symptoms successfully.

It is important when a patient is in the terminal stages of life to handle the patient's medical and psychological state, and this includes the family. To introduce assisted suicide as a topic would be harmful to all concerned. When I worked in emergency rooms in London and Reno, I saw several people who were brought in having taken overdoses. Those who were not comatose were suffering severe physical symptoms. Do we really want to subject people to that kind of death when I can treat all their symptoms of illness and they can experience a normal death which also helps the family in that situation? The very fact that the patient must administer the medication and the physician must basically not be there infers that the physician is not responsible. This is terrible. Section 25 states that taking the prescribed overdose is not suicide, though the whole procedure is titled "assisted suicide." If handing a patient a handful of pills to kill themselves would be okay, is it okay to hand them a gun which would cause instant death and not necessarily a slow death? Sections 1, 2, and 3 state that a physician must not state the true cause of death.

Chair Nguyen:
Doctor, you are at two minutes right now, I need you to wrap up your testimony. If you have some written testimony, please submit it.

Peter Fenwick:
The doctor must falsify the death certificate to state the patient's illness is the cause of the death. The actual cause of the death is the medical overdose, which must be left off the certificate. The death certificate should be 100 percent truthful [allotted time was exceeded].

[Exhibit W, Exhibit X, and Exhibit Y in opposition were submitted but not discussed and will become part of the record.]

Chair Nguyen:
Now we will go to neutral testimony.

Jamie Rodriguez, Government Affairs Manager, Washoe County:
I am here to testify in neutral. I want to thank Assemblyman Flores and the proponents for agreeing to accept our amendment. The purpose of our amendment was to create clarity and ensure the roles of the different participants in the process, wanting to make sure who was going to be signing the death certificate, treating this much more like hospice so that these cases would not come to the coroner or medical examiner and requiring us to do a full autopsy and sign off on the death certificate.

Chair Nguyen:
Is there anyone else here to testify in neutral? I will remind callers that this is neutral testimony. This is not in support; this is not in opposition. This is neutral testimony on A.B. 351. Again, if you did not have the opportunity, you came on late, or you did not get to submit your full comments, I would encourage you to submit those comments in writing within 48 hours of today's hearing on the bill.

Melissa Clement, representing Nevada Right to Life:
I am just amazed. We had over two hours of testimony in favor. There are some very serious issues with this bill and there has been insufficient [call terminated].

Chair Nguyen:
This is not testimony in neutral. Are there any more callers in neutral? [There were none.] I will turn this back over to Assemblyman Flores to make any closing remarks regarding A.B. 351.

Assemblyman Flores:
I wanted to thank everyone who called in. I do not think anyone who called in either in support or opposition came from a place of wanting to harm Nevadans. I think everyone came from a very personal and compassionate lens. I appreciate them engaging in this conversation. I do not take this conversation lightly, and by no means do I think it is easy engaging in this conversation. Quite the contrary, it was a difficult conversation for me to engage in. Through my personal experiences, I find myself here presenting this bill.

I also find it slightly disingenuous that we have so many folk call in in opposition, talking about this being a bill to harm people of color and poor communities. We consistently tokenize people of color and poor communities whenever it is to our advantage, which is precisely why I refuse to engage in that conversation. It is a political tool that is used consistently—all of a sudden, we are utilizing this medication to kill all people of color and poor people—when we do not necessarily have the data to suggest that even people of color are the ones who are engaging in this option to begin with. It is frustrating to me because it is often a political ploy that is utilized and often they see me, they see a person of color, and drop these key phrases in hope that they will trigger something not supported by data.

I come before you and engage in a very personal, very complex conversation. A whole host of other states are now engaging in that, which we can use and study and continue to evolve and grow in this subject matter. I will ask if our copresenters have any additional comments, and I will also say thank you to Senator Parks for his advocacy and work in this area. As I mentioned previously, I am picking up the work he has done in the past for us and I am appreciative to him.

Kim Callinan:
Thank you so much. For the record, I wanted to be sure that I had correctly noted the number of people who had ingested medication. It is fewer than 4,300 people across nine jurisdictions in about 50 years who have ingested the medication. Someone suggested that I may have added a zero to the end of that number, and if I did, I wanted to be sure I got that right. That brings such profound peace of mind to those people who choose the option.

I also want to note that the law specifically notes that people with disabilities do not qualify. Someone cannot qualify simply because they are disabled; they must be terminally ill with a prognosis of six months or less to live. I know how difficult it is. We have so many systemic issues within our health care system targeting people with disabilities. This law provides a structure and framework to ensure that they are protected and has far more safeguards in place than any other end-of-life care option out there.

I also want to note that it is illegal for an insurance company to deny health insurance. None of us would want health care to be denied by this becoming an option. If that were to happen, that is the kind of court case that Compassion & Choices will take on and litigate because we want people to be able to have this option, but we also want them to be able to have good medical care. It is important that both things can exist at the same time.

I also want to note that I attended and spoke at the National Academy of Sciences' two-day conference. I walked away from that conference hearing very clearly that the doctors who prescribed and were practicing medical aid in dying—they had a lot of people who came in from California—were experiencing that the law as written had too many regulatory roadblocks in place. What we have seen in the states that have authorized is no expansion of the law. It is not that different people are now eligible for the law, but you are seeing lawmakers begin to grapple with the fact that you have about a third of people who die during the 15-day waiting period, which is something your bill does address. That is what the outcome from that conference is and that is what the statement that the person read that I made was—that we needed to find that appropriate balance. But there has been no expansion of medical aid-in-dying laws to different populations. They are all designed with that same six-month prognosis that is tied to hospice care. Thank you for taking the time to consider this bill, and if any of the opposition concerns are things you remain concerned about, I am happy to answer questions offline.

Chair Nguyen:
Assemblyman Flores, do you have any other comments?

Assemblyman Flores:
Again, thank you to everyone who engaged in this dialogue and thank you to all the folk who helped me work on this.

Chair Nguyen:
At this time, I will close the hearing on A.B. 351 and open up for public comment. I will remind everyone that public comment is not a place to rehash the bill we just heard. If you have concerns in support, opposition, or neutral on A.B. 351, I strongly encourage you to reach out to the bill sponsor and send emails to the Health and Human Services Committee members as well as to your own Assembly representatives. You can also submit those comments in writing, and they will become a part of the public record if you do so within 48 hours. With that, we will begin public comment. [There was none.]

Are there any other comments at this time from Committee members? [There were none.] With that, I will adjourn the meeting [at 4:38 p.m.].

RESPECTFULLY SUBMITTED:

Terry Horgan
Committee Secretary

APPROVED BY:

Assemblywoman Rochelle T. Nguyen, Chair

DATE: ________________________

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is the Work Session Document for Assembly Bill 348, presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit D is the Work Session Document for Assembly Bill 287, presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit E is the Work Session Document for Assembly Bill 256, presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit F is the Work Session Document for Assembly Bill 374, presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit G is a proposed mock-up amendment to Assembly Bill 351 titled, "Proposed Amendment 3169 to Assembly Bill No. 351," presented by Assemblyman Edgar Flores, Assembly District No. 28.

Exhibit H is a proposed amendment to Assembly Bill 351, submitted by Jamie Rodriguez, Government Affairs Manager, Washoe County.

Exhibit I is written testimony dated April 7, 2021, presented by Kim Callinan, President & CEO, Compassion & Choices, in support of Assembly Bill 351.

Exhibit J is written supplemental testimony dated April 7, 2021, submitted by Kim Callinan, President & CEO, Compassion & Choices, in support of Assembly Bill 351.

Exhibit K is a copyrighted article dated 04/04/2021, published in the *Reno Gazette Journal*, authored by Debbie Black, titled "Give me back my rights at the end of my life," submitted by Susan Fisher, in support of Assembly Bill 351.

Exhibit L is poll results of 700 Nevada voters taken February 3-4, 2021, conducted by Public Policy Polling, Raleigh, North Carolina, submitted by Paul Klein, representing Compassion & Choices, in support of Assembly Bill 351.

Exhibit M is written testimony submitted by Kim Mazeres, Private Citizen, Reno, Nevada, in support of Assembly Bill 351.

Exhibit N is written testimony dated March 2021, submitted by Clare Johnson, M.D., Private Citizen, Reno, Nevada, in support of Assembly Bill 351.

Exhibit O is a letter dated March 9, 2021, submitted by Jenny Brekhus, Private Citizen, Reno, Nevada, in support of Assembly Bill 351.

Exhibit P is a letter submitted by Kitty Jung, Private Citizen, Reno, Nevada, in support of Assembly Bill 351.

Exhibit Q is a letter dated March 4, 2021, submitted by David Colborne, Vice-Chairman, Libertarian Party of Nevada, in support of Assembly Bill 351.

Exhibit R is a copy of an email dated April 1, 2021, submitted by Carrie Roussel, Private Citizen, Minden, Nevada, in support of Assembly Bill 351.

Exhibit S is a letter dated April 7, 2021, submitted by Christine Saunders, Policy Director, Progressive Leadership Alliance of Nevada, in support of Assembly Bill 351.

Exhibit T is a letter submitted by Daniel J. Corona, Private Citizen, West Wendover, Nevada, in support of Assembly Bill 351.

Exhibit U is a collection of letters and emails submitted by various individuals in support of Assembly Bill 351.

Exhibit V is supplemental information dated April 6, 2021, including a copy of a link to an article titled, "Physician-Assisted Death: Scanning the Landscape: Proceedings of a Workshop – PubMed," submitted by Mary Fechner, Private Citizen, Reno, Nevada, in opposition to Assembly Bill 351.

Exhibit W is written testimony dated April 7, 2021, submitted by Janine Hansen, President, Nevada Families for Freedom, in opposition to Assembly Bill 351.

Exhibit X is an email submitted by Maize Pusich, Private Citizen, Reno, Nevada, in opposition to Assembly Bill 351.

Exhibit Y is a letter submitted by Herb Santos, Jr., Private Citizen, Reno, Nevada, in opposition to Assembly Bill 351.