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

Eighty-Second Session
April 26, 2023

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 2:16 p.m. on Wednesday, April 26, 2023, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. 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/82nd2023.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Sarah Peters, Chair
Assemblyman David Orentlicher, Vice Chair
Assemblywoman Cecelia González
Assemblywoman Michelle Gorelow
Assemblyman Ken Gray
Assemblyman Gregory T. Hafen II
Assemblyman Brian Hibbetts
Assemblyman Gregory Koenig
Assemblywoman Sabra Newby
Assemblyman Duy Nguyen
Assemblywoman Angie Taylor
Assemblywoman Clara Thomas

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Edgar Flores, Senate District No. 2

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Eric Robbins, Committee Counsel
David Nauss, Committee Counsel
Shuruk Ismail, Committee Manager
Terry Horgan, Committee Secretary
Ashley Torres, Committee Assistant

OTHERS PRESENT:

Sara Manns, Nevada Campaign Manager, Compassion and Choices Action Network
Johanna Koch, M.D., Medical Director, Summit View Hospice, Reno, Nevada
Clare Johnson, Private Citizen, Reno, Nevada
Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities
Dora Martinez, Private Citizen, Reno, Nevada
Benjamin Zober, Rabbi, Temple Sinai, Reno, Nevada
Patricia Gonzalez Portillo, Private Citizen
Dan Diaz, representing The Brittany Maynard Fund
Dar Stone, Private Citizen, Las Vegas, Nevada
Geoff Sugarman, representing Death With Dignity National Center
Will Bradley, Private Citizen, Las Vegas, Nevada
Abad Piza, Private Citizen, North Las Vegas, Nevada
Laura Gray, Private Citizen, Las Vegas, Nevada
Vanessa Dunn, representing Nevada Public Health Association
Carrie Roussel, Private Citizen
Kim Mazeres, Private Citizen, Reno, Nevada
Jana Wright, Private Citizen, Las Vegas, Nevada
Herb Santos, Jr., Private Citizen, Reno, Nevada
Brianna Hammon, Private Citizen, Reno, Nevada
Leslie Quinn, Private Citizen, Las Vegas, Nevada
Katrin Ivanoff, Private Citizen, Las Vegas, Nevada
Jill Douglass, Private Citizen, Las Vegas, Nevada
Susan Proffitt, Director at Large, Nevada Republican Club
Michael H. Plumer, Private Citizen, Las Vegas, Nevada
Maggie Cecil, Private Citizen, Las Vegas, Nevada
Jim DeGraffenreid, National Committeeman, Nevada Republican Party
Michael Ryan, Private Citizen
Heather Areshenko, Private Citizen, Reno, Nevada
Barry Cole, Private Citizen, Reno, Nevada
Kathleen Rossi, Private Citizen, Reno, Nevada
Mary Fechner, Private Citizen, Reno, Nevada
John Abel, Director, Government Affairs, Las Vegas Police Protective Association

Richard P. McCann, representing Nevada Association of Public Safety Officers; and Member, Nevada Law Enforcement Coalition
Annette Magnus, Executive Director, Battle Born Progress
María José Fernández Flores, Coalitions Director, Patients' Rights Action Fund
Cristiane Mersch, representing Nevada Right to Life
Rosana Santos, Private Citizen, Las Vegas, Nevada
Cyrus Hojjaty, Private Citizen, Las Vegas, Nevada
Lisa Laughlin, Private Citizen, Reno, Nevada
Casey Rodgers, Private Citizen, Minden, Nevada
Melissa Clement, Executive Director, Nevada Right to Life

Chair Peters:
[Roll was taken. Committee rules and protocol were reviewed.] Welcome to Assembly Health and Human Services. Thank you for being here on our delayed schedule, and thank you to those who have patiently been waiting today. We have one bill on the agenda, and public comment will follow that. I will open the hearing on Senate Bill 239 (1st Reprint). This bill establishes provisions governing the prescribing, dispensing, and administering of medications designed to end the life of a patient.

Because we have quite a few folks who are interested in testifying on both sides, we will limit testimony periods to an initial 20 minutes each for support, opposition, and neutral. If we have additional time, and based on those who would like to participate, we will reallocate any additional time equally among support, opposition, and neutral testimonies. Welcome, Senator Flores. Thank you for being here. Please proceed when you are ready.

Senate Bill 239 (1st Reprint): Establishes provisions governing the prescribing, dispensing and administering of medication designed to end the life of a patient. (BDR 40-677)

Senator Edgar Flores, Senate District No. 2:
Good afternoon. I am here to present Senate Bill 239 (1st Reprint). Joining me are Dr. Johanna Koch and Sara Manns. I believe most of you have had an opportunity to interact with Ms. Manns, but maybe not with Dr. Koch. Ms. Manns will walk you through the bill, not line by line, but giving you a general overview of what the bill does, and Dr. Koch will give you her perspective as a doctor in the medical field.

I want to start off by thanking everybody who has reached out to me—folks passionately against this bill and folks passionately in support. I appreciate that because no one I have spoken to yet has not come to the table to engage in the conversation through the lens of what is best for Nevadans, what is best for humans. I appreciate that because we can start the conversation there. I will walk you through my journey. If I go back six years, I probably would not have supported this bill. I was not comfortable with this conversation. What I know and how I interacted with the conversation about death were guided by principles that were instilled in me, either through my church or my parents, at a very young age. Life has blessed me because, although it is a reality that all of us here are going to die and we cannot avoid it, I had a very detached relationship. It was not until I grew older that I realized it is a reality of life. As you get older, you find yourself surrounded by human beings you care about and love. Unfortunately, their times come. It was not until my intimate relationship and interactions with death that my perspective started to shift. It was no longer just what I was being taught; it was no longer what had been instilled in me as a child; it was now a very personal memory.

In my family, there was a person with a terminal illness, and we were talking about end of life. There was a prognosis of just a few weeks left in life. One of the questions we had was, Why are we doing this? Why are we keeping this individual alive—whether for an extra day or a couple of extra hours—knowing that this human being is suffering so much? In that conversation, I felt it was very self-serving of us to desire to keep somebody here longer without thinking about their suffering. That was the first time I started questioning. We were forcing an individual to endure more pain because that was what we wanted, never allowing the question of the person who was dying and suffering every second of that moment. That was the first time I started interacting with this question. I came with this bill last session because of that personal relationship with that moment. Then I realized it was unfair for a legislator, because of a single moment, to dictate through a bill a law that is going to impact the entire state of Nevada because I felt it was a very selfish act to force an individual to suffer more for us to keep them here longer. Then I turn around and support a piece of legislation I would be imposing on the entire state. If I thought the first part was selfish, the second part was even more.

What I did during this past interim was learn about palliative care, hospice, and end-of-life treatment through conferences, because I wanted to make sure I was not acting selfishly and that I was not coming in front of you through an emotional situation without having actual data or having an opportunity to get experts who deal with end-of-life care every day to give me their perspective. I went to palliative care conferences and learned about hospice. We talked to the nurses, the doctors, the folks who receive you in the front end, the folks who deliver certain items. I talked to all of them. In that conference, everyone said, We want to give control to a human who is at the end of life. We do not want them to be in a hospital bed, in a room that is cold, with human beings they do not recognize. We do not want your last breath to be the smell of an unfamiliar food with folks you do not recognize within walls that are not your own. If you go to a conference on end-of-life care, the science is saying, get out of that hospital room, go to your bed, go to your room, go to your backyard, sit around your family, cook with your family, eat, and do the things you are accustomed to. Those should be the last things you remember. That was important to me because I realized the entire science of this conversation is going in that direction.

What this bill is talking about is exactly the same thing. When you are about to die and there is a choice between suffering and not, who should control that? In that end-of-life symposium and all this science we have heard about, there are individuals who will be in a hospital bed who will get up and leave and stop taking medication knowing they are about to die because they are no longer taking that medication, and they will go home and do it in peace. That same individual, maybe because they are so ill and cannot get up and walk for themselves, may have so much pain medication in them to numb the pain that they will die of the pain medication. My question to you is, what is the difference? Human beings leaving their hospital beds, knowing they are going to go home and die because they are going to stop taking the medications, human beings who are going to ingest so much pain medication that the pain medication is going to kill them, or what this bill now allows you to do, which other states in this country allow you to do: say when you are going to die if you have a terminal illness, you have a prognosis of death, you have gone to two different doctors who say the same, and you have gone through a mental evaluation. You then have to get the prescription yourself, fill it, and you have to self-ingest, so what is the difference? We are putting death in control of you, and guess what, all of us are going to be in that end-of-life bed, and all of us are going to choose. Some of us may go in the middle of the night and at peace, but all of us are going to choose whether to stay on that deathbed or to go home where we are going to continue taking medication until we die or utilize this option. Whether you use this option or not, that is using the option, because this is only an option. Nothing in this bill requires anybody to do anything. It simply allows you the opportunity to have a choice of your end of life.

Before I hand this over, because it is important to go through some of these sections, I want to remind everybody that there is an amendment [Exhibit C]. It is uploaded on the Nevada Electronic Legislative Information System, and there are copies in the front of the room. I mention this because we amended the bill in the Senate numerous times, and we are now coming into the Assembly with yet another amendment. We share the concern. People are concerned that we may target poor people, I hear that often. It is the first question I am asked: How do we ensure we do not do that? If you think something like that could happen, please tell me and we will amend this bill. If you think there is a possibility of an individual falsifying a document; if you think there is a possibility of an individual getting a fake mental assessment or not getting the second evaluation; whatever you think, if you want me to create safeguards for that, we will continue to amend this bill to address those concerns, because we had them going in. We believe we have addressed them all now, but we will continue to work with the Committee with those concerns. In that, we are with you.

What I cannot argue with you, and I cannot change the discourse of what we are doing here, is through ideological notions. There are folks who have an ideological disagreement, and I respect that 100 percent. I respect your faith. I personally have a relationship with death. You have a different one; I respect that. But on the policy side, we can have this conversation, and we can work together on the policy side. I am not here to tell you what you should believe in terms of God. But in this building, we discuss policy, and I am here to discuss that alongside you, and that is our duty. I would invite Sara Manns and Dr. Koch to join me so they can continue the conversation through their respective areas of expertise.

Chair Peters:
You may begin when you are ready.

Sara Manns, Nevada Campaign Manager, Compassion and Choices Action Network:
[Sara Manns submitted additional information Exhibit D, Exhibit E, and Exhibit F.] As Senator Flores has described, we are here to talk about how Nevada can implement this policy, and that is what this bill does. I have spoken with most of you on the Committee, so I would like to briefly describe what the bill does and then hand it over to Dr. Johanna Koch, who has experience in providing medical aid in dying, because many of the questions you raised with me when I spoke with you individually had to do with what this is actually like. I can tell you what the bill does, and she will be able to tell you more about what the process is.

The End of Life Options Act allows a terminally ill, mentally capable adult with a prognosis of six months or less who is suffering from an incurable disease to ask their doctor for a prescription medication they can voluntarily take when they are ready to peacefully end their life [page 1, Exhibit D]. I am going to break that down into its pieces. What are the eligibility criteria in order for you to begin the process if you are a patient who has a terminal diagnosis? Well, there are three: a terminal diagnosis with a less-than-six-months-to-live projection. Of course, doctors make estimates. They can never tell us exactly. Sometimes those prognoses are long compared to what ends up occurring. Sometimes they are shorter, but six months is the requirement to enter hospice care. So terminal, less than six months to live, and the patient has an incurable disease. They need to be mentally capable. What does that mean? We had a lot of discussion in the Senate Health and Human Services Committee on the subject of what "competent" is; what is "capable"? What does that mean? Well, it is really simple. "Mental capacity" is the ability to make medical decisions for yourself. One of the protections written into this bill that is incredibly important is no one can decide this for you. You have to ask your doctor for it, and then you have to pursue a process I am about to describe to you. You have to have the capacity to consent to medical care. A person has "capacity" when they understand the information and the consequences of taking medical aid in dying. They are able to assess alternative options, and they can communicate that decision to their health care providers. Those are the base lines of what you have to do to start asking your doctor. Medical aid in dying is a trusted, time-tested medical practice. It is authorized in ten states and in the District of Columbia. Over the 25 years since Oregon first authorized it, the policy around how to make sure patients are choosing this for themselves and doctors are following the rules in order to make sure they prescribe to people who are able to consent, understand, and qualify has become more sophisticated.

This bill has 19 or 20 sections, and I am not going to go through each one because you have all had an opportunity to read it, but I will give the high points. There are two providers involved in this—the attending provider and the consulting provider. Two providers have to agree that this person is qualified—a terminally ill, mentally capable adult over age 18. Those providers have to inform the person who asked them about medical aid in dying about the full range of their end-of-life-care options. If they ask about it, this is included in that list, but they cannot just say yes. They are required by the statute—that is what is in the amendment we are bringing today—they are required to make sure the patient is aware of all the alternatives. That is part of what they have to do to be protected by the statute. No physician, no advanced practice registered nurse has to participate in this. If you as a pharmacist believe this is the wrong thing to do and you cannot do it, you do not have to fill that prescription. That is an important protection because people do have concerns and do not want to participate, so we want to make sure those people are protected in their expression.

The patient can withdraw the request for medication. They do not have to take it, and they can always change their mind. The patient has to be able to self-administer, so that means they are going to ingest the medication themselves. No one can give it to them. The doctor is not administering; the patient is administering. That is important because it is our door into one of the questions about this policy the Senator referred to which is, whose decision is this? Who is the person choosing when it is time? It is always going to be the patient with this bill, so that is an important protection. They have to self-ingest; they have to make this decision for themselves.

A lot of questions came up around how this is documented. Life insurance payments will not be denied. This does not impact estate at all, because the death certificate lists the underlying terminal illness, and Dr. Koch can talk more about that. The mechanics include two separate verbal requests with a 15-day waiting period between them [page 2, Exhibit D]. In that time, the patient also needs to make a written request, and this bill provides for a form on which that has to be done so it is easier for the doctor to be absolutely certain they have complied, so they get the liability protections from this bill, which is important for doctors. There are documentation and medical record requirements here, and they have to make those records available to the Department of Health and Human Services. The unused medication is disposed of according to state and federal law. Nationally, about 93 percent of patients who pursue medical aid in dying prescriptions are in hospice and palliative care. Most of them are looking for this because their hope, their plan, is to pass away peacefully at home in the event their disease progresses in a way that makes it intolerable to them. That means their house is full of medications. If you have been with anyone in home hospice, you are aware there are a lot of medications given to the patient. These medications, in the event the patient does not take them, will be disposed of along with all the other pharmacopeia in the home.

I want to close by saying this is an incredibly popular policy. I am not sure that it matters because you are not here to necessarily validate the public, but you should know, when we explain this to people in the language I just used with you, a remarkably high percentage of them say, Yes, I would want that for myself; and, Yes, I think Nevada should allow me to make that decision if I consult with my family, my spiritual advisers, and my doctor, and it is what is right for me at the end. I wanted to share those with you because it is remarkable. We do not see a lot of policies where rural counties and Clark County approve at 80 percent [page 2]. That is not something we see a whole lot here. Now, I want to turn this over to Dr. Koch, who has many years of experience in hospice, because she can tell you more about what it looks like when someone chooses this.

Johanna Koch, M.D., Medical Director, Summit View Hospice, Reno, Nevada:
I am speaking in support of the medical aid in dying bill. I am the medical director of the Summit View Hospice in Reno, and two years ago, I had a patient with advanced cancer who

was no longer responding to treatment. The drugs needed to control his pain rendered him so sedated he could not function. His suffering was so great he told us he just wanted to die. We provided spiritual support, emotional support, psychological support, frequent medical visits, frequent nursing visits, and aggressive palliative care or symptom management. Despite this, he begged us to help him die even while receiving this excellent palliative care. On one cold winter morning, he called the police and informed them there was a dead body in his garage. He went out to his garage alone, spread out a tarp, laid down on it, and shot himself in the head. No one should have to resort to a desperate measure like this when our medical system could have provided them with a peaceful alternative. This broke my heart, and no first responder or hospice team member should have to walk into a home and see that in front of them when it could have been avoided.

I am a board-certified family, hospice, and palliative care physician. I am and have been a practicing local family doctor for over 35 years. I also have been and am a hospice medical director for 20 years in both the state of Nevada and in neighboring California. As a hospice physician, I have cared for over 3,000 patients through my hospices. I have prescribed medical aid in dying for fewer than 40 patients. In contrast to the story above that is so tragic, my experience with medical aid in dying in California is that it affords the opportunity to have a warm and loving environment with time for sharing and closure and lots and lots of love. One of my patients in California waited for two months near the end of his life with cancer while his family worked to come to terms with the reality and the finality that his life was ending. Once they were finally on board, he was able to get his wish. After completing all the steps required by the law, he obtained his medication. On the day of his death, while I was preparing the medication, he and his family members watched a video compiled by friends and family wishing him bon voyage, reminding him of some of the funny things that had happened in his life, and telling him how much he was loved. The family encircled the bed and reminisced with him. When he took the first sip of the medication, he stopped for a moment, took a deep breath, laughed, and said, "Oh my God, this stuff tastes like something else." His family also began laughing as he drained the cup and fell asleep. He died peacefully a few hours later.

In my experience, this is representative of medical-aid-in-dying deaths. I have heard there are many fears regarding this bill, as mentioned here. I can only tell you they have not manifested. There are over 67 cumulative years of experience within the participating U.S. states that have never shown any systemic abuse of the system, and never shown any inappropriate use of the medication. The law is written to prevent those things, and it works. The majority of Nevadans support medical aid in dying. There are many in our state today who are wishing for a gentle and peaceful death in their own homes, surrounded by their families, and on their own terms. For your constituents, this legislation must be passed.

Chair Peters:
Thank you. We are ready for questions now. We have several. I will start with Assemblywoman González.

Assemblywoman González:
Thank you so much, Senator Flores, for bringing this bill. First, I want to make a comment about your willingness to hear everyone's concerns. When I was looking for the bill, there were so many different versions of it, I had a hard time finding the correct one. It is critical in the law-making process that we address the concerns of our community. I have a few questions. Why is there this narrative that this would be forced upon someone? I have read the bill and I heard your testimony, but I do not see anything that would force a person to go through this process, so I am curious. Where did that narrative come from? Why are we hearing that?

Sara Manns:
Many people fear that historic abuses in our health care system against people of color, poor people, and people with disabilities will be recapitulated in this process. That fear is completely understandable because those abuses have happened. That is real. What we also can be confident about the practice of medical aid in dying is that it will not be possible under this legislation to force it upon anyone because a disability is not a terminal condition. You might develop a terminal condition if you have a disability, but those are two separate categories. The anxiety and the fear about that is completely understandable because we have to be honest about the fact that there have been abuses, but this practice is not vulnerable to abuses. For example, one of the concerns I heard articulated was, What if someone is coerced into this? Well, the process for this is onerous; it is complicated. It is difficult to go through all these steps. Typically, the medication is not even covered by insurance, so it can be difficult to access. We have not seen in any other state that this has been forced on anyone. But again, as Senator Flores said, it is important to be respectful of those concerns because they are based in a reality. This policy, as encoded in this legislation, is not vulnerable to that, but it is understandable that some will be worried, and that is why you hear that.

Assemblywoman González:
My next question is a data question. In the last year, or maybe in the last five years, how many people have used this in those other states?

Sara Manns:
I can tell you over all jurisdictions in the past 20 years, just over 6,000 people have used medical aid in dying. That is 67 cumulative years. That is not a lot; less than 1 percent of the people in each jurisdiction where this is authorized use the law each year.

Assemblywoman González:
Thank you so much. You touched upon there being concern that this would impact poor people. I was curious if you had data on the socioeconomic backgrounds of the people in those states who have utilized this.

Sara Manns:
We have limited data, and the reason is we do not get consistent reporting across all the jurisdictions. We can tell you the overall demographics, and I would be happy to do that.

There is nearly equal use among men and women. The rate at which Asian, Black, Indigenous, and Latinx people access and use prescriptions under medical-aid-in-dying laws is consistently lower than the rate at which white people use it. Most of the people who use medical aid in dying have a terminal cancer diagnosis. That is the most common diagnosis. The challenge we face with giving further demographics among these jurisdictions is not just that they are all different, it is that there is a federal law that restricts the use of funding through any Medicare or Medicaid program for medical aid in dying. For that reason, individuals reliant on Medicaid and Medicare at the end of life often cannot access this even if they wanted to.

Assemblywoman González:
Thank you so much. That disproves the point that this would impact low-income people. As I am reading this, in the safeguards, the patient has to be seen by two different doctors. If there is a concern about their mental state, they are referred to a mental health physician. To me, it sounds like a lot of copays and even paying out of pocket because your insurance company is not covering this, so I wonder where the argument that this would impact low-income people came from. It sounds to me that you do have to pay out of pocket for this and for the many different appointments, including the medication—which I do not know the cost of. Can you touch on that, too, please?

Sara Manns:
Yes, it is about $700. That is not insignificant for someone who depends on Medicaid and Medicare coverage. But the point you raise is something I would like to highlight. The fact that this can be expensive and may have a lot of copays, meaning the argument that this is somehow going to be thrust upon people who are not actively seeking it, is tough to understand. If it were up to the doctor, the hospice practice, or the hospital, they can cover every treatment a person might pursue, but they cannot cover this one. Anything they could do to potentially extend their life, anything they could do that is a treatment that could give them more days and more hours, is paid for; but this is not. That is a significant protection against doctors pushing this or suggesting it to patients.

Assemblyman Gray:
Bear with me, as this is such an important and emotional topic. Since the beginning of the session, some folks know I have had three family members die, and all three of them could have fallen into this class, so I have some questions. None are meant to be inflammatory; they are truly fact-finding. The first question is, why do we have to codify this? Most doctors and patients have a relationship, so when you are close to dying at the end of life, they will make you as comfortable as you want to be. Meaning, if you want to push the medications, have at it. They understand it. First, do no harm. They do not want to see you suffer undue pain in your final moments, so why must we codify this?

Johanna Koch:
The reason we codify this is because what you are talking about is, first of all, illegal. In other words, what you are asking a doctor to do is illegal. You are asking them to give a patient enough medication to kill themselves. While I understand there is a nuance

there—you can say, Here is the bottle of morphine; this is how much you should take, and I am not going to look if you take more than that. It is so imprecise, and some people do not respond well to that approach. Instead, you end up with complications that end up with hospitalizations, intensive care unit stays, and people dying in ways they had no desire to have happen.

Assemblyman Gray:
The bill says, and this is where I have another problem with it, that the death certificate must certify that the death is primarily due to whatever the terminal illness was and must not mention the suicide. That is a lie that could defraud insurance companies that have suicide clauses. Like it or not, that clause is in there, and I have a hard time with that. If they are going to choose that route, why can they not choose that route and go with the ramifications of that route?

Johanna Koch:
I have completed somewhere close to 3,000 death certificates. Each time I complete one on a patient, I have to sift through the various possibilities of how to complete it in a way I think represents their journey toward death the most accurately. For example, if a patient dies of dementia, I put dementia as the primary diagnosis on their death certificate. But it might be more accurate to say that they died of heart and lung and other organ failures as a result of protein-calorie malnutrition, as a result of swallowing difficulties, or digestive absorption difficulties that were caused by their dementia. It serves all of us better to put the diagnosis of dementia down for that patient rather than those other extenuating circumstances. Another example of that is a patient who dies of congestive heart failure. Would it be more accurate to say that they drowned in their own fluids as a result of their heart failure? I do not think so. A patient who chooses medical aid in dying is not doing so because they want to kill themselves. They are not suicidal. Suicidal is a legal definition, and these are not people who are suicidal. These are people who have usually fought for every day, week, and month of life they could get, but they finally realized they do not have the choice to continue to live. It may be a matter of days or weeks, but they know their life is coming rapidly to a close. As strange as it sounds, the real reason they are doing it is not to kill themselves, it is to stop their suffering. To call that suicide misrepresents it.

Sara Manns:
That was a two-part question. I would like to answer the second part, which is about the life insurance aspect. The life insurance lobby raised that same point, so we did some work in the bill so they could feel comfortable with it. Their concern was having someone decide to do this. Their concern was, why is there a suicide clause? What was the reasoning for it? What they do not want is to have someone decide to end their own life who otherwise would not get a policy, and then they would have to pay on that policy, because that would be fraud, right? Because the person knew information the insurance company did not have, which is that they intended to take their own life. This is different because the person is dying anyway, so the life insurance clause in this bill says that they have to pay because what is happening in the timing of the person's death is changing, by a very short margin usually, but not whether the company would have to write a policy. They reserve the right to not write a

policy to someone who is dying, as of course, they should be able to do. They should not have to pay if someone is gaming the system in that way. However, this is acceptable to them to pay because what is happening is the timing of the person's death is changing—usually by a matter of days or weeks, sometimes as much as months—but it is hard to say.

Assemblyman Gray:
As a quick follow-up to that, what about the missed premiums they would have paid because that does cause financial hardship? Is the bill going to require that, if you had six months to live and you died in three months, are three months of premiums going to be deducted? You do not need to answer. Those are the questions coming to mind, and if you would like to respond, that is fine, but that is a question the insurance industry might be better poised to answer because it affects them.

Dr. Koch, referring to ending pain and suffering, I will be the first to tell you that I have suffered from post-traumatic stress disorder (PTSD). As a 26-year military guy, pain and suffering is real; the depression is real. Mental competency can be questionable at times. What about somebody in that case? Why do we not put on their death certificate that it was due to depression or PTSD? I have yet to see a veteran who ended their pain and suffering, which is very, very real; I am here to tell you it is very, very real. Why do we not put it as the cause of death instead of suicide?

Johanna Koch:
The difference is that the person you are talking about was suffering and chose suicide to put themselves out of their suffering, but they did not do that with the support of a medical team that did their best to fix their problem. The veteran who goes out on their own and kills themselves, or the person with PTSD or some other reason, is not doing so in a protected, safe, nurtured, and supported environment where everything that could have been done was done to save their lives and to keep them from suffering.

Chair Peters:
I appreciate how sensitive this topic is to folks. Assemblyman Gray and I share a lot of feelings about PTSD and the impact it has on our friends and family. We will move on to our next question from Assemblywoman Taylor, please.

Assemblywoman Taylor:
We have all received many emails on this, as both of you can imagine, so I am going to ask a couple of questions related to those emails. Some of the emails have centered on the insurance companies. Let us say someone received a terminal diagnosis—and I think that might be part of the difference, as my colleague, Assemblyman Gray, mentioned someone who suffers from depression and PTSD, but they have not received that terminal diagnosis. But what if they did get that terminal diagnosis? Would that encourage insurance companies to say, We are no longer going to pay for your treatment because you can take this suicide pill. That means you die in a couple of days instead of in five or six months. Are insurance companies allowed to say, Well you have a terminal diagnosis, so you have to take this pill, or we are not going to support your treatment going forward? Does that make sense?

Sara Manns:
Yes, that is something I have heard about a lot. And here is the thing, the math does not really work because if you are qualified for this, you are qualified for hospice. Hospice pays for a wide range of treatments, and you can choose palliative care—which you would also be eligible for—to continue to fight your illness and treat your illness with everything possible. There really is no opportunity for health plans to save money with this because the people who are eligible to even request this in the first place are already at the end of all the expensive things that can be done. The health plans have already paid for all that, so they are at the end of those typically. The math does not work because hospice coverage goes however long. The health plan will give coverage for treatments beyond the point. When we ask people, Do you want to do everything? Most people say, I want to die peacefully in my own bed at home and not be in the hospital with a machine that goes "beep." So obviously, 80 percent of people say they want to be at home. That machine that goes "beep" in the hospital is extremely expensive, but health plans pay for that. Medicare pays for that. Medicaid covers that; but they do not cover this, so it is not really an opportunity for them to save money, because they cover those things and are compensated for them, and typically, people are beyond that point.

Assemblywoman Taylor:
I want to dig in a little bit further from the question standpoint, because the way I have heard it is that insurance companies will say they are not going to keep paying for that machine that goes "beep" for that person who says, I want to fight this until the bitter end because I love life. I do not want to go. The machine that goes "beep" is very expensive, but an insurance company would say, We are not going to continue to pay for that because you can take this suicide pill. That is the nature of the questions I am getting around this.

Sara Manns:
Thank you so much for clarifying that so I can give a clearer answer. Insurance companies cannot send people to this remedy. The individual must request it. The health plan cannot change what they cover based on this being available. In ten states, starting 25 years ago, if health plans could have found a way to do that, they would have. They are trying to make sure they are controlling costs because our system is very expensive, but with respect to that, however, we have not seen it. The reason is that by the time individuals have to make the decision they want this, they have to pursue it through this process. No one can make them do this process, and no one can tell them they have to, and health plans do sometimes say this treatment is experimental: It does not show 5 percent improvement in time for 5 percent of the patients. It does not even meet that low threshold. Therefore, we will not cover this treatment. That happens in Nevada today; that happens in every state without regard for medical aid in dying, and that will continue to occur. If this is authorized in Nevada, we will continue to have patients whose insurance plans say this treatment does not pencil out. We do not believe it is likely to lead to more days of life for you, and we are not going to pay for it. That is part of our system and is going to remain true after this.

Assemblywoman Taylor:
Thank you. I appreciate that. Some of the emails named a couple of states that are doing it all the time, and then you said your research has not found that. Research is a wonderful thing, so that is something we can certainly find out. Another email question that was sent to me often concerned these medications used for those who request them. I know most who request them end up using them, but nonetheless, they are not approved by the Food and Drug Administration (FDA).

Johanna Koch:
The individual medications used in the end-of-life cocktail are each approved by the FDA. The combination of them is not approved, but there is not one single combination. A prescribing physician may choose to prescribe whatever they feel is the best cocktail, if you will, for that patient. There is some work being done to collect data on this subject so we can learn what works best, but that is as far as it goes. There is no specific FDA approval for the formula because there is not one formula.

Assemblywoman Taylor:
But each individual medication—does it have FDA approval?

Johanna Koch:
Absolutely.

Assemblywoman Taylor:
You spoke about the process because you have been involved in this for many years. You gave an example of a gentleman with his family. They watched a video and so on, and then he drank the beverage and lay back. Do they just fall asleep?

Johanna Koch:
The average person falls asleep within ten minutes. In fact, I think over 80 percent are asleep within ten minutes, and they never wake up. That is an absolute. There has never been somebody who woke up from an end-of-life cocktail. The next step of actually dying can take anywhere from minutes to hours, and most deaths occur within two hours.

Assemblywoman Taylor:
Okay. Thank you very much. I appreciate those answers from all of you.

Assemblyman Hafen:
Today, we are talking about the difference between death with dignity versus murder. We have had conversations about the cost of a beeping machine, which I do not find relevant to this conversation at all, and I have heard some things that are actually upsetting to me. We sit here in this Committee time and time again listening to the fact that we have a mental health crisis going on right now in this state. A lot of it is due to the pandemic and the lockdown, and we are trying to address that with legislation.

The statistics we are being presented with are that one in four people are going to go through a mental health crisis or mental health issues throughout their lifetime. There are 12 legislators sitting here today; that means 3 of us at some point in our lives are going to have some sort of mental health issue, whether it is depression, anxiety, or others. What we are seeing in other countries and in other states that are doing this is they are allowing this for depression. Other states in this country are allowing this for anorexia, and in those other states, we are now seeing a substantial increase in suicides—not assisted suicides—but suicides. In some states up to 40 percent.

Senator Flores, you know how much I respect you, and I know you mentioned there were safeguards, but I am struggling with these safeguards today to see how we are going to prevent our youth, our citizens who are struggling with mental health, from being one of those 40 percent statistics in the other states. Please help me understand the safeguards you are putting into place to address those other individuals who are not at the end of life but are struggling with mental health and might see this as an alternative out when they could be getting actual help.

Senator Flores:
It is incredibly important that we start the conversation with there must be a terminal illness with a six-month or less prognosis of life, right? The reason I am saying that is mental health is a huge issue. Mental health is something we will be dealing with every legislative session for the rest of every individual's life in this body because we still do not understand so much of it, and all of us are probably committed to working and improving it. I will start off there, because that immediately captures a whole group of folks who will not engage in this conversation because there is no terminal illness with the six-month-or-less prognosis.

Second, this does not apply for anybody under the age of 18. For our youth—and we know mental health is a huge issue with our youth—this will not apply to them. Third, and equally as important, we have to remember for the individual who has been diagnosed, who is suffering, there has to be a conversation. There have to be two different doctors who make the same finding and agree, and there has to be a mental health assessment. On top of that, you then have to go and fill that prescription. You then have to pick it up, and then take the medication. All of that needs to happen—that entire process—and that does not happen in a day.

I have had conversations with folks saying, Look, we have all been in a moment of crisis, and I am concerned that an individual in a moment of crisis will make a decision dictated by the deep hole they are emotionally in. But this entire process I just told you about cannot occur in one day. In one day, you are not going to have two independent doctors, a psychologist, a prescription, a pickup, and taking it all in. It is going to be over a course of time. I am not suggesting that will take months either, but I just want to make it abundantly clear, it is not going to happen in a single moment. I also want to make it abundantly clear that the psychologist and the two doctors, all of them are assessing this, right? There is no reasonable doctor who believes this should be an option if they see a scenario happening—coercion, folk pushing folks into a certain position, whatever it may be. They are saying, Well, wait a minute. I need to engage in this conversation a little bit deeper. I believe there is coercion. We are putting all that in this bill because we know it could happen.

We want to remind folk of that, and I also want to make it abundantly clear there have been 67 years of this; 6,300 people in other states have utilized it. If the data and a lot of the myths out there were true, it would not be 6,300. It would be that in just a single state. If the notion that the insurance companies are somehow going to be pushing everybody towards this direction, it would be in the millions by now. Just think how many human beings have a terminal illness every single day in our country. If all of that were true, the data would be very different.

Assemblyman Hafen:
I am going to be respectful, Senator Flores, because I do consider you a friend, but you did not answer my question. My question has nothing to do with assisted suicide. My concern is that we are in a mental health crisis right now, and the states that are doing this are seeing a substantial increase in unassisted suicide. Do not shake your head. I am reading the data right here. I do not appreciate that. I find it very disrespectful. This is a very, very serious conversation we are having about mental health, and I would like to know what safeguards are being put into place so that our citizens are not looking at this as an out and a justification for unassisted suicide. And I would like to have that question answered.

Sara Manns:
The chart I am looking at [Exhibit G], which is Centers for Disease Control and Prevention data since 1993 which was when the first medical-aid-in-dying law was authorized in the U.S., shows the suicide rate of the five states which first authorized it, and there does not appear to be any correlation between rising suicide rates. They are a national trend, they are a tragedy and certainly a problem, but there does not appear to be any correlation whatever between states authorizing medical aid in dying and the rising suicide rates.

Senator Flores:
For the record, we could also share this specific chart with the entire Committee so that you can see specifically what we are referencing. I am not sure, Assemblyman Hafen, what specific data you were looking at, but we are more than happy to share this specific data point so you can see our position on that.

Assemblyman Hafen:
I would appreciate that information. Just so the record is clear, there are no safeguards put into place for unassisted suicide in this bill.

Senator Flores:
I do apologize. I thought you were referencing specifically this bill, and that is why I went down that talking point, but I agree with you that this bill does not address suicide in general

conversations about suicide or mental health outside of the scope of a human being who has a six-month-or-less prognosis, a terminal illness. And I do agree with that, but this bill does not address anything outside of that scope.

Assemblyman Hafen:
Senator Flores, again, I have the utmost respect for you, so I hope you understand my concern when we are in the middle of a mental health crisis, and what we are doing by normalizing this. My concern is that we need to be doing everything we can to get out of this mental health crisis, and then have this conversation. I genuinely respect you, but I am going to have to disagree.

Chair Peters:
I appreciate your comments. We have spent a lot of this session talking about mental and behavioral health and the deficiencies in the state of Nevada. I appreciate the point, Senator Flores, that we are really focusing on the bill at hand, which unfortunately does not have the full scope of policy related to public and behavioral health, nor have most of the bills we have heard in this Committee.

Assemblyman Nguyen:
This is a difficult topic, and I have been getting a lot of emails over this just like all my colleagues, and so have you, Senator Flores. Assembly District 8 is one of the most diverse Assembly districts in Nevada with at least a couple dozen languages and backgrounds. Ms. Manns, I believe I covered this with you when you talked to me in my office. Many of these families are not aware of these options, all the medical availability out there. Sometimes it could be a language barrier; it could be too much information, or not enough. I learned recently about palliative care, and we did a focus group on that with the Asian community to see what their understanding of that and hospice care was. I am an immigrant. I was not born here, and I grew up in a bilingual household. Every time there is a life event, whether it is a happy one or a sad one, we struggle with the understanding and the dynamic of the complexity of the options that are available.

A lot of the opposition coming through and most of the emails I have been getting are about losing control and not having choices, that this law is going to force control out of their hands. They will not be able to have control and those choices are being taken away; those are most of the concerns. But going back to the bill, I want to make sure folks have the ability to control this narrative in terms of making this a part of their process when they choose their end-of-life option. Section 25 of the bill addresses a requirement for a written form in English. I am concerned that would eliminate a segment of our community being able to utilize this law, should it pass. For folks who have language barriers, they cannot even write in English, and having this part just for this one language could be a disadvantage in implementing this law, should it pass. I am trying to speak for the immigrant community of whom my district is mostly comprised. They have a lot of challenges navigating some of the current things already, so in terms of when we make these changes, I would like to see how we can work with folks who might not be able to write or read in English or not be able to verbalize the request in English. There needs to be some sort of process that would allow those families and those patients to have the ability to communicate their wishes and have it done correctly.

Senator Flores:
Assemblyman Nguyen, thank you for that question. It is an incredibly important point. I identify with a lot of your story—maybe different backgrounds; but a similar immigrant story, and I appreciate your being so in tune. In fact, I know you are working on ensuring prescription medication is in different languages, and I appreciate and applaud your work for that. I would like to turn it over to the Legal Division. Maybe our Legal Counsel could provide some guidance in terms of when a physician or a doctor is providing any type of medical care, what the requirements are now to provide that in any other language. If the answer is there is no real requirement that it be provided in any language other than English, then what I would do is mandate that this be provided in the language preferred by the patient. But I do not know enough about what the standard practice in the medical community is now. Maybe our Legal Counsel could jump in on that. I would appreciate your support.

Chair Peters:
Thank you for the question. I want to point out that our own Assemblywoman Torres has been working on cultural competency in the health care industry—specifically addressing some of these issues. But I would go to Mr. Robbins, please.

Eric Robbins, Committee Counsel:
When someone receives care, they have to provide informed consent to that care. That informed consent requires informing the patient of what type of care is going to be provided, what their condition is, what their options are—giving them the information they need to make that decision with all the knowledge they would need to make that decision. In this case, it would be the same. The physician would have a duty to ensure that the patient has an understanding of what those things are as outlined in the bill: What is their diagnosis? What is their prognosis? What are their options for care? If we are talking about a patient who speaks a language other than English and is not going to understand that information if provided in English, then the physician would have a duty to get a translator or something like that before providing care to the patient because the standards of care in the health professions would entail that the patient be informed of all those things and be able to voluntarily and knowingly consent.

Assemblyman Nguyen:
That is exactly to my point. If it is going to be the doctor's responsibility, and all they have is this legal form that is in statute and the words are in English, the patient may not be able to comprehend and sign off on it, right? That could also create some challenges. As we go along with these amendments, or some sort of regulations, we can think about how to do this from less of a hardship standpoint so that it is not coming from the doctor but coming from the patient.

Eric Robbins:
One other thing for the record: The section about the form states it must be in substantially the following form. It does not say it has to be in exactly that form. If you had a patient who spoke a language other than English, the wording of section 25 would allow the form to be provided in that language.

Senator Flores:
For the sake of clarity, I am more than comfortable ensuring we provide what we consider a friendly amendment to ensure that this information is provided in the language of the patient so the patient knows exactly what they are doing when they are filling this out. I do appreciate your perspective, and I will make sure we work on that.

Chair Peters:
Thank you, Mr. Robbins. Committee members have more questions, and we still have up to an hour of public testimony that we will get to shortly.

Assemblywoman Gorelow:
I have a quick question regarding an email I received about there being a lawsuit in California regarding their legislation on the right to die. Are you familiar with that?

Johanna Koch:
Do you know specifically what the issue was that was being brought up? I might be familiar with it.

Assemblywoman Gorelow:
The email was referencing that it was against constitutional rights. I was a little confused because I did not see how this would be.

Johanna Koch:
I am not familiar with that. Sorry.

Assemblywoman Gorelow:
That is okay. I get a lot of emails that do not have the correct information, so I just wanted to double-check.

Assemblywoman Newby:
Thank you, Senator Flores, for bringing this bill. Dr. Koch, earlier in your discussions you mentioned it is an onerous process that has to be followed, and I appreciate all the safeguards. From an operational standpoint, I think back to when my mother was passing away. The idea of trying to get her to various doctor's appointments on certain time frames was nearly impossible for her with the amount of pain she was in. How does that work for someone who is at the end of their life and in a lot of pain to be going to all of these different appointments and trying to check all the boxes if this is something they want to do?

Johanna Koch:
That concern is what eliminates many patients from qualifying for medical aid in dying. They do not have the physical stamina or wherewithal to get to a doctor's office. Some doctors are willing to go to a patient's home to do those visits, and I am one of those if they are within a reasonable distance from my home. But some patients do not have that option available to them because they are so ill. It is one of the reasons hospices try to have arrangements with providers who are willing to go into a home if they have a family seeking that out, and it is one of the reasons many people will complete the process a little bit earlier in their disease course in order to ensure that they are able to. But then, they do not request their medication be available to them until they are closer. They just jump through the hoops, then when they are ready, they request the medication if they choose to.

Assemblywoman Thomas:
I appreciate this presentation. Like my other colleagues, we have been receiving thousands of emails regarding this subject. Earlier you mentioned data, and I was wondering if you could go back to Oregon's 25 years of data and maybe the abuses. Does it show the demographics—Black, Brown, Asian? Can we get those numbers if you have them?

Sara Manns:
We have categories of data that show us the patient who uses medical aid in dying is most likely to be white, to be in their 50s, 60s, or 70s, and to be suffering from a terminal cancer diagnosis. When we try to go into detail in states, we get into a little bit of a difficult data problem in terms of determining what the rate is at which different groups may select this because of some of the disparities in our system having to do with which demographic groups are more likely to be dependent on Medicaid as well as Medicare at the end of life. For that reason, it is difficult to know, but you had asked about abuses—

Assemblywoman Thomas:
We have heard some really controversial questions here today, like insurance with assisted suicide, mental health, and lawsuits. My question has to do with the death penalty. It is like assisted suicide by state, so I was wondering if this is a cocktail that the states use to terminate a life.

Johanna Koch:
What a great question. No.

Assemblywoman Thomas:
Thank you. I appreciate it. For the record.

Chair Peters:
Vastly different legal processes as well. There are two more questions left, and then we will move on to testimony. I appreciate everybody hanging in there; it has been a long hearing. Assemblyman Hibbetts, we will start with you.

Assemblyman Hibbetts:
I have a question related to what I believe is the process. I am going off the latest version of the bill, so I have not seen what it started out as. If you look at section 3, subsections 1 and 2 talk about the coroner's deputy—I will refer to it as the coroner for the sake of brevity—conducting investigations. In subsection 1, it says they are "not required to certify the cause of death of a patient who dies after self-administering . . . ." Section 3, subsection 2 says "any records," everything, is accessible. This is great until you get down to section 7, which reads, "Except as otherwise provided in NRS 259.050 and section 3 of this act, the coroner . . . shall immediately investigate the death and certify the cause of death." Then, when you pop over to section 46.5, subsection 2 notes "when the coroner's deputy is informed or otherwise discovers that a person has self-administered a medication pursuant to . . . ." Paragraph (a) reads, they "May make an appropriate investigation." Section 46.5, subsection 2, paragraph (b) reads, they "Must cease investigating the death after determining that the terminal condition with which the person was diagnosed resulted from a natural cause." Is this the revised version after the concerns that were brought by Washoe and Clark Counties in the Senate hearing?

Senator Flores:
The answer is yes; this is the revised version.

Assemblyman Hibbetts:
My follow-up to that concerns section 46.5, subsection 2, paragraph (b). Why must they cease investigating? What are we hiding?

Senator Flores:
In general, there is a duty to investigate, and that is necessary because we want to make sure whatever it states on here is, in fact, the reason. What I am trying to get at is, there are scenarios where an individual said that they died of cause A, then after an investigation realized, well wait a minute, there are all these different things in their system. We think there may have been foul play; it might have been cause D. That is what they are usually trying to figure out—making sure there was not foul play. That is why we work with them, and there are a whole host of other things they were also trying to capture.

What we are trying to make sure of with that section you quoted is once they have determined that is what it was, that is where we stop. We want them to understand their investigation allows them to find out this is exactly what happened: Here is the cause of death—this terminal illness; there is medical aid in dying—and then they are done. We still want them to be able to make an investigation and realize that is what it was. If, in that investigation, they were to find something completely different, and it was not medical, obviously, at that point, there may be X, Y, and Z things that will take place including an investigation with law enforcement, et cetera.

That was part of some of the conversations that were happening with that, just to make it abundantly clear. This language was done in conjunction with them, explaining what they do, when they do it, and why they do it. Do you want to add anything to that Ms. Manns?

Sara Manns:
The only thing I would like to add is this language was arrived at after lengthy conversations about what the obligations of coroners and investigators are. Their concern was, they did not want to be forbidden to determine what this death was after that prescription was issued. Also, they did not want to be required, as they would otherwise be by a different part of the code, to investigate the death to determine no crime had been committed. They do not want to be required to do that because folks have been through this whole process: The patient got this prescription and used it—two-thirds of patients use the prescription; one-third of them do not. You are retired law enforcement, so as you know very well, the process of investigating an unintended death is extensive. It has a lot of legal requirements for the coroner's department. It can cause the family to go through an extensive process with the remains and all that. They wanted to make sure they could do their duty and fulfill their obligations to the public but not be required to impose that on the grieving family in every instance of the use of this. That is what that was for.

Assemblyman Hibbetts:
If I am understanding what you are saying, the coroner's offices in Washoe and Clark Counties had concerns during the Senate testimony. They wanted this language in here to have them stop investigating so they did not have to fill out a certificate of death that said either suicide—which legally is what this is—or, based upon the language of this bill, put something other than what it factually was. Is that what their concern was in needing this language in here?

Sara Manns:
I am sorry, I would not be able to answer that.

Senator Flores:
I do not know if anybody from Clark or Washoe Counties is here. If they are not, we could see if they are in the building. This was at their request. I think it would be best if we could have them walk you methodically through their entire thought process. There was 100 percent compromise to their request concerning the language they wanted added. I will reach out to them and see if we can get them in here prior to the hearing ending.

Assemblyman Hibbetts:
When you said you were working on this language, was that with lobbyists from the counties or from the actual coroner's representative?

Senator Flores:
They were in consultation with their folks. It was with the lobbyists in the room, but they were in consultation with their folks.

Assemblyman Hibbetts:
Thank you very much.

Chair Peters:
I am going to encourage you to take that off-line and follow up as you need to with the appropriate parties. I do not see anybody in here from the Washoe County or Clark County Sheriff's Office, so that follow up would have to happen afterward. I have one last final short question from Assemblywoman González, and then we will go into testimony.

Assemblywoman González:
There has been a lot of conversation about mental health in our youth. Do we know any data on the people who have utilized this and if they had any mental health diagnoses along with their terminally ill diagnoses? I bring that up because there are decades of research that show firearms account for more than 50 percent of suicides. When we try to pass legislation to impact this, my colleagues vote against it every single time. What I am struggling with is that there is no data that supports these arguments. Could you address that?

Chair Peters:
We are not talking about mental health in general as a public and behavioral health issue. But if you would like to respond as it pertains to the bill, please go ahead.

Sara Manns:
I am sorry, could you repeat the question?

Assemblywoman González:
My question is, What is the data supporting the fear that people who experience mental health issues are going to be vulnerable to this bill if it were to pass? The conversation around this bill has been that folks are worried that people who struggle with mental health are going to somehow be vulnerable to tactics that pushed them into choosing this option. I just wanted to be clear on the record, what is that correlation?

Johanna Koch:
There is no correlation between mental illness and requesting assisted suicide. There is no correlation there. Mental illness that is leading to depression that is leading to a desire to end one's life is actually a contraindication if it is the mental illness driving the process. If it is a physical illness driving the process, and that creates a life expectancy of six months or less, then that person qualifies, and their mental illness might not disqualify them. Although it would complicate the approval process because it would be more important to separate their physical and mental illnesses. But someone with a mental illness does not have a life expectancy of six months or less, and therefore, does not qualify. And just for the record, that actually does include somebody with anorexia, for example, unless they have reached an irreversible point of end organ damage, meaning their kidneys are failing, their heart has failed, and there is no coming back even with the best of care. At that point, that person becomes terminal, and then they could qualify, but that is really far down the road for that mental illness.

Senator Flores:
I know we are done with questions, and I have a very lengthy agenda in my Senate Government Affairs Committee where the Governor's staff is waiting for me, and I am being summoned back. I will have our experts in this area remain for any additional questions that may be brought during opposition. I want to apologize to all those testifying in support, opposition, and neutral. Please do not think I am disrespecting them, but I do have the Governor's staff waiting to present a bill. We have a short window of time to be able to do that in my committee and in the following committee, so out of respect to them and to give them ample time for their hearing, I need to step out.

I thank everybody for your questions, and I thank you for your time. We are going to continue working on this bill should there be anything else I can do, and that includes those of you who will not support the bill. I have amended the bill numerous times already in the interest of having the best possible safeguards in place at the request of individuals who said they would not support the bill anyway. I am not looking to amend the bill to get you to agree with me, I am looking to amend the bill to ensure we have the best possible safeguards in this legislation so we can ensure we are taking care of the folks we are concerned about—the most vulnerable populations in the state of Nevada who, unfortunately, have a terminal illness and are presently deciding between suffering or not. Thank you, Madam Chair.

Chair Peters:
Thank you for your time today, Senator Flores, and we know this time of year there is a lot of back and forth between the houses, so we appreciate your being here today. We are at the end of questions anyway, so we are going to move into testimony. At this time, I would ask the presenters to please take a seat in the audience, and we will invite support testimony on Senate Bill 239 (1st Reprint). We are going to start in our physical locations. We will take about seven minutes of testimony here in Carson City, seven minutes of testimony in Las Vegas, and seven minutes of testimony on Zoom and the phones. Any time that is not used in those other locations, we will come back around and make sure we catch as many folks as we can. I have staff setting the timer, so we have an accurate calculation of our time, and I would ask that you please state your name for the record before you begin. Begin when you are ready.

Clare Johnson, Private Citizen, Reno, Nevada:
[Clare Johnson provided additional written testimony, Exhibit H.] I am an emergency medicine physician and live in Reno with my husband and daughter. As an emergency room doctor, I see a great number of patients suffer at the end of their lives. I see patients lose their ability to eat as stomach cancer takes over their bodies. I have seen men who are 6 feet 2 inches weighing only 130 pounds as they finish chemotherapy. I am relieved to know that we in Nevada are once again considering a bill that would honor the options of terminally ill people to decide how and when they die when death is inevitable.

It has become evident to me that with great medical advances, we have created great suffering. We live longer, but often not better. I believe it is our moral imperative as a society to give options that alleviate the suffering. We have embraced hospice; we must go a step further by passing this bill. There is a common misconception that people die of natural and peaceful causes in the last six months of life. This is untrue. Some of us will die after days of dehydration and weeks of starvation as we lose our ability to swallow. That is how my father died in 2020 after a long illness. Some of us will die with severe pain, persistent vomiting, or air hunger. A coworker in California recently lost a family member after a three-year battle with metastatic cancer. In the end, she could not eat and was completely bedbound. California fortunately has authorized medical aid in dying, so she died in the comfort of her own home with loved ones by her side. I ask you to please set aside your personal belief system and consider passing this bill. We owe it to the diverse population in Nevada to provide diverse options at the end of life.

Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities:

[Catherine Nielsen supplied additional written testimony, Exhibit I.] Medical aid in dying is sometimes incorrectly referred to as assisted physician suicide, physician aid in dying, death with dignity, and euthanasia. Medical aid in dying is not assisted suicide or euthanasia. These terms are misleading and factually incorrect. Medical aid in dying protects patients, affords dying people autonomy and compassion during a most difficult time, improves end-of-life care, and would cost our state almost nothing to implement except for the minimal cost associated with collecting data and producing the annual statistical reports. The Nevada Governor's Council on Developmental Disabilities supports the individual's right to make informed choices on decisions that will impact their life, and this includes the right to make end-of-life informed choices.

Informed choices occur when a person, with or without reasonable accommodations, understands all of the options available to them, including the benefits and the risks of their decisions. The process of informed choice does not have an end and does not just occur at one time. Informed choice is part of an ongoing process of engaging people in person-centered conversations about their goals and decisions that will impact their life, and informed choice allows an individual with disabilities to be in control of their life's decisions and ensure they are making meaningful choices about what will impact their future. Our Council believes that all people with intellectual and developmental disabilities should be provided with all options that impact their lives, and if possible, should be provided the opportunity to experience and/or explore their options before making such a decision. To save you time, our policy recommendations will be printed on our statement.

Dora Martinez, Private Citizen, Reno, Nevada:

I am cofounder of the Nevada Disability Action Coalition. I was really confused coming to this hearing. Before you all spoke, I was sort of opposed, but after hearing all the debates, I am grateful to Senator Flores for giving us disabled people and those who are terminally ill a choice. Assemblyman Nguyen brought up the language issue. Please include American Sign Language (ASL) because ASL is not English. As a person who is visually impaired and could lose my hearing, I am learning the English language and can do hand-over-hand, if you have seen Helen Keller. But I am sorry, Madam Chair, I am going overtime. I cannot see your clock, but thank you.

Chair Peters:
We do not have a clock today, so please, continue with your story.

Dora Martinez:
Thank you so much, and I say "Ditto" to everybody who spoke before me.

Chair Peters:
It is very nice to see you in person, Ms. Martinez. Thank you so much for making the trek up here. We appreciate your being here. To clarify that statement, we do have a seven-minute timer going, but we are not timing individual testimony. We do ask that you be thoughtful of the other people who would like to testify, so if there is an opportunity to say "Ditto," please do.

Benjamin Zober, Rabbi, Temple Sinai, Reno, Nevada:
I was approached to speak on this issue to provide religious perspective in Judaism. We believe that whatever God's role in death and dying is, human effort on the side of compassion is a moral act. It is not moral or compassionate to tell a person whose life is no longer a blessing but a curse they should be experiencing joy in life and gratitude to God for keeping them alive and they only need to change their attitude. I am not alone in this view. I have spoken with a number of my colleagues in a variety of locations throughout the state in different religious communities. They stand with me today in recognizing the need for this bill. As much as I would like to go on and talk about religious views, and believe me, I have some good rabbinic stories and biblical highlights that support my position, this is not about finding the religious view as there are more religious views than there are religions or religious people. It is about something else. There is a line in the Talmud, our collection of Jewish law, saying that all is known, yet choice is given. Whether there is someone or something that indeed knows all is a matter of our respective religious views and our theologies. But the idea of choice being given to us is one that remains relevant, and indeed, is at the forefront of our liberties. Whether this bill is in alignment with our religious values is not the question we should be asking. Indeed, every religion has its own opinion on that matter, if not several. But to adopt one of those views would be to privilege that religion and establish something outside of what our law allows.

What passage would mean is that the people of this state have a choice in this matter, a choice that is not taken lightly. As has been said, there are many safeguards intended to make sure this is only undertaken under very certain circumstances with every safeguard in place and that no one who goes down this path does so lightly. It is a choice, as is the privilege of a free person: people free to consult with their families, with themselves, with their religion, and, if need be, with God. If people's religious or moral beliefs cannot allow for this act, then they are not forced to take it, not forced to participate. Defeating this bill on grounds that it would violate one religion, or even a few, forces all to live by that standard. Forced standards are not liberty, not for those who would never even think of choosing this as an option, and not for those whose faith leads them to this choice as an act of moral compassion. Liberty demands that we have choices, especially for the most difficult decisions of life and death.

Chair Peters:
Thank you. We have reached seven minutes up here and will go to Las Vegas.

Patricia Gonzalez Portillo, Private Citizen:
Good afternoon. My name is Patricia Gonzalez Portillo. I am here to testify on behalf of Hanna Olivas, a 49-year-old mother who lives in Las Vegas. Unfortunately, Hanna's condition is deteriorating, and she is unable to be here today. I am reading verbatim:

> In 2017, I was diagnosed with a rare form of blood cancer called multiple myeloma. This incurable disease has taken over my life since 2017. At the time, doctors gave me a five-year prognosis. This end-of-life care option is more important to me than ever. I am relieved that once again, legislators are considering this compassionate bill that would honor the options of terminally ill Nevadans to decide how and when they die when their death is inevitable. I was very disappointed when similar bills introduced in Nevada did not move forward during the 2019 and 2021 Legislative Sessions. At the time, I urged state lawmakers in Nevada and other states nationwide to pass these compassionate laws. But this rare aggressive cancer has taken a toll on my body. I am not the same Hanna I was in 2021. God has given me one more opportunity to use my voice. I am tired. I am in pain. I am scared. I do not have the time or the energy to fight for this bill any longer. I am exhausted mentally and physically. I am nauseous. I do not have much more time. My focus is to live my last day surrounded by my four children and two grandbabies. Terminally ill Nevadans are dying in pain and agony with no other options right now. Government or state agencies should not decide how much suffering is too much to bear at life's end or tell us how much pain is acceptable. No one should be able to tell me how I say my last goodbye. Honorable Nevada Legislators, I urge you to put yourselves in my shoes. I plead that you listen to my story. I am terrified that my right kidney is shutting down from all the treatment and progression of the disease. My body is badly broken as a whole. I do not want to leave my family with those horrific images as I die slowly in unbearable pain. I am tired of the endless hospital visits, CT [computerized tomography] scans, MRIs, PET [positron-emission tomography] scans, biopsies, and blood tests. I refuse to spend my last days connected to machines, catheters, and tubes that will cause more pain and vomiting that will only debilitate my body. When my Lord calls me, I want to die peacefully, surrounded by my husband and our sons and two daughters and our precious grandbabies, Dominic and Damien, holding my hand in prayer. There are others like me who need this option, now. I urge you to please help me pass this compassionate bill to make what is left of my life and my death a peaceful one. Thank you.

Chair Peters:
Thank you for sharing that story.

Dan Diaz, representing The Brittany Maynard Fund:
I am reading somebody else's testimony as well. I am reading on behalf of a friend of mine who cannot be here today because she is currently receiving medical care. This is her testimony [Dan Diaz read testimony from Lynda Brooks-Bracey]:

> My name is Lynda Brooks-Bracey. I am 57 years old, and I live in Las Vegas, Nevada. I am dying of metastatic pancreatic cancer. I am dying. Metastatic pancreatic cancer is killing me, and it will end my life. That is a hard fact, and that cannot be changed. But what can be changed is how much suffering I might have to endure. To have the option of medical aid in dying in Nevada would mean the world to me and to other terminally ill Nevadans who are in the same predicament. Since my initial diagnosis in February of 2021, I have undergone months of aggressive treatments including chemotherapy, a major surgery that required months of recovery, and additional rounds of chemo and a clinical trial. Yet still, my cancer came back with a vengeance very clearly. The doctors tell me we have done all we can do medically. I am currently on palliative chemotherapy to manage my symptoms and potentially give me some more time. As a Christian, I am not afraid of where I am going after I die. My personal faith is deeply rooted in a loving God. But what is unacceptable is dying in pain and leaving my children so early in their lives. It is unfair to force my family to watch me die in the kind of pain pancreatic cancer so often causes, especially when there is a safe option like medical aid in dying that so many other states offer their terminally ill individuals. Please support S.B. 239 (R1). Thank you, Lynda Brooks-Bracey.

The reason I am here is because my wife, her name was Brittany Maynard, died on November 1, 2014. Brittany utilized medical aid in dying, so I can speak to this firsthand. I can speak to the safeguards. I can speak to what it takes to actually get that prescription. Brittany was only 29 years old and battling a brain tumor, but she was able to experience a gentle death only because of this option. Lynda here in Nevada should have the same end-of-life option Brittany had. Period. The people of Nevada deserve better. They should not have to leave their homes just to ensure a gentle dying process.

Dar Stone, Private Citizen, Las Vegas, Nevada:
I live in Las Vegas District 41, represented by Assemblywoman Sandra Jauregui. I have been a physician assistant for 40 years, the last 25 years here in southern Nevada. Prior to that, I was a registered nurse and commissioned officer with the United States Public Health Service. I would like to thank you for once again introducing this compassionate bill that would allow terminally ill adults the option to die peacefully. Throughout my career, I have stood bedside with patients and their families at the end of life, and it has too often been fraught with pain, suffering, and intense anxiety. These dying individuals want the option to ease their pain and suffering so they can die peacefully. I understand this decision is not for everyone. No one has to opt in to this decision: No patient, no physician, no pharmacist. It is a choice. It is important to clarify that medical aid in dying is not assisted suicide.

It involves mentally capable people who request medication to be able to die peacefully in their own beds, surrounded by their loved ones. People who request medical aid in dying are not depressed. They are not wanting to die. They simply want the option to ease their pain and suffering so they can die peacefully. It is not suicide. We should always provide quality end-of-life care for people who are suffering from an incurable and irreversible terminal illness. But when a person only has months, weeks, or even days to live, and there is nothing else that the world of medicine can offer, we should allow the person the option to end their pain and suffering when the time comes.

For those concerned that this decision may be impulsive or coerced, these concerns have not been borne out in the evidence gathered over the last two decades in states and Washington, D.C., where medical aid in dying 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. We are all going to die. The patients themselves and not the health care system should be in charge of their end-of-life decisions. 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 should be allowed to ingest a medication to end their suffering if that is what they choose. Honorable legislators, I urge you to support this compassionate legislation that would allow terminally ill Nevadans the option to die peacefully and not painfully. Thank you very much.

Chair Peters:
Thank you. That testimony brought us to over seven minutes in Las Vegas, so we are going to move to the phones. But if there are more folks who would like to testify in support in Las Vegas, please come up to the table so we can get an idea of how much testimony there is in support down there. I am going to check Zoom first to see if we have anyone on Zoom who would like to testify in support, and then we can go to the phones. [There was no one on Zoom.] We will go to the phones for testimony in support of Senate Bill 239 (1st Reprint).

Geoff Sugarman, representing Death With Dignity National Center:
The Death With Dignity National Center is an Oregon-based organization that works on legislation across the country and serves to amplify the voices of terminally ill patients. We are in strong support of Senate Bill 239 (1st Reprint). I was the campaign director for the original Oregon Death With Dignity campaign in 1994. We sought to develop a process that ensured dying patients would have this option under a set of safeguards and a well-defined process. You have heard Senator Flores and others describe the many safeguards in this law, from the initial oral requests to the self-administration of medication. What I can add are the following observations after having worked on this issue for over two decades.

This law is rarely used. On average, less than 0.5 percent of deaths reported in all states can be attributed to medical aid in dying. There has never been a prescription written to anyone who did not have a diagnosis of a terminal disease within six months of death. Not once.

No patient or medical professional has ever been forced into using this law. Both the safeguards and the opt-out provision have worked, ensuring there is no fraud or coercion, and no one is forced to participate. In Oregon in 2022, 91 percent of the people using this law were enrolled in hospice. Ninety-two percent died at home. Over 60 percent had cancer, and over 90 percent had health insurance. This law has worked. Under S.B. 239 (R1), you can be assured it will be used in Nevada with the same care, compassion, and caution as it has in all other ten states where it is legal.

Will Bradley, Private Citizen, Las Vegas, Nevada:
I do rise in support of Senate Bill 239 (1st Reprint). To give you some background, I am a conservative Republican. I am a graduate of a seminary as a Christian, and I am a retired lieutenant colonel and combat veteran. I have had some experience on both sides of this, and after prayerfully considering it, I want to join the 80 percent of my fellow Nevadans—in the latest poll—who are in support of someone's right to choose their own death, knowing they are doing so out of compassion for themselves—No. 1, to put up with the amount of pain. I will never forget the first time I investigated the suicide of a soldier in Iraq, and it did not ring true to me. I have never had those thoughts—why this person would kill themselves. After investigating what was happening in their life, and they were under the care of a psychiatrist in the United States Army, this person chose to end their life with a nine-millimeter shot to his head. I understand why he chose to end it. Because it is logical, it is ethical, and it is moral that if someone is in pain, they should have the choice to end their pain. Whether you are a soldier going through whatever you are going through or whether you are going through medical issues. Matter of fact, I would like this extended. Recently, three people in prison committed suicide, so I would like it extended to where if someone wants to avoid or end the torture of one of our state prisons, they can opt for this. I know it is not part of this bill, but there are people going through pain all over our state, and they do not have a reasonable way of ending their life. If they choose to do it, they should have a right to do it. So again, I am in support of this bill. Thank you.

Abad Piza, Private Citizen, North Las Vegas, Nevada:
Incurable, inevitable. These are words I have heard in several testimonies today. Pain, another one suffering; to feel pain is to know you are alive. Knowledge today is money. Let us not forget, Assembly Bill 289—human composting—or the death penalty. My sister was in the U. S. National Guard until she got lied to when she got cancer and was only given a few weeks to live. We were able to get my sister out of the country to find her a cure or to seek alternative care, only to come back after she was cured to be arrested and held or forced to do chemotherapy. She was basically forced to die here all because doctors' knowledge was negligent of ancient medicine or holistic medicine. Now, I do not want to be against people's choices, but when the law in a sense dictates how people can seek medical attention and possibly cure themselves with some elements, I find it horrific that an option to die would be given to that person because, as I mentioned before, to feel pain is to know you are alive. Now, I do not oppose some people's opinions of wanting to end their life due to the pain and suffering they are going through, but again, knowledge, whether it is coming from

someone we trust, someone we admire, or someone we may not know, can always hold keys that are valuable. With that, I end my testimony. But again, I will not oppose this. I am for it. Thank you.

Chair Peters:
Thank you for your testimony. Based on the context of the testimony, I am going to put that into the opposition category, but I appreciate the narrative. We will add that time back into support testimony. Are there other callers on the line in support of S.B. 239 (R1)?

Laura Gray, Private Citizen, Las Vegas, Nevada:
[Laura Gray provided additional written testimony, Exhibit J.] June marks the 30-year anniversary of my father, Roy Gray's, death. His death certificate indicated he died as a result of the cancer he struggled with for months. In reality, he died as a result of dehydration and starvation. My father was unable to eat or drink in the final week of his life. During that week, my father constantly writhed in pain and discomfort. Eventually, his nurse urged us to start administering morphine to make him "comfortable." My family and I knew this would mean we would no longer be able to communicate with my dad, and this was true. I certainly would not refer to my father's morphine haze as comfortable. He was simply incapacitated. The only thing my father responded to after administering his morphine was when his adult children changed his diapers. He would grimace in agony as if we were violating his very pride. Could you imagine this being one of your final experiences in life? We sat with my father, ironically praying for our loved one to die. We anxiously watched for the signs that would indicate his passing was near—discolored nail beds, changes in his extremities, and the dreaded death rattle. If you have never witnessed death rattle, it is the most horrendous state for a human being to be in. It is like an old car running in the heat desperately trying to get to its final destination. I support S.B. 239 (R1) because if I were to become terminally ill, I would not want to endure the suffering and horror that was forced upon my father. I would also most certainly not want my loved ones to endure the experience either. More importantly, I want this bill passed so that anyone out there facing the consequence of a terminal illness can choose to end their life peacefully and on their own terms. Thank you for listening to our stories today. I know they are difficult to hear, but they are certainly even harder to witness and to endure. Thank you for your consideration.

Chair Peters:
Thank you for your testimony. Seeing that there are many more folks who would like to testify in support, we are going to come back around to the folks who are at the table currently, and then move to opposition testimony and give them the same amount of time. We will see where we are at, and likely come back for another round of support, opposition, and neutral testimony after that. We will take these three folks in Carson City, go to Las Vegas and take the last person at the table in Las Vegas, and then move on to opposition testimony. Please proceed when you are ready.

Vanessa Dunn, representing Nevada Public Health Association:
I am here representing the Nevada Public Health Association (NPHA). The NPHA follows the guidance of the American Public Health Association on this topic and is in support of S.B. 239 (R1), which will expand the options of dying and suffering patients in Nevada at the end of life. Thank you for your consideration.

Carrie Roussel, Private Citizen:
Hello, and thank you for taking time to hear me today. Within the last five years, I have been bedside with two close family members who both succumbed to death from cancer. One had the option of medical aid in dying, and the other did not. My aunt lived in California, and she suffered so much pain in her last weeks of life that she chose to stop and be done and make a decision of when to end her life. We gathered around her and ordered in sushi. We shared cocktails, sang songs, and talked about all the things that we needed to talk about. And then we gathered around her and said, "Cheers" with Dom Perignon. She handed her champagne glass to me, and we handed her the cocktail, her final cocktail. She also made a joke about it and started with that big thick straw, said, "It is chunky," and took her last sip of her final cocktail. She looked at us and raised her glass and then she shut her eyes and gently fell asleep. She was gone within minutes. It was easy; it was right, and it was not difficult. The family and friends who surrounded her bed at that time looked at each other, and we knew we had done the right thing. It was not easy, but it was not difficult to choose this path. She lifted off with light, surrounded by her family members, and she left us in a gentle, really right way.

About a year later, I lost my best friend to cancer. She was 36, she was a local, and she did not have the choice to use medical aid in dying. She did not speak to us in her final three days. When she finally went, she suffocated in liquids that were filling up her lungs. She sank into the muck, and it was anything but light and right. It was deep, and it was dark, and it was difficult. Being there for both those experiences showed just how opposite they were. One was light and easy and respectful and compassionate; the other was not. Giving Nevadans this option, this choice, is truly the compassionate choice to make and is the right thing to do. I have seen it both ways, and I will always make the choice to choose medical aid in dying.

Kim Mazeres, Private Citizen, Reno, Nevada:
I am a retired executive from the utility industry, having lived in northern Nevada for over 40 years. My husband Steve loved life. He was a determined, intelligent, and caring man; a devoted father and grandfather, a veteran who late in life went to law school, spending the best days of his career at the Washoe County District Attorney's Office as a prosecutor. Our wonderful marriage of 30 years took a drastic turn in 2017. Steve was in his fifties when doctors initially diagnosed him with chronic obstructive pulmonary disorder. He spent years without disruptive symptoms until the spring of 2017 when he had a life-threatening exacerbation event. Steve's best hope was a lung transplant, which he opted for. He did well for a year, but something kicked off chronic rejection, and it was continually harder for him to breathe, but he continued treatments that could stop the rejection. During this entire process, Steve wanted the option to decide when enough was enough. We had numerous

conversations about his end-of-life wishes, including a potential move to Oregon to access that state's Death With Dignity Act. I was really angry about the idea of uprooting ourselves to establish residency in a state where we have no family, a place that was not home for either of us. I do not know if Steve would have ultimately used the medication to die peacefully, but simply having it as an alternative in our hands would have eased both of our minds and lessened the stress and fear of his pain and suffering. Steve's last 24 hours were horrific. He was in a tremendous amount of pain, and I scrambled to get him enrolled in hospice, because remember, we were still fighting at that point. His pain was unbearable without a more serious opioid. They let us know they could apply a fentanyl patch, but it was likely that he might not wake up once it was applied. Steve understood and agreed to move forward. Less than five hours later, my husband of 30 years took his last breath with that death rattle somebody talked about earlier, on June 9, 2020. Honorable legislators, I urge you to support the End of Life Options Act so terminally ill Nevadans have the option to shorten their suffering at the end of their lives. I wish my husband would have had that option. Thank you.

Jana Wright, Private Citizen, Las Vegas, Nevada:
I am speaking in strong support of S.B. 239 (R1). I would like to say "Ditto" to all the comments that have been made in support and would like to thank Senator Flores, Dr. Koch, and Sara Manns for their thoughtful presentation. I urge the Committee to support this bill and get it on the Governor's desk. Thank you.

Chair Peters:
Thank you. We are done with our first round of support testimony. That was 38 minutes total with no limit on individual speaking time.

[Exhibit K, Exhibit L, Exhibit M, and Exhibit N in support of Senate Bill 239 (1st Reprint) were submitted but not discussed and will become part of the record.]

We are going into opposition testimony on Senate Bill 239 (1st Reprint). We are starting in Carson City. We will do about seven minutes in Carson City, do about seven minutes in Las Vegas, then go to Zoom and the phones for about seven minutes as we did with the support testimony.

Herb Santos, Jr., Private Citizen, Reno, Nevada:
I oppose S.B. 239 (R1) because I am scared, not for myself, but for my children and my grandchildren. They will be the ones whose health care will be in danger if this bill passes. I am also scared for the vulnerable, the elderly, and the disabled. In fact, I fear for everyone in this room, your children, your grandchildren, your nieces and nephews, because they will all be the ones whose health care will be in danger if this bill passes. If passed, you will be giving insurance companies a direct path to profits over people. Insurers will deny expensive life-sustaining medical treatment, and in their place offer lethal drugs leading patients to hasten their own deaths. If passed, this bill will threaten the health care of every person in this state. You may have heard the proponents represent that there is no evidence of this type of abuse. That is a blatant and offensive misrepresentation to this body and to those who

have been victimized, people like Barbara Wagner. Senator Stone mentioned Ms. Wagner during the Senate committee hearings. She was denied treatment and offered a suicide prescription. The response from the proponents was that it was sad, but that is what insurance companies do. They deny all the time. In 2019, the National Council on Disability released the findings of a federal examination of the country's assisted suicide laws and their effects on people with disabilities. They found that the law safeguards are ineffective, and oversight of abuses and mistakes are absent.

I am also scared for the quality of care my children and grandchildren will receive if assisted suicide becomes medical treatment. Catherine Judson learned this in Oregon when she brought her husband to the doctor for treatment, and she overheard the doctor giving a sales pitch for assisted suicide. Any benefit of assisted suicide does not outweigh the harm this bill will cause on all Nevadans. I have submitted a more detailed written opposition, and I ask that you review it with all the supporting data [Exhibit O]. I would also like to add from listening to the testimony today talking about psychological consult. That is not the norm. Since this started, and Oregon does a study every year, and looking at the study, there were 431 people who requested assisted suicide last year. Three people received psychological counseling. Since its inception, of the 2,454 people who have taken the lethal drugs, 74 people—3 percent—were referred for psychiatric counseling. That goes from 1998 up through 2020, and that is in their statistics.

There was a comment that there is no evidence of a person ever waking up. In the documents I submitted to you, there is a story of Mr. David Prueitt. He took the cocktail, and his family was there along with members of Compassion and Choices. After 65 hours, he woke up, and the Oregon department said they could not investigate it.

In my legal practice, I do workers' compensation and have been doing it for over 30 years. I have seen this happen all the time—insurance companies denying treatment to people who have been injured on the job. That is what happened and that is what will happen if this law is passed. In conclusion, S.B. 239 (R1) is bad law, and I respectfully request that you vote no, not only for your constituents but for your children, their children, and the majority of people in Nevada. Thank you.

Chair Peters:
I just got a notice that we have someone on Zoom who has been waiting patiently for opposition who has to leave. I would like to go to Zoom next to include her in the testimony. Hello, Ms. Hammon, thank you so much for being here, and I apologize for the delay in your opportunity to speak.

Brianna Hammon, Private Citizen, Reno, Nevada:
[Brianna Hammon's video testimony was submitted, Exhibit P.] My name is Brianna Hammon. 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 treatment. In fact, I have several disabilities, so 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? The 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 a disability, 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 if the only alternative to death of those in power for people who require assistance is poverty and segregation and nursing homes, then it makes no sense to talk about assisted suicide as a choice because according to the Oregon statistics, the No. 1 reason that people choose assisted suicide is not wanting to be a burden. No one even tells them about attendant support and all the other myriad supports that help us stay connected to community.

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 a 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 offer to suicide 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 do not resuscitate (DNR)? Everyone wants to educate me. No one wants to tell me my life is worth living. If you pass this bill, you make it worse. If the death penalty makes racism and errors of the legal system permanent, then assisted suicide makes ableism and errors of the medical system permanent. You cannot have it both ways. Did you know that children whose parent commits suicide are three times more likely to commit suicide themselves and far more likely to struggle with depression? If this bill passes and I call the suicide hotline to say I am depressed because Medicare will not approve a new wheelchair or my attendant has quit, are they going to ask me if my state has a suicide option?

Chair Peters:
Thank you, Ms. Hammon, and I would ask if you have your statement in writing that you send it in so folks can read it. We struggled to hear you at the very beginning and through portions of your testimony. Thank you so much for being here.

We are going to move on to the folks in Carson City.

Leslie Quinn, Private Citizen, Las Vegas, Nevada:
Thank you, Madam Chair, and legislators. My name is Leslie Quinn, and I oppose S.B. 239 (R1). My brother fought non-Hodgkin's cancer for ten years. Throughout those years, we were told many times his end time had come. Thankfully, he would get better with treatments at the City of Hope. He would have more time to impact his children's lives. Never give up, he would tell them. Give full effort. My brother fought for a life for himself, his wife, and especially his children. He taught them that life is a gift, and only God can give it or take it away. Two years ago, my pop passed. He lived in excruciating pain daily from various health issues. He refused meds to maintain his life before he did this. He canceled his life insurance policy, so there was no payout. He wanted no lying on how he passed or false life insurance payouts. He died as he served in the Korean War—courageously and with honor.

Senate Bill 239 (1st Reprint) requires coroners, doctors, et cetera, to lie on death certificates, as shown on page 5, lines 26 through 30. We already have DNR orders and advance directives. If passed, S.B. 239 (R1) will raise life insurance premiums from the abuse and fraud of paid out policies. What about the Americans With Disabilities Act or any patient who cannot administer the shot to themselves or the drink because they are too weak or physiologically unable to? Who administers the shot or the drink? What are the ramifications to the person who gives that to them? I am definitely for death with dignity, thus the DNR and advance directive statutes. However, this bill opens up too much abuse and fraud. Last year, my best friend of 33 years passed from pancreatic cancer, multiple sclerosis, and a boatload of other health issues. Regardless of her extreme pain, she chose life and letting God choose when her last day would be. I oppose S.B. 239 (R1) and ask my Assemblywoman Brittney Miller and Senator Marilyn Dondero Loop, as well as all the legislators here, to oppose S.B. 239 (R1) as well. Thank you.

Katrin Ivanoff, Private Citizen, Las Vegas, Nevada:
I am opposing this bill for many reasons. People who spoke for the bill were talking about informed choice. After two years of involuntary house arrest in which we did not have a choice; after coming up with some kind of concoction that was not tested but was mandatory for us to keep our jobs—we had to choose between some kind of medical intervention or keeping our jobs and feeding our own kids—

Chair Peters:
Is this connected to the bill?

Katrin Ivanoff:
Yes, it is connected to informed choice. We were not given informed choice.

Chair Peters:
We are not talking about the COVID-19 pandemic. We are talking about the bill at hand.

Katrin Ivanoff:
That was the medical establishment plus legislatures plus government employees and governors, and other people we put in charge to help us. They were not making informed choices; they were making choices scared not to lose their positions. People in these positions put us in this predicament. It is connected because we were not given an informed choice.

There are other things people do not want to talk about. There are a lot of elderly people who are rich, and their families want them to die so they can take the money. Who is going to prove that they wanted to die? This bill is open to so many bad ways of using it. Senator Flores was asked several times, "What are the safeguards?" There were several people testifying that the bill is full of safeguards. But when the presenters of the bill were asked about safeguards, they did not answer. They were asked a second time, maybe they misunderstood the question. What are the safeguards? They said there are no safeguards. I do not know where the other people who were testifying heard about safeguards, but there are no such safeguards in the bill. The bill is open for a lot of bad ways of using it, and I am really hoping you are not going to allow it to pass. We have so many problems in this state, helping people kill themselves should not be a priority. People can kill themselves any time they want to. They do not need a bill for that. I am sorry to be blunt, but this is the reality of the situation. Thank you so much for listening to us and thank you for the work you are doing. I know you are trying your best. Please do not pass that bill.

Chair Peters:
Thank you for your testimony. We have reached seven minutes. I am going to take Dr. Cole since you were at the table. Dr. Cole has suggested we move down to Las Vegas since we have used up our seven minutes here in Carson City. We will come back around as we did with support, but I would like to make sure we have equal opportunities for folks on different platforms in Las Vegas. Please remember to state your name for the record. You may begin when you are ready.

Jill Douglass, Private Citizen, Las Vegas, Nevada:
I am submitting my testimony in opposition to Senate Bill 239 (1st Reprint). According to our Nevada Electronic Legislative Information System website, public opinion on this bill shows that 64 percent are opposed and 34 percent support. I am one of those who oppose this bill as written. Life-and-death decisions are difficult. This bill establishes troubling provisions governing the prescribing, dispensing, and administration of medication designed to end the life of a patient. I am extremely sensitive to those receiving a terminal diagnosis. However, I do remain concerned about abuses that will and can occur. Greed of heirs is real. Spousal abuse is real, and elderly abuse is real. Not everybody is surrounded by a normal,

functioning family unit. I would ask people to read the exhibit submitted by Dr. Brian Callister. He is very articulate in his reasoning in opposition to the bill. One of the things he testifies about is that medical literature shows the average margin of error in terminal diagnosis is 50 to 70 percent. I encourage everyone to read his article and his testimony.

Existing law already authorizes a patient with a terminal condition to refuse life-sustaining treatments, and hospice care today assists patients with a pain-free and pain-controlled death with dignity, both in home and in facilities. I am concerned with numerous provisions, especially those that relate to self-administration of the medication to end one's life. I question how we would know that, in fact, it was self-administered. I would think that a change in the provision that would allow supervision would be important. I am concerned about the requirement that you can request a prescription. Supposedly, that would not be done under coercion, deception, or undue influence. Again, how could we know or measure that? There are many people who would be coerced and would be under undue influence. There is no way to measure that. It does create opportunity for abuse.

Section 26 requires that the patient be advised that they have the right to revoke a request. I am confused by that because if I request to have a prescription filled, how quickly is that filled? What would be the time frame if I already have the medication? How would I revoke that? And then I am concerned that there is medication sitting around in people's houses until they decide to administer it. Section 32 establishes a requirement for disposal of the unused drugs. Why would there be an unused amount of the drug? And again, how would that be enforced? Sections 48 and 49 have to do with the prohibitions on life insurance companies. I am very concerned because you are saying life insurance companies cannot enforce their legal contract which has a two-year suicide clause that would cause life insurance premiums to increase. Finally, I am opposed to death certificates falsely not listing the actual cause of death. Death certificates must always accurately reflect the cause of death. I ask that we protect the sick, the elderly, the disabled, and the depressed among us. Do not let us become like Oregon and California where patients are pushed toward an assisted suicide over medical care. Please vote no on S.B. 239 (R1). Thank you.

Susan Proffitt, Director at Large, Nevada Republican Club:
Before I tell you a story about my own family's experience, which is very pertinent to this, I would like to read part of a letter from a professional who has had to deal with the emotional aspects of assisted death.

> Madam Chair and Members of the Committee: My name is Rowena Harrison. I have been a hospice nurse in Washoe County since 2008. Currently, my position is also working in pediatric hospice. Bill S.B. 239 (R1) to allow physician assistants, advanced practice registered nurses to prescribe medication to end a person's life is a dangerous bill to pass. This bill puts health care workers in a position of decision making that is not in our training nor ethics to assist a patient to end their life.

She goes on to talk about other available ways, but then she mentioned something else we need to add to this bill, because I am not completely opposed to it. We need to fix it, and we need the service, but not in its present form. She also says,

> I would like to help you understand the pressure that is put on health care providers is unparalleled—having to provide a lethal prescription dose to a patient they have been caring for also puts families and interpersonal relationships at odds when one of the partners does not agree.

I would like to suggest if you are going to be requiring mental health evaluations, that the people involved around them who are administering them and dealing with the emotional aspects of having cared for them have the special training and support they need from our professional mental facilities.

This is my story. I oppose it as it is written because it will do more harm than good in its present form. I, too, want to die as I choose and my husband, who is dying of lung cancer, does too, but we do not want anyone else making that decision or anyone to put undue influence on us in our moment of pain and despair. First, I do not think it is necessary because we already have DNRs and advanced directives that offer us an ability to die in dignity. On the surface, this bill sounds reasonable and will save the families from having to endure watching their loved ones pass very slowly, but it opens up a lot of opportunity for fraud. Even people hacking into our computers can find a way no matter what we do to fix it, and I think the crooks can find a way to get what they want with regard to moving some people out of their way. In my case, our father was admitted to the hospital three times over three years. Each time I was told by my siblings that he was in his last phase of dying; that his kidneys were going. Yet, each time he rallied within hours of being hooked up to an IV. That was all it required. The second time it happened, they were able to bring in family services to keep it from happening again, and he passed away a year after that. But there was no reason for him to die other than my sister and brother were tired of waiting for their inheritance, and my sister was tired of taking care of him. It was really unfortunate.

Were this bill the only one of its kind that the Democrat Legislature has brought before us this season pertaining to death, I would think it is okay, but this is not just the only bill that relates to death. One bill changes our driver's license to automatically donate our organs, so we need to opt out because now we are automatically donors the minute we get a driver's license. Another bill makes it legal for the medical staff to harvest our organs if our family members are too far away to tell them what we want or what our wishes are before the organs are too old to harvest. That is troubling.

Chair Peters:
We have reached seven minutes in Las Vegas at this moment. I do not want to cut folks off, but we have several other people who would like to testify.

Susan Proffitt:
May I finish? I will address the bottom line. You all have been micromanaging your constituents in every one of these bills, especially this one. I believe we need to make absolutely sure there is oversight, and this is being done for the right reasons. It is not an inconvenient truth; it is the truth. People have their own agendas. With all of these harvesting bills, somebody is looking to control the population and make a little money on the side harvesting all these organs and tissues like Planned Parenthood does while we pay for their overhead.

Chair Peters:
Thank you. The next person in Las Vegas, please go ahead, and because we are at seven minutes, I am going to take the two of you, and then we will move to the phones and keep going with opposition testimony.

Michael H. Plumer, Private Citizen, Las Vegas, Nevada:
[Michael Plumer submitted additional information, Exhibit Q.] I am a practicing physician, a hospice physician with more than 50 years' experience as an anesthesiologist and now as a hospice physician. The question is, Do we need this law? My answer is emphatically, No. However, listening to the stories today, we do need a lot of improvement in provision of hospice care and in provision of pain relief. As an expert in both of those, I think there are some "F" grades out there. Why do we think the patient care in Nevada will be improved if doctors are able to help kill their patients rather than curing them? Nevada already has in place the infrastructure to honor all citizens at the end of life. We can relieve pain, manage symptoms, and maintain dignity in the face of the loss of function. We can care for the dying with love and compassion. We do not need to kill patients in order to move things along and make things better.

Nevada is targeted this year, along with a number of other states, by a powerful lobbying group with a fairly relaxed relationship with the truth. This group's MO is to introduce a 30-year-old identical law made to look as though it has stringent safeguards. We have heard lots of conversation about that today. In reality, all this law does is protect a doctor from being charged with homicide if he helps you kill yourself. The group does very smart lobbying work to get the law approved in the state, and then it acts as guardian of the law thereafter making sure the law does not change without their approval. They decide who dies and what the lethal mix is, making sure no state ever gathers meaningful information because of the way the law is set up. They gather their own statistics. They trade recipes for death drugs. They have virtually no actual state oversight. They know that information is power. They gather all the information about the deaths in which they are involved, which quickly becomes all the deaths in the state. The lobbying group over time becomes a powerful and shadowy dispenser of death free of any government regulation. I would say assisted suicide is not medical care. Not every activity that involves doctors and drugs is medical care. This is most surely not despite attempts to dress it up and disguise it. Not medical care. Assisted suicide, death from the doctor. Thank you.

Maggie Cecil, Private Citizen, Las Vegas, Nevada:
[Maggie Cecil submitted additional information, Exhibit R.] I am here to testify against S.B. 239 (R1). My mom, who died in May 2020 just two months shy of her ninety-ninth birthday, was a staunch supporter of the philosophies espoused by the death-with-dignity crowd. She explored end-of-life options presented by the Hemlock Society and made it crystal clear that she would not live being dependent on anyone, including any of her four children. She even moved, in her mid-eighties, to Oregon believing she would be able to implement plans to end her own life if she lived in a state where the right to die was legal. Her fierce insistence that she would take her own life rather than become dependent had completely dissipated by the time our family moved from Southern California to Las Vegas. Eager to be part of the adventure and despite some evidence of dementia, Mom moved with us. If it did not work out, we figured she could be in memory care in Las Vegas as easily as in Southern California, though that proved to be unnecessary. She loved being with her family, and we loved having her. The six months her hospice doctor had predicted she would not live past stretched into a year and a half during which we had a major family reunion. She was able to reconnect with several relatives during the reunion, and a couple of special friends came to visit and spend time with her. She died at home in her own room, her beloved cat purring beside her. Her situation illuminates some of the risks to people unable to comprehend or authorize wishes they previously expressed—in this case, obtaining medication from a doctor for the sole purpose of committing suicide. At one time, Mom believed her suicide would prevent burdening any of her kids or losing control of her destiny. Turns out, she did not need a doctor's prescription to kill herself. Hospice and palliative care, available to everybody right now without S.B. 239 (R1), enabled her to die peacefully and on her own terms. Thank you.

Chair Peters:
Thank you. We are going to move to the phones and Zoom for seven minutes. We took Ms. Hammon early, so I will take three minutes off the time for phones for that testimony.

Jim DeGraffenreid, National Committeeman, Nevada Republican Party:
I am in opposition to S.B. 239 (R1) on behalf of the Nevada Republican Party. Our platform states that we affirm the inherent dignity of each human being from conception to natural death, and we oppose assisted suicide, euthanasia, and the nonconsensual withholding of medical treatment resulting in serious injury or death. I would like to explain further why the word "nonconsensual" is there. Republicans believe very strongly in liberty, the freedom of individuals to make their own decisions up to the point where those decisions infringe on the rights and liberties of others. Some want us to view S.B. 239 (R1) through a lens of liberty as its nominal goal is to allow each individual the freedom to decide for themselves how their life will end. Unfortunately, most situations where man tries to play God get complicated. In this bill, the goal of allowing end-of-life patients to determine their own destiny runs headlong into the insurance industry and the government. Only a few very wealthy individuals have true freedom to make their own end-of-life decisions. They have that freedom only because they pay out of their own pocket for their medical care. For the rest of us who have to rely on our insurance plans or Medicare to pay for us, we are at their mercy. If S.B. 239 (R1) passes, it is in their best interest to encourage patients to end their lives

rather than continue to live and consume insurance company profits or government funds. Anytime you ask someone else to pay for something you need, you give that person or entity the power to say yes or no. As an insurance professional who helps people with their health care plans, I know S.B. 239 (R1) is a dangerous bill for any patient who cannot pay their own medical bills. Supporters say this does not happen, but nobody can honestly say that because anyone who has been coerced into this decision is already dead and cannot speak up. It is up to us to protect those who have no voice. I strongly urge this Committee to resist the false freedom this bill promises and protect vulnerable end-of-life patients from the very real dangers of S.B. 239 (R1). Thank you.

Chair Peters:
Thank you. Next caller, please.

Michael Ryan, Private Citizen:
I am a long-time resident of Nevada and a Marine Corps veteran. I am calling in to express voting no on S.B. 239 (R1)—assisted suicide. Respect life; protect the vulnerable, the old, the disabled, and the depressed. Senate Bill 239 (1st Reprint) is a horrible bill. Please vote no. Thank you very much.

Chair Peters:
Thank you. We are at seven minutes on the phone. I will take one more caller before we do another round.

Heather Areshenko, Private Citizen, Reno, Nevada:
I am the mother of a chronic illness patient. I also work in health care. I have worked in hospice. I have a degenerative and progressive neurological disease that impacts my central nervous system. In 2018, after having a severe relapse and progression of my disease, I was told by my physician that I should get my affairs in order, and it would not be long before I was in need of full-time care. I have feared in the past that I was a burden to my family. Instead of following the dark path the doctor described to me, I went against medical advice. I joined a patient-funded clinical trial I found independently of my doctor who was under financial incentive not to tell me about all of my options, and I have testified about this to this Committee in previous legislative sessions. Eventually, through therapeutic rehabilitation and a long recovery, I restored my function. The healed part of my brain is fine. I am an active mother. I am working in gainful employment. I am able to advocate for myself, my child, my community, and families with disabilities because I am alive today. As a consumer of medical insurance, I am still cheaper dead.

This bill is in violation of the Americans With Disabilities Act. It will lead to the unnecessary deaths of people with disabilities over treatment costs. Many conditions will or may become terminal if certain medications or routine treatments are withheld or stopped. Any person who becomes terminal because they do not receive treatment for any reason would qualify for death under this bill. There is nothing I see in this bill that would prevent a health or medical insurance carrier from denying coverage of life-prolonging or disease-stabilizing medications or procedures and instead suggesting life-ending medications to an already vulnerable population, either directly or through coercion or as a secondary or tertiary aspect of the ongoing battle for coverage of care. They do their best to wear us down, so we stop fighting.

I have had many medical providers over the years have zero faith in my ability to heal. I have been abused. I have been coerced, and yet here I am today, and my life has so much value. I am better off alive, and so are all Nevadans who have disabilities. What is alarming to me is that the author earlier today described a gross misunderstanding of what appropriate hospice care is and what a normal death looks like. I encourage the Committee to look into that. Further, I see no protections in S.B. 239 (R1) against including any mental health disorder including PTSD as falling under the category of terminal. How can we prevent a doctor from saying that all options have been exhausted for someone with PTSD when we do not even have enough competent mental health providers in the state to cover people who are struggling as it is?

I am in firm disagreement with S.B. 239 (R1), and I hope that you will also not support this bill that puts insurance carrier profits over people, especially people with disabilities. And I am happy to answer any questions. Thank you so much for listening.

Chair Peters:
Thank you for the testimony. We are going to come back to Carson City for a few more folks and then we will go into neutral testimony.

Barry Cole, Private Citizen, Reno, Nevada:
[Barry Cole submitted additional information, Exhibit S.] I have been trained as a psychiatrist, neurologist, and anesthesia pain specialist. I self-taught myself hospice and medical directing. I became the administrator of two national pain organizations, and I was an educator for the American Medical Association (AMA) project to educate physicians on end-of-life care, which was the response to Jack Kevorkian. Remember, Jack Kevorkian killed 200 people. It turned out none of them were imminently terminally ill. They came to him, and he was willing to oblige. He was a pathologist; he helped them die.

I want to address some critical issues. The need for this bill is because we have a failure of our health care system. We have providers who are providing care to people who do not know how to provide care to terminally ill people. We are not supposed to know how to do that; we are supposed to cure people. So, the idea that we provide comfort care and palliative care, and forgo curative care is an alien concept for how I was trained in medical school. The fact that anyone is dying in agony in America today is proof something is not working. As a pain specialist, I can assure you 19 out of 20 patients can be made comfortable, and data suggests a 15 to 20 percent reduction in overall pain intensity correlates with improvement in your perceived quality of life. I do not have to get rid of all your pain; I have to take the edge off. I have to make you comfortable. Even in hospice where I did blocks and I did meds, sometimes I had trouble controlling pain, but what I committed to was changing medicine daily; being in the patient's home daily so they knew they were never abandoned.

There are conditions like locked-in syndrome, end-stage ALS [amyotrophic lateral sclerosis], and high cervical fractures where you do not have use of your hands. I do not understand how you self-administer anything at that point, so this bill will need to be amended in some way if we are not going to be discriminatory so that those people can receive intravenous or subcutaneous medications. I do not know when we will get there, but we will get there eventually.

For me, the heartburn comes from section 27 which creates a loophole where a psychiatrist is supposed to do what? I could write a report according to this that makes a decision about whether or not the patient can make a decision, but the real question is why the attending physician and the consulting physician, when they realized the patient could not make a capable decision, did not just stop. Why do you need to drag in a psychiatrist? Just stop the process. The AMA's curriculum is intended to give alternatives to death in a sterile hospital. It is intended to create opportunities for comprehensive end-of-life care. We can make people very comfortable, and while I have not had 3,000 hospice deaths; I have had 300. I was a founder of the Academy of Hospice Physicians, which is now called the American Academy of Hospice and Palliative Care. Pain is very easily managed for the majority of people, and we can keep people comfortable until the end of life.

I want to go back to the beginning of all this. The original bill in Oregon was called Measure 16. I thought it was ironic, it was M16, that those who ended their lives turned out to be white males living alone, often in rural locations with no social support who feared being incapable of caring for themselves. My question always was, where was hospice? Where were visiting home nurses? How come these people were isolated and nobody was doing anything about it? Again, a failure of our system. Ending one's life due to lack of care is more an indictment of our system than it is about making good choices. I believe with proper support, hospice that takes care of patients in life and their family for one year after their death, we provide resources, we provide meds, we provide materials. They do not need to self-destruct, and in my experience, I never had one who did. I would ask that we take a good deep breath about S.B. 239 (R1). Thanks.

Chair Peters:
Thank you, Dr. Cole.

Kathleen Rossi, Private Citizen, Reno, Nevada:
[Kathleen Rossi presented written testimony, Exhibit T.] I am a native of Nevada and a registered nurse who has worked in critical care. I have taken care of hundreds of dying patients over my 36-year career. I am currently caring for my sister who is dying of a brain tumor. Fourteen years ago, Peggy was given 18 months to live, yet another example of doctors getting prognosis of time left wrong. Indeed, if she had utilized assisted suicide 14 years ago, her death certificate would have read "cause of death, brain tumor" which shows the deception that is built into these assisted suicide laws and their claims of accurate data collection. Her survival directly affects future prognostications for others with the same diagnosis. She was able to raise a small boy in that time.

I take issue with the proponents saying that these people do not use these drugs until they are in the last stages. There have been several cases where people have taken these drugs when they had months or years to live. These laws are based on the desire for patient autonomy, which is a high medical priority, but it is never the only one. Law should be based on the common good and the effects of the whole of society. Historically, we know that there was a strong push for assisted suicide and euthanasia in the United States in the 1920s and 1930s. It was only after the Nazi Germany euthanasia programs were discovered that some of that momentum wore off. But here we are again, as the Hemlock Society has changed its name to Compassion and Choices, counting on the fact most Americans have short memories and will not see the connection between a physician writing a prescription for death now and the slippery slope to euthanasia—euthanasia being where the doctor gives you the medication, you do not self-administer.

Contrary to what proponents tell you, there are many reported abuses of these laws, and yes, they do escalate. As recently as March, the *Colorado Sun* reported a 36-year-old anorexic receiving assisted suicide in direct violation of the law that stipulates it should not be used for mental illness—Compassion and Choices even states that on their website. Canada passed physician-assisted suicide in 2016, similar to the law you are considering today. They expanded it in 2021 for the nonterminal, and again last month for the mentally ill, causing many Canadians to have second thoughts about what they have agreed to. Logically, any argument you make for suffering and end of life, you can make for nonterminal diseases and for mental illness, which is suffering maybe of a worse kind. The Netherlands just last week expanded it for children.

What I find very disingenuous from Compassion and Choices is these safeguards they claim are in the bill and which we see in other states, they come back later introducing bills to remove the very safeguards, claiming they are now barriers to access. Assemblywoman González, you asked about the data collection. In two minutes, I cannot refute the proponents about abuses, but I will tell you who can—disability rights groups that document these abuses. I will submit to the Committee all their studies that have shown this. The physician in Las Vegas mentioned there is not an independent agency overseeing this. The doctors who are giving assisted suicide collect their own data. I am quoting Dr. Katrina Hedberg of the Oregon Department of Human Services who says, "We are not given the resources to investigate assisted suicide cases and not only do we not have the resources to do it, we do not have any legal authority to insert ourselves."

Other problems with this bill: It perpetuates falsehoods. It asked doctors to lie about the cause of death, and then there is a weird Orwellian matter—it specifies that the terms physician-assisted suicide or assisted suicide or mercy killing can never be used as if by calling this by another name does not make it the same thing. There are no conscious rights at all in here. The doctors must refer our transition. I am not even sure what that term means. There is a lack of an examination requirement. It requires that a patient be diagnosed with a terminal condition, but there is no requirement that the attending and consulting practitioners examine the patient in person or otherwise. What we see in other states is there are a few doctors here and there who people search out who are known to be the assisted suicide doctors; not the treating physician who has a relationship with the patient. There is no requirement to evaluate for depression, and there is no requirement that a physician be there. All we see is this mental capacity term which I think could be interpreted in several different ways. We never know exactly. Thank you very much.

Chair Peters:
We are at 15 minutes total for opposition, and there are still several people who would like to participate here in Carson City, and then we will do another round of support and opposition.

Mary Fechner, Private Citizen, Reno, Nevada:
On August 5, 2018, while vacationing in Arizona, my husband of 46 years suffered a paralyzing stroke. During the six weeks he was hospitalized, he suffered seizures, atrial fibrillation, and multiple blood clots. He was in and out of the intensive care unit three times. One tearful night, we said our goodbyes. We expressed our love for each other, and we discussed how to deal with his body after his death. Slowly, his strength and movement began to return. He was moved to rehab, and finally released from the hospital. We returned to Reno where he followed up with intense physical and occupational therapy. Steve worked very hard in therapy and at home. By the summer of 2021, we were hiking in the Sierras. We enjoyed picnics beside beautiful mountain lakes and trails. Then suddenly, unexpectedly, Steve died in the early morning of February 12, 2022. I am so grateful for the three-and-a-half years we shared after his stroke. We never took each other for granted. Small annoyances were measured against the joy of being together. We lived intentionally and even were able to go on a cruise. I once asked Steve, if had it been available at the hospital, would he have requested physician-assisted suicide or medical aid in dying. He replied that after all he had been through, he would have considered it had physician-assisted suicide been legal. We could have been denied the three most wonderful years of our marriage—the most loving, caring, giving years anyone could ever hope for. We would have missed so many experiences. Please do not deny the possibility for even one couple, one person, one friend or family member. Physician-assisted suicide takes away hope. It removes the potential for a future, and it closes the door for a miracle. I am so thankful that physician-assisted suicide, medical aid in dying, or death with dignity was illegal in 2018. Legalized, it would have changed the trajectory of our lives. Thank you.

[Exhibit U, Exhibit V, and Exhibit W in opposition to Senate Bill 239 (1st Reprint) were submitted but not discussed and will become part of the record.]

Chair Peters:
Thank you for sharing your story. We are going to move into neutral testimony. As a reminder for folks who are waiting to testify, we will come back to support and opposition testimony. This is for neutral testimony that has no position on the bill. We will start here in Carson City, move to Las Vegas, and then go to the phones. Please remember to state your name for the record. You may proceed when you are ready.

John Abel, Director, Governmental Affairs, Las Vegas Police Protective Association:
I am here testifying neutral. As everyone knows, police officers respond to every suicide in Las Vegas or in Washoe County. I have responded to several, and several have been terminally ill patients. Whether you approve of this bill or not, or you vote against it, keep us in mind because of those scenes. I was wondering if I should get too gruesome, and I am not going to do that. I am not going to get into the gruesome details of the suicides I have seen, but that being said, keep that in mind. Keep us in mind when you are voting for this bill as to what we have to see. A lot of people who are terminally ill and with no other means to other care, commit suicide, and we end up responding. That is all I have. Thank you.

Chair Peters:
Would you stand for questions? Assemblyman Hibbetts, I do not know if you had any questions you would like to ask. [Assemblyman Hibbetts declined.] All right, we will move on.

Richard P. McCann, representing Nevada Association of Public Safety Officers; and Member, Nevada Law Enforcement Coalition:
I am not here to provide you with any moral guidance or any philosophical compass. I am not good at either one of them. I am here simply to support my colleague, Officer Abel, and I ditto what he said. Thank you.

Chair Peters:
Thank you. In Las Vegas, are the people at the table in neutral? [There was no one.] It appears there is nobody in neutral in Las Vegas. Is there anyone on Zoom or on the phone line to testify in neutral on S.B. 239 (R1)? [There were no callers.]

Okay, we are going to go back into support. We have had 38 minutes of support; 55 minutes of opposition. I gave a little bit more leeway because we were having a hard time hearing Ms. Hammon, so I added a few minutes into opposition as well. I am going to take another 10 minutes for both support and opposition. I encourage folks to keep your comments brief. We will take your written comments, but you have spent your day here with us, and I would like you to have the opportunity to speak. If we have a way to keep things a little more succinct so everyone can get through, that would be great. I am going to start here in Carson City with support testimony. We will move to Las Vegas for support testimony, and we will go to the phones for support testimony. I am only taking about 10 minutes, so being as brief as you can would be helpful.

Annette Magnus, Executive Director, Battle Born Progress:
We are here today in strong support of S.B. 239 (R1) because we believe that the real Nevada way is affording our neighbors across the state the freedom to make their own medical decisions, including when they choose to pass. I have struggled with severe anxiety and depression my entire life and been open about that struggle. I also had anorexia in my teenage years. This conversation is a very different conversation than what I struggle with in my day-to-day life. I do not have suicidal thoughts and then would be able to use this bill. If you want to have a real conversation about mental health issues in this state, that is a

different conversation and a different bill. As someone who has lived with depression and is currently on medication for it, please do not conflate dying in a compassionate way for folks who are terminally ill with those who have suicidal ideations. It is incredibly offensive to us who struggle with this. I would not qualify under this bill unless I was terminally ill, as has been made clear today by the sponsor.

For a very different example, when a loved one of yours is in a hospital bed dying and enduring horrible pain and a lack of agency or ability, the choice to end their pain is one they should not be denied. I have seen this firsthand. I watched my grandmother, who to this day is my idol, die of terminal lung cancer. When they found out, she was given three months to live. That was August, and she died on October 26, 2006. She was in the hospital for weeks coughing up blood as I watched her waste away before my 12-year-old eyes. She was on so many medications and was hallucinating that there were spiders on the walls and on her face. She was in so much pain, she would cry and scream constantly at the end. She was not the grandmother I knew. She was already gone before she had even passed. I know for a fact if she were given the choice to take this option over the suffering she and my family endured, she would have done it. I will never forget the day we lost her and how relieved I felt that she was no longer suffering anymore. I was raised as a Catholic, and I hope and pray when my time comes, if I am terminally ill, we can all make this educated choice. It is the most compassionate choice we can give to all Nevadans who desperately need it. Thank you for your work on this critical legislation, and I urge the Committee to support S.B. 239 (R1).

Chair Peters:
Thank you. Is there anyone else in Carson City who would like to provide support testimony? For the record, we missed 10 to 15 people who were waiting for their opportunity but had to leave apparently. I hope they take the opportunity to write us or send us emails so we can include their testimony in the record. We will go to Las Vegas. Is there anybody in Las Vegas who would like to come up for support testimony? [There was no one.] Okay, we will move to the phones. Is there anyone on the phones who would like to provide support testimony at this time? [There were no callers.]

All right, the hour is late. That was about four minutes extra of support testimony. I am going to go ahead and take about ten minutes of opposition testimony, first, here in Carson City, then we will move to Las Vegas, and then go to the phones. At this time, I do not believe everyone will have the opportunity to speak within that ten-minute period of time. I would encourage you to please be gracious to each other in the time you take. We all have stories we would like to share, and we would love to hear your stories, and we are more than happy to review your stories in written format. You are welcome to send them into the Committee to be distributed to the entire Committee.

María José Fernández Flores, Coalitions Director, Patients' Rights Action Fund:
The Patients' Rights Action Fund is a leading national nonpartisan single-issue organization that protects the rights of patients, people with disabilities, elders, and people who are poor from deadly harm and discrimination, inherent and assisted-suicide laws. We advocate for all patients to be treated with equal human dignity no matter their health or disability status,

nor perceived low quality of life. As a Latina Deferred Action for Childhood Arrivals recipient and someone who grew up low income, I see the dangers that this Legislature will bring to my community. I went many years without health care due to my immigration status. When I finally had the opportunity to qualify, the high cost made it extremely difficult to seek help when needed. I would not seek adequate preventive treatment because it would be a financial burden on myself and my family. Therefore, I only visited when I was in extreme pain or sickness. Now imagine the distress that I would be in if I were to have gotten diagnosed with a terminal disease at that time and assisted suicide would have been legal in the state where I was growing up. When given the choice to choose to persevere and seek treatment or to take my life away, I would have chosen the latter due to the financial burden the former would have been on myself and my family. I do not want that situation to happen to anyone. People should not feel forced to make a decision they do not want solely because of a lack of access to funds or support. We cannot talk about true autonomy and choice without having equal access to health care.

Senate Bill 239 (1st Reprint) endangers disadvantaged diverse populations often overwhelmed by institutional bias for disproportionate tracking toward or imposition of grave outcomes, and it has widespread implications in the historically racially oppressive society. Those who suffer most from inadequate health care options are the financially poor, the illiterate, the poorly educated, the addicted or mentally ill, the non-English speaker or English language learner, the disabled, and culturally diverse. The proposal of S.B. 239 (R1) is offensive to myself and my community where the attention should be focused on just and quality health care including palliative care and caregiver support for all minorities, not just the wealthy and privileged. I ask for a no vote on S.B. 239 (R1). Before I end, I would like to add that the lawsuit mentioned earlier is a real thing. It was just submitted yesterday, and that is why not everyone is aware. It is challenging the violation of the Americans With Disabilities Act section 504, and constitutional due process and equal protection provisions. You can go to the website assistedsuicide.org for more information. Thank you.

Cristiane Mersch, representing Nevada Right to Life:
I am representing Nevada Right to Life, and I am here to oppose S.B. 239 (R1). We should take as an example what is going on in Oregon right now. Assisted suicide laws have failed to safeguard disabled and elderly people. It is difficult to control coercion and abuse, so most of the people who have disabilities are the ones who are against this bill. It is perpetrators, discriminatory attitudes toward the disability community and the vulnerable. Assisted-suicide laws open the door to promote a society who judges who lives and who dies. Never in our reading of the Founding Fathers do you hear the words "right to die," but the right to life instead. Assisted suicide is never going to be a solution or substitute for medical care because assisted suicide is not medical care. As you heard here today, many doctors oppose this bill. Their oath is to heal and to do everything they can to help and comfort that patient who is suffering pain, but not to help them to die. Please, oppose this bill. Thank you.

Rosana Santos, Private Citizen, Las Vegas, Nevada:
I am a social worker. In my profession as a social worker, I witnessed working with the elderly facility in a rehab center and I saw a lot of patients' relatives taking advantage of their vulnerability and trying to exploit them. This bill will not protect the adult vulnerable. We should not assume they want to die because they are in pain and they are unable to decide. Please vote no to S.B. 239 (R1). Thank you.

Cyrus Hojjaty, Private Citizen, Las Vegas, Nevada:
Ditto.

Chair Peters:
Thank you for the effective testimony. We appreciate it. We will come back to Carson City as we are losing our Las Vegas location. Thank you all who are in attendance for S.B. 239 (R1). We will come back to Carson City and take the three of you at the table, and at that time, we will probably be at ten minutes.

Lisa Laughlin, Private Citizen, Reno, Nevada:
Madam Chair and Committee members, my name is Lisa Laughlin, and I am testifying against S.B. 239 (R1). Cancer took the life of my father and 58-year-old brother. Both received hospice care, thankfully. Experiencing the process of dying with them taught me that dying is not to be feared and allowing it to unfold naturally provides time to express your love, provide care for them, share a last martini, or, in the case of my brother who was very much afraid, reassure him that he would not be alone, and he would not be in pain. And that turned out to be true. I was with him. He breathed his last breath with all of us around him. My own recent cancer diagnosis also affirms my opposition. Should my cancer return, this bill incentivizes my insurance company to deny me lifesaving treatment. Additionally, as I approach Medicare age and watch the explosion of federal debt, I suspect the government will continue to seek ways to reduce the funding of care. This bill will put the lives of elderly Nevadans at additional risk. If implemented, S.B. 239 (R1) will harm lives by giving insurance and government bureaucrats control over them. Additionally, as I watch more and more physicians work for hospitals and insurance companies bundle payments to hospitals, it will create a perverse incentive to deny care and for doctors to just give a pill because it is cheaper. Their pay is going to be based on how much they spend.

This is not a bill of compassion as it devalues human life and ultimately takes control away from patients. Its unintended consequences outnumber its benefits. As we have heard, guardrails do not work; they come back and chip away at those. Find the courage to vote no. It turns healers into agents of death, breaks the bond between patients and their doctors, and will hasten the death of people who want to live. I know I want to live because I had to think about that a lot last summer. I know I do not want a stranger deciding whether or not I get to live. Thank you.

Casey Rodgers, Private Citizen, Minden, Nevada:
I have to say the opposition is on fire right now. My concern with this bill is that it makes human life less significant than it ever has been by the hands of the people who make laws and legislative policy. When you start with assisted suicide, where does it go from here? Is it about money or is it about compassion? Is it about a depopulation agenda? Does this give parents the option to kill their child because it was born with a birth defect? If not, when? Can children and teens who are suicidal get hold of this medication and use it because they were bullied at school? The aforementioned are just some of the concerns, but what about the idea of allowing someone to help murder someone else? Hereafter, how are we to view murder and suicide? Jews and gentiles alike were given the Ten Commandments. The Ten Commandments says, "Thou shalt not murder." Whether you believe that or not, we have a moral compass and ethics we are supposed to abide by when it comes to human life.

It is gross negligence to say mental health is not something you should look at when looking at this bill. It is definitely something you should look at. I have friends who have been on the battlefield. They lost limbs, and arms, and were burned almost to death. Many of them were suicidal, but when they are able to see their family, and they come in and they see their family, they decide they want to live. Where does it go from here? Does the battlefield become the next place we say, Screw it. You can just die? I would like to know.

Melissa Clement, Executive Director, Nevada Right to Life:
[Melissa Clement supplied additional information, Exhibit X.] Madam Chair and members of the Committee, Nevada Right to Life is here in opposition. There are a tremendous number of issues the proponents of this bill brought up, saying there have never been instances of abuse and misuse; there are. I would ask you to read a document I am going to submit, a document that talks about the instances of abuse and misuse that have been documented. We have several years of Oregon, Washington, Canada, and other countries, so we have a body of knowledge. Unfortunately, Dr. Brian Callister is not here, because he could testify. He is in Nevada and a very talented doctor. He asked for life-saving treatment for patients here in Nevada. One patient was from California; one was from Oregon. They were denied. The insurance companies in both situations asked him to talk about assisted suicide. He has submitted something, also. The safeguards against depression are truly inadequate. If you look at the bill, it talks about defining the person as mentally capable. "Mentally capable." Please look at the definition. It has nothing to do with a mental health screening whatsoever. There is no screening for depression, and there is not even a requirement for screening for depression. Anyone who has had a terminal diagnosis knows that depression is one of the first things that happens. Having walked this with three family members, I know that for sure. There are many problems with this bill. I know there are some people on the telephone who would like to talk, so I am going to cut myself short, and I appreciate your fairness, Madam Chair.

Chair Peters:
Thank you. It is a balance, and I know it is hard to strike. I appreciate your sticking around and bearing with us as we move through a long day. We exceeded those ten minutes by a little bit. We did not make it through everybody, and I apologize for that, but please

remember written testimony will be a part of our record if you want to send it in up to 24 hours after we adjourn today, and we will get copies to Committee members. I would like to invite the bill sponsors to come up for closing comments.

Johanna Koch:
I want to thank all of you for your patience this day. It has been a long afternoon, and I would love to stay after and talk to anybody who still has the energy to stay after and talk. With regard to capacity and depression, this is a really complicated issue, but the diagnosis of depression does not qualify you for medical aid in dying. It also does not disqualify you for medical aid in dying. In other words, you can admit to being depressed, but if you still have a terminal illness and you are not acting out of an impulsive response to your depression, and your depression has been managed to the best of the medical world's ability, then you can still qualify for medical aid in dying if you have the right terminal diagnosis. I wanted to start by clarifying that point.

With regard to consent, the question I wanted to respond to was who can provide consent? There is concern that people with disabilities might be picked on or people who are poor English speakers or who are learning English, people who are elderly or in some other way at risk. That population is very unlikely to fall into the category for medical aid in dying. If they did, they would need to be able to demonstrate clearly and succinctly what their reason for requesting it was, in other words what their medical condition was, what the consequences of their action would be, what alternatives they have to treat that condition, and that they understand what would happen if they requested the medication. A person who is challenged in any way that would make them special needs or disabled is not going to qualify easily for medical aid in dying.

Sara Manns:
I want to say we do not need to speculate about how this law will work. We have decades of data and experience. I believe over 90 percent of patients who use medical aid in dying are enrolled in hospice. They have an interdisciplinary team of professionals who are focused on the comfort, psychological well-being and support and providing every possible treatment, not just for the patient but for their families. Hospice also provides spiritual care, whether it is residential or at home. This is an additional layer of protection ensuring patients who request medical aid in dying and follow this process have employed every means possible to relieve their suffering. There are many hypotheticals about this, but this is what we know and why Nevadans are asking for the same option for themselves if they should choose as people in ten other states have. Thank you for your time today.

Chair Peters:
Thank you. Thank you, again, to all who stuck around for this long meeting. I will close the hearing on Senate Bill 239 (1st Reprint), which brings us to the end of our hearing agenda today. We will move into our last agenda item which is public comment. We will start in our Carson City location and then move to the phones. Is there anybody who would like to

provide public comment in Carson City? [There was no one.] Seeing none, is there anyone on the public line who would like to provide public comment today? [Public comment was heard.]

Again, I want to state my sincere apologies to those who were not able to provide testimony today. Please send in your written statements. We will keep an eye out for those and review them when they come in. I will close out public comment at this time. With that, we are adjourned [at 5:55 p.m.].

RESPECTFULLY SUBMITTED:

____
Terry Horgan
Committee Secretary

APPROVED BY:

____
Assemblyman David Orentlicher, Vice Chair

DATE: ____________________________________

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a proposed amendment to Senate Bill 239 (1st Reprint) presented by Senator Edgar Flores, Senate District No. 2.

Exhibit D is a document titled "End Of Life Options Act, SB 239," submitted and presented by Sara Manns, Nevada Campaign Manager, Compassion and Choices Action Network, in support of Senate Bill 239 (1st Reprint).

Exhibit E is a document titled "Medical Aid-in-Dying Utilization Report," submitted by Sara Manns, Nevada Campaign Manager, Compassion and Choices Action Network, in support of Senate Bill 239 (1st Reprint).

Exhibit F is a document titled "Mental & Decision-Making Capacity," submitted by Sara Manns, Nevada Campaign Manager, Compassion and Choices Action Network, in support of Senate Bill 239 (1st Reprint).

Exhibit G is a chart titled "Aid in Dying Does NOT Increase the Suicide Rate," submitted and presented by Sara Manns, Nevada Campaign Manager, Compassion and Choices Action Network, in support of Senate Bill 239 (1st Reprint).

Exhibit H is written testimony dated March 2023, submitted by Clare Johnson, Private Citizen, Reno, Nevada, in support of Senate Bill 239 (1st Reprint).

Exhibit I is a copy of a memo from Nevada Governor's Council on Developmental Disabilities, submitted by Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities, in support of Senate Bill 239 (1st Reprint).

Exhibit J is written testimony submitted by Laura Gray, Private Citizen, Las Vegas, Nevada, in support of Senate Bill 239 (1st Reprint).

Exhibit K is a letter dated April 27, 2023, submitted by Tess Opferman, Nevada Women's Lobby, in support of Senate Bill 239 (1st Reprint).

Exhibit L is a document titled "2023 Us for Autonomy Lawmaker Toolkit; Polling, stories, videos, and FAQ from advocates living with disabilities in support of end-of-life options," submitted by Rachel Motley, in support of Senate Bill 239 (1st Reprint).

Exhibit M is a collection of letters and emails to the Assembly Committee on Health and Human Services submitted by Brenda Arredondo, et al., in support of Senate Bill 239 (1st Reprint).

Exhibit N is a collection of comments from readers of *The Vegas Voice* and copies of petitions submitted to *The Vegas Voice* submitted by Dan Roberts, Publisher and Editor, *The Vegas Voice* in support of Senate Bill 239 (1st Reprint).

Exhibit O is supplemental information, dated April 25, 2023, submitted by Herb Santos, Jr., Private Citizen, Reno, Nevada, in opposition to Senate Bill 239 (1st Reprint).

Exhibit P is a copy of a video submitted by Brianna Hammon, Private Citizen, Reno, Nevada, containing her testimony in opposition to Senate Bill 239 (1st Reprint).

Exhibit Q is additional information dated April 26, 2023, submitted by Michael H. Plumer, Private Citizen, Las Vegas, Nevada, in opposition to Senate Bill 239 (1st Reprint).

Exhibit R is additional information dated April 26, 2023, submitted by Maggie Cecil, Private Citizen, Las Vegas, Nevada, in opposition to Senate Bill 239 (1st Reprint).

Exhibit S is additional information dated April 24, 2023, submitted by Barry Cole, Private Citizen, Reno, Nevada, in opposition to Senate Bill 239 (1st Reprint).

Exhibit T is additional information submitted by Kathleen Rossi, Private Citizen, Reno, Nevada, in opposition to Senate Bill 239 (1st Reprint).

Exhibit U is an opinion piece from *The Linacre Quarterly*, Vol. 84, May 2017, pages 108-110, authored by Nancy Valko, National Association of Pro-Life Nurses, titled "Why are suicide rates climbing after years of decline?" submitted by Assemblyman Gregory T. Hafen II, Assembly District No. 36, in opposition to Senate Bill 239 (1st Reprint).

Exhibit V is a letter dated April 6, 2023, submitted by Most Reverend George Leo Thomas, Ph.D., Bishop of Las Vegas, Board Chair of Nevada Catholic Conference, et al., in opposition to Senate Bill 239 (1st Reprint).

Exhibit W is a collection of letters and emails in opposition to Senate Bill 239 (1st Reprint).

Exhibit X is a letter dated April 26, 2023, submitted by Melissa Clement, Executive Director, Nevada Right to Life, in opposition to Senate Bill 239 (1st Reprint).