MINUTES OF THE MEETING
OF THE
ASSEMBLY SELECT COMMITTEE ON END-OF-LIFE CARE

Eighty-Third Session
April 2, 2025

The Select Committee on End-of-Life Care was called to order by Chair David Orentlicher at 5:03 p.m. on Wednesday, April 2, 2025, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 3 of the Nevada Legislature Hearing Rooms, 7120 Amigo Street, 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/83rd2025.

COMMITTEE MEMBERS PRESENT:

Assemblymember David Orentlicher, Chair
Assemblymember Rebecca Edgeworth
Assemblymember Danielle Gallant
Assemblymember Cecelia González
Assemblymember Cinthia Zermeño Moore

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblymember Joe Dalia, Assembly District No. 29

STAFF MEMBERS PRESENT:

Davis Florence, Committee Policy Analyst
Eric Robbins, Committee Counsel
Bonnie Borda Hoffecker, Committee Manager
Traci Dory, Committee Secretary
Nancy Davis, Committee Assistant

OTHERS PRESENT:

Elliot Malin, Private Citizen, Reno, Nevada
Charles Blanke, Private Citizen, Portland, Oregon
Sandra Koch, representing Nevada State Medical Association
Maxmillian Lowe, Council Chair, Nevada Governor's Council on Developmental Disabilities, Department of Health and Human Services
Elizabeth Grimm, Private Citizen, Reno, Nevada
Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities, Department of Health and Human Services
Melissa Chanselle-Hary, Private Citizen, Sparks, Nevada
Tatiana "Tia" Smith, Policy Counsel, American Civil Liberties Union of Nevada
Timothy McFarren, Private Citizen, Carson City, Nevada
Johanna Koch, Private Citizen, Reno, Nevada
Emily Barney, Private Citizen, Reno, Nevada
Illia Ludwig, Private Citizen
Tiara Flynn, Private Citizen, Las Vegas, Nevada
Gina Schneider, Regional Campaign and Advocacy Manager, Nevada Compassion and Choices Action Network
Ian McIntosh, Interim Executive Director, Not Dead Yet
Melissa Clement, Executive Director, Nevada Right to Life
Kirk Bronander, Private Citizen, Reno, Nevada
Jason Guinasso, Private Citizen, Reno, Nevada
Jason Luis, Private Citizen, Carson City, Nevada
Deidre Hammon, Private Citizen, Reno, Nevada
Henry Rex Greene, Private Citizen, Henderson, Nevada
Leslie Quinn, Private Citizen, Las Vegas, Nevada
Jesus Marquez, Co-Founder and Executive Director, American Christian Caucus
Kerry Enright, Private Citizen, Las Vegas, Nevada
Brianna Hammon, Private Citizen, Reno, Nevada
Daniel Smith, Private Citizen
Katrin Ivanoff, Private Citizen, Las Vegas, Nevada
Brianna Cowan, representing Douglas County Republican Central Committee and Douglas County Republican Women
Kenneth Wilson, Private Citizen
Kathleen Rossi, Private Citizen, Reno, Nevada
Cristiane Mersch, Private Citizen, Las Vegas, Nevada
Tim Underwood, Private Citizen, Las Vegas, Nevada
Chris Marquez, Private Citizen, Las Vegas, Nevada
Kimberly Johnston-Wednesday, Private Citizen
Grace Trujillo, Private Citizen, Henderson, Nevada
Theresa Sharp, Private Citizen, Las Vegas, Nevada
Danielle Evans, Private Citizen, Las Vegas, Nevada
Lisa Bedotto Laughlin, Private Citizen, Reno, Nevada

Chair Orentlicher:
[Roll was called.] We have some housekeeping to start. Please silence your electronic devices. If you wish to testify, please sign in at the table by the door and provide a business card to the committee secretary. When testifying, please remember to turn on the microphone, and here is the hard part, clearly state your name and affiliation and spell your name. Turn off the microphone when you are done speaking. When we get to the testimony, I will remind you that we do have time limits, but I will remind you then.

Members of the public may provide testimony by telephone as well as in person. If you want to call in, the number is 888-475-4499, and you will provide the meeting identification number, which is 88976512826. You will press the hash tag when prompted for a participant identification number. The meeting agenda and Committee information is available on the Nevada Electronic Legislative Information System (NELIS), which can be accessed through the Legislature's website and you can watch us on NELIS or on YouTube.

We will do public comment at the end of the meeting. Each person, whether you are testifying or doing public comment, will be limited to two minutes, and we have a handy timer there to remind you. We expect courtesy and respect in our interactions during the meeting, even if we may not agree with each other. I do not expect consensus tonight, but it is very important that we respect each other. Committee members will be using their laptops to view handouts and other documents. Please do not view this as a sign of disrespect. They just want to make sure they are on top of the language for the bill and other exhibits.

I think we are ready to open the hearing on Assembly Bill 346. This measure establishes provisions governing the prescribing, dispensing, and administering of medication designed to end the life of a patient. Assemblymember Dalia, please come forward. You have some copresenters, I gather.

Assembly Bill 346: Establishes provisions governing the prescribing, dispensing and administering of medication designed to end the life of a patient. (BDR 40-600)

Assemblymember Joe Dalia, Assembly District No. 29:
I am here today proudly presenting Assembly Bill 346, which would legalize medical aid in dying for terminally ill patients who have demonstrated they have not been coerced and are mentally capable of making the decision of their own accord. With me today virtually to copresent this bill are Elliot Malin, who will walk through the mechanics of the bill and the safeguards we have put in place, and Dr. Charles Blanke, who has had over 20 years of experience with end-of-life care in Oregon and is one of the nation's foremost experts in this field.

I want to say at the outset that this is an important bill to a lot of people who do not have a voice right now, and those who are suffering are largely doing so in silence. I also want to begin by thanking those who have brought forward this legislation before me. Former Senator David Parks and Senator Edgar Flores were champions on this issue, and I am proud

to take up the mantle from them and continue their work. I would also like to thank my copresenters who do not have a client here today. They are not making money off of this. They are here because they believe this is the right thing to do.

The reason this bill came to me is because, unfortunately, I have had a few personal experiences that I believe underscore the shortcomings and, frankly, the failings of our current system and our palliative and pain management options. I have had two family members pass away in hospice care under undignified circumstances over the past few years. But today, I just want to talk to you about my dad because I think his situation really underscores the nature of the problem and why this legislation is so important.

I think it is important that you know who the person my dad was. He lived his life with humor and energy, and he really had no reason to be that way because he had a really hard life, but he found a way to make something of it. Right out of high school, he served his country in Vietnam, and it changed the trajectory of his life. He became a dad, a small business owner, and a beloved poker dealer in the Henderson community. There were people who came to play poker during his hours just to hang out with him. And I get why, no matter what kind of day he was having, you could not catch him without a smile and a joke. He was not always perfect. He was not always necessarily even a role model. But he was always my hero.

In December 2019, that all came crashing to a halt. He was hospitalized with end-stage chronic obstructive pulmonary disease (COPD). The doctors were not sure if he was going to make it out of the hospital. They said if he did, he had maybe a couple of weeks, and they would be defined by pain and fear. What would eventually happen is—to those unfamiliar with COPD, it is a lung disorder—essentially, his lungs stopped working. They told him he was eventually going to have a coughing fit, which he had had for years. That was not new, but the last coughing fit would be different because it would not end. He would not be able to clear his lungs. They were essentially telling him that he was going to drown above water, and hearing this, my dad being the way he was, he said, Well jeez, doc, that does not sound great. Can I die any other way? I will take a car accident. The doctor did not advise he pursue that route, but we did pursue other options.

The first thing we looked into was whether death with dignity was legal here. Obviously, we are here today; it was not. We also looked at where we could take him because he really wanted to go out on his terms. That death did not sound good. He wanted any other way to do this. We looked into it, but we were told by the doctor he would not be able to get on a plane because he was dependent on oxygen. No plane was going to take off with him in that state. If we drove him somewhere and he happened to have a medical emergency on the way, we could be criminally liable for reckless endangerment. That was enough for my dad to be uncomfortable with that option. He did not want him dying on his terms to come at a price for anybody in his life. So that was off the table. But the result of this is that he was trapped here.

Ultimately, the hospice nurse who came to the home—because he was in home care the final two weeks—promised us that when the day came when that coughing fit came that he just could not finish clearing his lungs, she would come take care of it. The current palliative care options were sufficient, and a cocktail of morphine and Ativan would be sufficient for him to drift off peacefully. That was not true. That was resoundingly untrue. When that day came, we called the nurse. She arrived, and my dad could not even get a word out. When we called her, he just kind of gestured her card at us, and we called her, and when she arrived, she provided us with the morphine and the Ativan, and she gave us instructions on how to dispense it. It was over—12 hours of misery. He was awake, struggling, gurgling, and convulsing, and he could not communicate. He was suffering the entire time.

When he did manage to say something, it was very brief, and it was not goodbye, or I love you. It was, She promised. She lied. This "f-ing" sucks. He did not censor himself, and I would not have either. Those would be his last words. They were not close to the time of death. He continued to be in pain for several hours after that. But in those words, and in that bed, I could not see my dad anymore. Not only did he not get the death he wanted, his family had to have that be the enduring image of him. So, because of the state of affairs, my dad died exactly the way he did not want to die: scared, slowly, and in unimaginable pain, and that was wrong. He should have had a choice in a state that prides itself on personal liberty, autonomy, and self-determination. It strikes me as bizarre that the government of our state has any say in that final decision you make; that should have been his call alone to make.

For my dad and for all the folks who are suffering the way he did, I believe the time is now for us to fix this and allow terminally ill patients the freedom to write their own dignified ending. I will pass the presentation over to my copresenter, Elliott Malin, who will walk you through the mechanics and safeguards we put in this bill as well as the conceptual amendment [Exhibit C] we are prepared to address stakeholder concerns.

Elliot Malin, Private Citizen, Reno, Nevada:
Thank you for hearing A.B. 346 or, known simply as the "End-of-Life Options Act." Thank you to Assemblymember Dalia for being such a champion on this issue for Nevadans and for keeping his father's memory alive and telling his story. What we aim to do is give Nevadans the dignity and respect at the end of life to make the choices that are right for them. I will be running through the bill for you today, the proposed conceptual amendment, and making a few observations for you.

Existing law currently authorizes a patient who has been diagnosed with a terminal condition to refuse life-resuscitating or life-sustaining treatment in certain circumstances. Sections 5 through 33 of this bill authorize a patient, under certain circumstances, to self-administer a medication designed to end the life of the patient. Section 14 defines practitioner to mean a physician, osteopathic physician, or advanced practice registered nurse.

Sections 6 to 13, 15, and 16 define other relevant terms. Section 17 authorizes a patient to request that his or her attending physician prescribe a medication designed to end their life if the patient 1) is at least 18 years of age; 2) has been diagnosed with a terminal condition by

at least two practitioners; 3) has made an informed and voluntary decision to end his or her own life; 4) is mentally capable of making such a decision; and 5) is not requesting the medication because of coercion, deception, or undue influence.

Section 18 prescribes certain requirements concerning the manner in which a patient may request a medication designed to end the life of the patient, including that the patient make two—not may, but must—verbal requests and one written request for the medication, and that the written request for the medication be signed by a witness. Section 19 prescribes the form for the written request for the medication.

Section 20 imposes certain requirements before a practitioner is authorized to prescribe a medication designed to end the life of the patient, including that the practitioner: 1) inform the patient of his or her right to revoke a request for the medication at any time; 2) determine and verify that the patient meets the requirements for making such a request; 3) discuss certain relevant factors with the patient including the diagnosis and prognosis of the patient and alternative options for care; 4) refer the patient to a consulting practitioner who can confirm the diagnosis, prognosis, and mental capacity of the patient and that the patient has not been coerced or unduly influenced; and 5) instruct the patient against self-administering the medication in public.

Section 21 requires a practitioner who determines a patient who has requested a prescription for a medication designed to end their life may not be mentally capable to refer the patient to a qualified mental health professional and to receive confirmation about the patient's mental capability.

Section 22, subsection 1 prescribes procedures for the issuance of a prescription for a medication designed to end the life of the patient, and subsection 2 provides that only an attending practitioner or pharmacist may dispense such a medication. Section 23 prohibits an attending practitioner from prescribing a medication designed to end the life of the patient based solely on the age or disability of the patient, which I want to reiterate. Section 23 prohibits a practitioner, a physician, based solely on the age or disability of a patient, to give them the option for medical aid in dying.

Section 24 requires certain providers of health care to include certain information concerning requests and prescriptions for and the dispensing of a medication designed to end the life of the patient in the medical record of the patient. If the patient who has requested a medication designed to end the life of the patient transfers care to another practitioner or care facility, sections 24 and 31 require the practitioner or health care facility that previously provided care to the patient to forward the patient's medical records to the new practitioner or health care facility.

Section 27 prescribes certain information that must be reported by an attending practitioner to the Division of Public and Behavioral Health of the Department of Health and Human Services relating to a patient who has been prescribed or self-administered such a medication.

Section 28 requires the Division to compile an annual report concerning the implementation of the provisions of this bill authorizing a patient to request a prescription for a medication designed to end the life of the patient.

Sections 27, 40, and 43 of this bill provide that such information is otherwise confidential when reported to the Division. Section 25 authorizes the patient at any time to revoke a request for a medication designed to end his or her life. Sections 26 and 35 of this bill provide that only the patient to whom a medication designed to end their life is prescribed may administer the medication. Section 26 establishes requirements for the disposal of any unused portion of the medication.

Section 33 makes certain persons exempt from professional discipline and immune from civil and criminal penalties and provides that such persons do not violate any applicable standard of care for taking actions authorized by this bill to assist the patient in acquiring a medication designed to end their life. Section 29 provides that a death resulting from the self-administration of a medication designed to end the life of the patient is not mercy killing, euthanasia, assisted suicide, suicide, or homicide when done in accordance with the provisions of this bill. Section 2 of this bill requires a death certificate to list the terminal condition of the patient as the cause of death of the patient.

Sections 1 and 3 of this bill provide that a coroner, coroner's deputy, or local health officer is not required to certify the cause of such a death. Section 42 of this bill 1) authorizes a coroner to make an appropriate investigation after discovering that a person has self-administered medication designed to end the life of the person to the extent necessary to determine the cause of the terminal condition with which the person was diagnosed; and 2) requires a coroner to cease such an investigation after determining that the terminal condition resulted from a natural cause.

Section 41 of the bill makes a conforming change to revise certain internal references. Sections 30 and 38 of this bill prohibit a person from preventing or requiring a person to make or revoke a request for a medication designed to end the life of the person as a condition to receiving health care or as a condition in an agreement, contract, or will. Section 31 clarifies that a practitioner is not required to prescribe a medication designed to end the life of a patient but remains responsible for treating the patient's pain. However, if a patient who is diagnosed with a terminal condition requests information concerning the prescription and self-administration of a medication designed to end the life of the patient, section 31 requires further that a practitioner provide that information or facilitate the transfer of the patient to another provider of health care. Section 31 also provides that a pharmacist is not required to fill a prescription for or dispense such medication.

Section 32 authorizes the owner or operator of a health care facility to prohibit an employee or independent contractor of the health care facility or any other person who provides services on the premise of the health care facility from providing any services relating to prescribing a medication designed to end the life of the patient while acting within the scope of his or her employment or contract with the facility or while on the premises of the facility.

Section 33 prohibits a health care facility or a provider of health care from taking certain actions against an employee or independent contractor who 1) provides accurate scientific information concerning end-of-life care to a patient or 2) facilitates the prescription or self-administration of a medication designed to end the life of the patient. Sections 34 through 37 of this bill make conforming changes to clarify that a practitioner or pharmacist is authorized to dispense medication designed to end the life of a patient that is a controlled substance or dangerous drug, and a patient may self-administer such medication in accordance with other provisions governing medications designed to end the life of the patient.

Section 39 of this bill provides that a proposed protected person shall not be deemed to be in need of a general or special guardian solely because the proposed protected person requested a medication designed to end his or her life or revoked such a request. Sections 44 and 45 of this bill prohibit insurers from conditioning life insurance benefits, group life insurance benefits, or the payment of claims on whether the insured makes, fails to make, or revokes a request for medication designed to end the life of an insured or self-administer such medication. Again, life insurance companies cannot deny coverage to a person who utilizes this. Section 46 of this bill makes conforming changes to reflect this prohibition on a policy of group life insurance.

You also received an updated conceptual amendment [Exhibit C] from me. I will run through those really quickly as well. The first one is to change the death certificate to include a checkbox for use of medical aid in dying. The purpose is to ensure that the cause of death remains the underlying cause of death, the illness, while also providing a method for statistical capture and abundant honesty on the death certificate. We have heard from practitioners that they were not comfortable with what they felt was not being fully honest on the death certificate, and this would allow them to do so.

The second one is the doctor may only bill for the appropriate Current Procedural Terminology (CPT) codes for diagnosis and prescribing. This ensures that this remains revenue-neutral for providers while allowing them to receive compensation for services provided. Third, first responders, if called, must use a prescription used by the intended user as a do-not-resuscitate (DNR). The reason is if an individual third party calls emergency responders because of use of the drug by the intended and prescribed party, the prescription would act as a DNR to stop them from providing lifesaving treatment.

Fourth, first responders should use the code "medical aid in dying" for their impression on the reports if they respond to an individual who has ingested the prescribed medicine and the prescription was intended for them. The purpose for this one is it would limit first responders from using the first impression of "suicide" on the reports to other providers and would fall in line with the rest of the provisions of the bill. Fifth, revise section 11 to say, "understand the nature and consequences of the decisions." This would align section 11 with the definition of mental capacity in Assembly Bill 461. Having now run through the bill and amendments,

I want to address a few concerns we often hear about this bill. But first, I remind the Committee that it is unlawful under *Nevada Revised Statutes* (NRS) 218E.085 to intentionally mislead the Legislature, a legislative committee, or otherwise communicate to a legislator.

When it comes to this bill, over the years, we have heard numerous statements that have been factually unfounded, categorically false, and oftentimes profoundly offensive. To discuss those misconceptions: misconception number one is that insurance companies will offer this as an option instead of treating the patient. This bill requires providers to offer all options to the patient, and there is no history available in any state that demonstrates an insurance provider does this.

Misconception number two is that this will be used as a tool to "euthanize" people with disabilities. I find this one to be the absolute, most reprehensible of all of the preposterous positions. This bill clearly stipulates that only a person with a terminal illness with six months or less to live, having been confirmed by at least two doctors, and having the capacity to make an informed decision is eligible for the prescription. A person with a disability has the ability to live their life to the fullest, and they also deserve dignity and respect from people to recognize that. To be absolutely clear, a person with a disability does not qualify for this unless they have the capacity to make an informed decision, that they are terminally ill with six months or less to live, and is of the age of majority per section 17 of 23 of this bill.

Misconception number three is that doctors will charge in excess and turn this into a profit-bearing business. First, to be clear, doctors do have a right to earn a living. Second, our amendment aims to address this and makes providers able to reimburse the CPT codes.

Misconception number four is that individuals will coerce their relatives into seeking medical aid in dying. We have seen stories of this reportedly happening—notably an individual in Oregon. However, what is often misrepresented in that story is the individual in question was denied access to medical aid in dying because a doctor followed the law due to the fear of coercion. That person was later granted the medication when doctors were comfortable that they were doing this of their own free will and coercion was not occurring. Per sections 17, 30, and 38 of the bill, the semblance of coercion requires a provider to deny access to the medication.

Misconception number five is that this will lead to a "slippery slope," and this will allow people with depression access to medication. Yet, in the decades this has been permitted in various states in the United States, at no point has anyone tried to amend the existing laws to expand access to individuals suffering from mental anguish. Nor does depression qualify an individual for this.

Misconception number six is that this bill will lead doctors who do not want to treat patients to offer this in lieu of treatment. Section 20 requires practitioners to provide all available options, including treatment, to a patient. Section 23 prohibits a practitioner from prescribing the medication based solely on age or disability. They must provide all available options.

Misconception number seven is that this bill would lead to the denial of life insurance coverage and payouts for individuals who participate in medical aid in dying. Sections 44 and 45 specifically prohibit insurers from conditioning life insurance benefits, group life insurance benefits, or the payment of claims.

Misconception number eight is that this bill is "anti-life." We agree that we must protect life at all costs. However, sadly, there comes a time when we can no longer do that; the person is going to die. If they have pancreatic cancer, for example, they will likely suffer pain that I hope none of us ever have to experience. This is not a choice between life and death for these people. The choice for them is between suffering and not suffering at the end of life. It is disingenuous to paint this as a life issue. It is simply not; it is not a choice we get to make for the patient. Last session, we had an individual and activist who was counting on us to get this done because they were suffering from pancreatic cancer. Unfortunately, we could not do it for them, and I had to tell that person how they were going to die, and that is exactly how they died—in agony.

Misconception number nine is that this bill would subvert palliative care. At no point does this bill aim to subvert palliative care. It gives patients options at the end of life. Hospice and palliative care are great options for patients, but they are not the only options. Furthermore, we have heard that we are advanced enough that we can make people comfortable at the end of life. This is largely true; however, it is not entirely true. As we just heard from Assemblymember Dalia, that is not always the case, and patients deserve the dignity and the respect at the end of life to have options. We have also heard of cases where individuals have been administered excess drugs to ease pain, and that excess instead ends the life of the patient.

Misconception number 10 is that this bill requires people of certain religious backgrounds to do something they object to. This is patently false. As stipulated in the bill, we do not require anyone to do anything they are uncomfortable with or object to. Every single Nevadan has a right to practice their beliefs free from a government mandate or government coercion. That includes the language of this bill. For example, I am a practicing Jew. I think that is not a secret to all of the members of this Committee. I do not want others to force their beliefs on me, nor do I want to do that to other people, other Nevadans, I would never want to do that to Catholic doctors, for example. The provisions of this bill under sections 31, 32, and 33 specifically permit people, entities, and employers to deny participation in any stage of this. Speaking of the Catholic Church, we know that the church remains in strong opposition to this bill. We have reached out to the church, and I hope to have a conversation with them

soon to discuss how Catholic Nevadans must also be respected and how we do not want to force anyone to do anything they object to or are not within their belief structure. That being said, I, like many Nevadans, am not Catholic; what works for me may not work for them, and vice versa.

This is a respect I must have for Nevadans who do not share my beliefs. It is a respect that I also expect in return. This is one of the fundamental concepts of the First Amendment's religious freedom protections: that we do not pass laws that favor one religion over another. In Judaism, we have a few rules. As one of my rabbis recently told me in relation to this specific policy and this bill, in particular, the first rule in Hebrew is "ve-ahavta l'rei'kha kamocha" [testifier spoke in Hebrew] or love your neighbor as yourself. The second is to do everything we can to save a life. However, we must remember that, at times, the second rule is not possible. We cannot save that life because that person is actively dying due to illness and is terminal, and God is calling them home. In that case, we must revert to the first rule, to love your neighbor as yourself, and to give them the dignity they deserve to make the choice that is best for them, the choice of individual liberty and one of the last comforts they may know.

Thank you, Chair, for the opportunity to be here today and to help present this bill. I will now turn it over to Dr. Blanke.

Charles Blanke, Private Citizen, Portland, Oregon:
I am a tenured professor of medicine at the Knight Cancer Institute in Portland, Oregon, and a board-certified medical oncologist with an end-of-life specialty practice. My clinic focuses on medical aid in dying (MAID), and I have been participating in this field since 1998. I have written more than 500 prescriptions for lethal medication intended to end the suffering of patients with a wide variety of terminal illnesses. Over those three decades, I have attended several hundred deaths personally, and all of my patients died peacefully and without suffering. To the best of my knowledge, I participated in the most MAID procedures of any doctor in Oregon, the state with the longest experience with MAID and likely in the United States. I have also served as a MAID consultant for the states of Hawaii, New Jersey, and Washington, the Canadian Royal College of Physicians and Surgeons, and the French Ministry of Health, advising on practical applications once MAID legislation has been passed. I served as research director for the Academy of Aid-in-Dying Medicine, the largest medical professional organization devoted to MAID, and I have published and presented extensively on a variety of end-of-life issues. I have advised innumerable physicians and nurses on MAID practices. I consult weekly with physicians considering MAID for their patients, and I am quite familiar with community standards for actual MAID usage.

Why do I believe MAID is a necessary option in end-of-life care? Because a small but significant fraction of patients suffering from terminal disorders like cancer are suffering in ways we cannot fix. Some are unable to interact meaningfully with their family or loved ones and thus have no quality of life. Others are more actively miserable. I have seen dozens of patients with nerve or bone pain that could not be controlled regardless of how much morphine was prescribed. They were truly living in agony. I am a huge supporter of

palliative care, and I believe it is dramatically underused in the United States, but we cannot palliate the out-of-control symptoms of many patients at end-of-life. In fact, 25 percent of referrals to my clinic come from palliative care experts who have done everything else possible for their patients.

Medical aid in dying offers benefits to many who do not even take the medication. In fact, Oregon data demonstrates about a third of patients prescribed lethal drugs each year do not self-administer them and instead die directly from their underlying disease. But having the medication available, just in case things become unbearable, is a huge comfort to both patients and their families. Patients with these illnesses have almost no control over their lives, but MAID offers them complete control over their deaths, and knowing they have the option to relieve suffering should it worsen is a huge benefit that comes from legalizing the practice.

I recognize there are concerns regarding potential abuse of the MAID laws. Some arguments were put forward even before the legislation first passed in Oregon in 1994; none came to pass. One fear, as you have heard, is that MAID might be foisted upon patients with disabilities to make things easier for families or for financial reasons. This simply does not occur voluntarily or involuntarily. First, every U.S. venue in which MAID is legal requires a potential patient to have an underlying terminal disease to even be considered for that option. Terminal disease means an incurable and irreversible disease that has been medically confirmed and which will, within reasonable medical judgment, produce death within six months. It is not old age, chronic illness, or a disability, as echoed in your own proposed legislation.

Next, there are numerous safeguards against coercion, including a required demonstration by the patient that they are capable of making and communicating health care decisions by themselves. In fact, MAID is probably underutilized. I am always asked when I lecture if it is even legal for a physician to offer MAID as one of many end-of-life options. Essentially, all of my patients say they had to bring the topic up on their own with their physician at their own instigation. I know most doctors, in fact, almost no doctors, are offering it proactively. It is not being forced upon the impoverished or poorly educated. Seventy-three percent of Oregon MAID users have attended college. Finally, families never tell a loved one MAID is their best option.

Medical aid in dying is certainly not euthanasia: the administration of lethal drugs, even with permission, to another person. That practice is illegal throughout the United States. There is absolutely no evidence of a slippery slope from legalizing MAID to encouraging or allowing even a medical professional to take the life of a patient. Having MAID available does not lead to more people committing suicide. Several studies from Oregon and other parts of the United States prove the rate of non-assisted suicides does not rise in states where MAID is legal. Rather, it is possible MAID provides an effective and humane alternative to standard suicide for those seeking to end the suffering due to terminal illness. The drug combination now used throughout the U.S., known as DDMAPh [diazepam, digoxin, morphine sulfate, amitriptyline, and phenobarbital], is highly effective and it offers an incredibly peaceful and

humane death to our suffering patients. It is both more reliable and safer than simply "winging it," as you just heard so movingly from Assemblymember Dalia with hospice, prescribed narcotics, or Valium. The median time to the patient being unconscious and completely unaware of pain, anxiety, shortness of breath, et cetera, is six minutes, with an average time to death of 96 minutes. Ninety-five percent of patients die within a few hours, and that period is not in any way unpleasant for them. Other complications are quite rare. The scariest possible outcome for patients, of course, is the fear of waking up. While regaining consciousness from the MAID-induced coma is historically quite uncommon to begin with, at 0.3 percent of cases, no one has woken up with the regimen we currently use, and it has been used more than 2,000 times.

I have learned quite a bit about how to make things easier for the patient or prescriber over the years I have been practicing. Nevada is already ahead of the game. For example, Oregon formally asked a physician putting the cause of death on official state paperwork to say "drug overdose legally prescribed." Now, we simply list the underlying terminal condition. This has the added benefit of more safety in terms of insurance companies not being allowed to invoke a suicide clause. But I acknowledge it might present ethical challenges for individual physicians who know the immediate cause of death was actually the medication they prescribed. I commend Nevada for its honest but patient and physician-centric approach to that record keeping.

Nevada is also far ahead of Oregon in anticipating problems that I have learned about only through experience that I try to address upfront in my clinic. In Oregon, we do not have statutory language to guide us in advising patients on the procedure, how to store drugs, what to do with unused medication, and that it is legal for family members to help prepare the medication as long as the patient self-administers it, is truly prescient.

I will close by remembering another patient whose death I attended. I met a wonderful young woman with Lou Gehrig's disease or ALS [amyotrophic lateral sclerosis]. She was becoming paralyzed and was slowly suffocating as she lost the ability to breathe on her own. She was terrified of what her end would look like, and she worried about its effect on her family. Instead, she self-administered medication with a host of caring friends and loved ones by her side; she slipped away peacefully, completely ending her potential and actual suffering. Medical aid in dying deaths will almost certainly make up only a tiny fraction of Nevada mortality as they do in Oregon and the other ten venues where the practice is legal, but a much larger fraction would benefit from making it legal. I hope you pass this legislation. It helps many, many patients and would not endanger anyone. Thank you very much for this opportunity.

Chair Orentlicher:
Are we ready? Do you have any more before we move to questions?

Assemblymember Dalia:
Thank you. Chair. We are ready for questions.

Assemblymember González:
I really appreciate the courage it takes to tell your story here in public. My question is—and I apologize; we went over the bill rather fast there—do we know what the timeframe will be from when a patient requests medication to when they actually get that medication?

Elliot Malin:
We do. There are two different time frames. There is the one where they are imminently going to die. The first part is they have to make the first request, and then they have to wait two weeks for the second request, and then do the written form. In the case where an individual does not have two weeks or 14 days, I believe it was, they can make the request immediately, if I am not mistaken. It is 15 days.

Charles Blanke:
I wanted to add that 15 days is the most common waiting period, although it varies from immediate to that time frame.

Assemblymember González:
If I am the patient and I request this option and go through the process, from the time I make the request, it is 15 days in which I would actually have that medication in my hand. Is that correct?

Elliot Malin:
Not necessarily. There is the first request, then you have to wait 15 days to make the second request, and then you have to make the written request. From what I understand, the written request and the second verbal request can happen almost simultaneously. Then, at that point, the physician has to contact—and you have to remember in this process, you also have to go with the second diagnosis and prognosis, so you have to see a second individual doctor. But after all of that is done, the doctor, the attending physician, then must get your consent to notify the pharmacy, give you the prescription, and then send the prescription to the pharmacy. At that point, the prescription has to be filled by the pharmacy. I do not know how long that could take. Pharmacies are quite different, and Dr. Blanke might actually know a little bit more about that part of it.

Charles Blanke:
When I get the first request from my patients, I get a sense of how urgent the situation is for them. I discuss the legally mandated waiting period if they are not imminently dying, which is 15 days in Oregon. If they want—and I always ask them what they want—I will set up that second appointment on day 15. I will try and get that second opinion during the 15 days. We have a little bit of a difference in that there has to be a 48-hour waiting period between the written request and the prescription writing. We try to do that before day 13 so it does not wind up being 17 days, if that makes sense. I also tell them that the pharmacy usually has the medication in stock and usually will do same-day filling, but they do need to be prepared for the possibility that it will take the pharmacy a couple of days.

Assemblymember Moore:
Thank you, Assemblymember Dalia, for being so willing to share with us your story. I know it is hard. So, I really appreciate that. I do have a question, and I do not know if this was covered during the presentation because we went through it pretty fast. In section 18, subsection 1, paragraph (b), where it talks about the written request for the medication, on page 8, there is a form that states the request for medication form that people have to fill out—once they fill that form out, who will keep this on file?

Elliot Malin:
The attending physician should also be the one who keeps this on file. The patient should keep this on file. This is unique to Nevada. We offered this up for the first time last session to ensure people were making informed decisions for themselves. But to fully answer the question, the attending physician should be the one who keeps this on file, as well as the patient. Dr. Blanke might have some input on that.

Charles Blanke:
Yes, I would have to look back at your legislation to see what forms have to be submitted to the state health authority, but there is a requirement to do so. In Oregon, we have to submit paperwork shortly after we write a prescription, whether or not the patient takes it. That information includes the attending physician's opinion, the consulting physician's opinion, and that written record. So, the state also has a copy of it. Needless to say, I keep a copy myself.

Assemblymember Moore:
Thank you for that answer. Regarding the form, I did not see anything in the bill mandating or suggesting that this form be made available in languages other than English for folks who prefer to receive their information in their native language.

Elliot Malin:
I am making a note of that right now, and I will talk to the sponsor about amending section 19 since we already have amendments to include the availability in native languages for an individual as long as it conforms to the same translation.

Charles Blanke:
In Oregon, we do at least have a Spanish version.

Assemblymember Edgeworth:
Thank you for sharing your story. That was a lot. I really appreciate it. Not very many people are brave enough to tell their whole story, and it is a lot. Thank you for giving us that background. I have a question in section 21; I am not going to get too technical because I am just a doctor. My question always would be that I would want somebody to have the capacity to make this kind of decision. This could be Dr. Blanke who answers. It is my understanding the attending physician would decide if the person had the capacity to make a full decision.

Then it says in section 21 that should they not be able to make the determination, a person professionally qualified in the field of "psychiatric mental health." I am not sure what that means. Does that happen often that we refer to a psychiatric person? And if we did, is that usually a psychiatrist or a therapist, or who would that person be?

Charles Blanke:
That is a great question. Either the attending or consulting physician, the second opinion, has the right to ask for a psychiatric or psychological evaluation if there is any question about decisional capacity. That actually very rarely occurs. It is about 3 percent total over the history of the Oregon bill and that law. In some years, it is zero percent. For whatever reason, we think we are pretty good, as doctors, at certifying whether the patient truly understands what is going on. Supporting that, I will tell you that on rare occasions, I have sent people—95 percent of them are certified as capable, and those were situations where I was myself uncertain. We can use a psychiatrist or a psychologist. In other states, it is actually even broader, I believe, although I would not swear to this on the record, but I believe in Hawaii, it could be other mental health specialists outside of psychiatry and a Ph.D. in psychology.

Chair Orentlicher:
Our counsel, Eric Robbins, will have this set out in statute.

Eric Robbins, Committee Counsel:
A person professionally qualified in the field of psychiatric mental health is defined in section 12 of the bill to have the meaning ascribed to it in NRS 433.209. That section defines a person professionally qualified in the field of psychiatric mental health to refer to a psychiatrist, a psychologist, a marriage and family therapist, a clinical professional counselor, or certain social workers and registered nurses who have advanced psychiatric like master's level psychiatric training. It would have to be a clinical social worker. The social worker and the nurse are also limited to people employed by the Division of Public and Behavioral Health of the Department of Health and Human Services.

Charles Blanke:
That sounds almost exactly like Hawaii, to the best of my recollection.

Assemblymember Orentlicher:
Are there other questions from members?

Assemblymember Gallant:
Sorry, when you asked, I was still thinking about the legal definition of a psychiatrist. In Oregon, you said you had to notify the health department pretty quickly, and in our bill, it says within 30 days of prescribing the medication and then within 60 days after the patient has passed. Is that in line with Oregon or do you have quicker timelines in terms of reporting?

Charles Blanke:
It is actually ten days. It is in line, but ours is a little teeny bit shorter. I will say that every once in a while patients, we are not aware of their deaths, particularly if they do not take the medication and they die of something else very far down the line. I try to put a checklist into my chart note so I can come back to it later. For what it is worth, the health authority has been very, very diligent in collecting that data, but they are not out to punish doctors who do not do it within that time frame.

Assemblymember Gallant:
You had also explained that you will prescribe the medication; it is like peace of mind for them to have it. A lot of times, they end up not taking it and dying of natural causes. What is the process in terms of that medication sitting in the medicine cabinet? Is there anything where the family has to return it? What would that process look like?

Charles Blanke:
It is a great question. First of all, the Oregon statute is a little bit interesting in that the prescription does not go directly to the patient. It must go to the pharmacy. The advantage to that is they will hold it, which has a financial advantage in that if the patient does not take it, they are not out the $800, but it also means they have less time when that medication is at home. If they bring it home, I do tell them they need to be very careful with the medication and treat it as a potentially dangerous substance. So, potentially, if they have a safe, like a gun safe, I always preventatively advise them to put it in a safe. That is sort of the standard for the professional organization that I belong to as well. I am fairly sure your statute mentioned how to store it and how to dispose of it. In terms of the latter, I advise them on local pharmacies that have a dropbox, or, to be honest, I will offer to pick it up myself so the family does not have that additional stress.

Chair Orentlicher:
Are there any other questions?

Assemblymember Moore:
During the presentation, Oregon has been cited a lot and mentioned, and I understand it is the first state to have ever passed this. How many other states have this already in their laws?

Charles Blanke:
There are 11 U.S. venues where medical aid in dying is clearly legal. I say venue instead of state because Washington, D.C., is one of them. Most of them have had either ballot initiatives or direct legislation that allowed it. Montana has legalized it through a Supreme Court ruling. But I can tell you, which I believe you are indirectly asking, that every state collects data on the use of medical aid in dying, and it is remarkably similar across all 11 venues. Cancer is always the most common underlying illness. The people are always well educated, for whatever reason. It is just remarkable how similar the outcomes are in those 11 venues. I believe there are 16 states currently considering it this legislative session.

Chair Orentlicher:
As you said, Dr. Blanke, Oregon has had almost 30 years of experience. How many times have physicians had to be disciplined for not employing the statute properly?

Charles Blanke:
It is rarer than hens' teeth. In fact, the 2024 report just came out, and as usual, no one was disciplined. I do not want to make up a number, but I believe it is under five. People really try and do this in good faith, and the law is there to protect the patient and is, in general, very well applied. But I will tell you, I look at the report every year, and I only remember one case where it actually happened. And to be honest, it was just one case.

Chair Orentlicher:
Any other questions? [There were none.] I think we are ready to move on to testimony. Before we do, we have been at this for almost an hour, so let us take a five-minute break, and then we will come back to testimony.

[The meeting was recessed at 5:59 p.m. The meeting was reconvened at 6:04 p.m.]

Chair Orentlicher:
We are ready to move to testimony. I know there are a lot of people who want to testify, and we are eager to hear your testimony. That said, we do have limited time. We are going to allow 30 minutes for support testimony, 30 minutes for opposition testimony, and 30 minutes for neutral testimony. For each person, we also limit it to two minutes maximum. There is a timer there. Please be mindful, and we will remind you as we are getting close to your two minutes. I do need to be strict about it because there are a lot of people who want to testify, and the longer a person speaks, the fewer people can speak, and it is better to have more people. We will be strict about the two minutes. It is fine if you are the tenth or fifteenth person to say, "I want to echo the comments of the previous speakers," and there is no need to use your full two minutes. Again, be respectful. Please remember—this is the hardest part—to state your name and to spell your name because our transcribers do not know everybody in the room. So please speak fairly slowly, as I have trouble keeping up with some of the spellings.

All right, we are going to start with support testimony. Those of you in Carson City come forward. After you complete your testimony, please go back to your seat so the next person can come up, and then we will just keep filling the seats. We will start with ten minutes here. Then we will go to Las Vegas and then do some rotating. So please start when you are ready.

Sandra Koch, representing Nevada State Medical Association:
The Nevada State Medical Association is the oldest and largest organization representing physicians in our state. At our core, the Nevada State Medical Association is a patient advocacy organization. Our physicians believe their first and foremost duty is to provide the best possible care for patients, supporting them through both their health and suffering. Our members recognize that end-of-life choices for their patients are deeply personal and should be made with dignity, autonomy, and respect. Eighty-two percent of Nevadans support

legislation such as the bill you are bringing today. Seventy-nine percent of Nevadans, from a survey in 2023, personally want the option of end-of-life care. Therefore, we are in support of A.B. 346.

Maxmillian Lowe, Council Chair, Nevada Governor's Council on Developmental Disabilities, Department of Health and Human Services:
Assembly Bill 346 provides individuals the right to choose to end their life if they have an end-stage disease that is incurable and have been through extensive medical treatments. This bill provides options to make their own decisions about end-of-life care that works for them. This is not doctor-assisted suicide but about an individual's right to decide their end-of-life choices. Assembly Bill 346 is about choice and self-determination. Please support this bill and individuals' right to self-determination and respect their right to their choice for their decisions.

Elizabeth Grimm, Private Citizen, Reno, Nevada:
I come before you to support the Death with Dignity bill from a deeply personal story. As a teenager, I battled an illness that took eight years just to diagnose. What followed was four and a half years of grueling treatment, daily intravenous (IV) therapies, a chest port, and countless medical appointments. My quality of life diminished to the point where I slept 22 hours a day. This was how I spent my twenties, years that should have been filled with growth and opportunity. My doctors supported my withdrawal from college, uncertain if I would survive my treatment. I was placed on palliative care. Though I fought for my life every day, my existence was reduced to a bare minimum of living. During that time, I learned about death with dignity legislation. While I was not ready to make that choice for myself, knowing such an option existed in other states provided a kind of comfort. The knowledge that if my treatment stopped working and my life continued to diminish, I could work with my doctor to end my unbearable suffering with dignity.

This bill is not about choosing death. It is about empowering people facing terminal illness to have a sense of control. It is about valuing quality of life over quantity of days. Today, I am grateful to be before you, healthy and with a full life ahead of me. But I speak for those who face what I faced—a life diminished by medical circumstances beyond their control. The safeguards in this bill ensure that these decisions are made with medical oversight, sound judgment, and compassion. I urge you with every fiber of my being to support this legislation that honors human dignity in life's most vulnerable moments.

Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities, Department of Health and Human Services:
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, suicide in general, or euthanasia. These terms are misleading and factually incorrect. Medical aid in dying protects patients and affords dying people the autonomy and compassion during the most difficult time. It actually improves end-of-life care and would cost our state almost nothing to implement except for the minimal costs 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. This includes their rights to make end-of-life informed choices. We did submit a longer piece of testimony for you guys to read as well [document was not received].

Melissa Chanselle-Hary, Private Citizen, Sparks, Nevada:
I am the founder and owner of Sacred Transits, and I am a member of the Doula Co-Op of Nevada. I am an end-of-life doula and a Reiki practitioner. I help people before, during, and after death. This option is crucial, and it is desperately needed. No one can predict how their end will come. I have seen and worked with families who believe they know their wishes and desires and they have them, and then they change when the reality of their situation becomes clear to them. Palliative care and hospice care are amazing and incredible resources that are also drastically underutilized, and they do not provide the full spectrum of care that is needed. This is a critical option that is missing that we have an opportunity to change. We have a death-phobic society, and I see care teams resist acknowledging that death is even likely when we have a diagnosis. This bill will not cause the pendulum to swing so far that it is used inappropriately, and the language is responsible for making sure and preventing any of the fears that have been listed previously and currently. I think you are going to hear some difficult opposition today to this bill. I urge you to consider which statements are ideological in nature and which ones come from lived experience. One of your own is here today, and because of what he had to endure and because of what he continues to carry, and other people are speaking from their lived experiences because, for those in favor, it is because they have lived through or are currently living through an excruciating experience and are looking for a type of relief and solace. Please hold close what is from lived experience and what is not.

Tatiana "Tia" Smith, Policy Counsel, American Civil Liberties Union of Nevada:
We strongly support A.B. 346 because it affirms the fundamental right of every mentally capable adult to make deeply personal decisions about their own body, health, and end-of-life care. This legislation empowers terminally ill people to preserve their dignity and autonomy by allowing them to choose a medically guided and voluntary path that ensures patients, and not the government, retain the right to make informed decisions based on their own values, beliefs, and quality of life. Respecting bodily autonomy at the end of life is a compassionate and just policy. We urge the Committee to support this bill.

Timothy McFarren, Private Citizen, Carson City, Nevada:
I am just a physician like Assemblymember Edgeworth. The majority of physicians and nurses support this end-of-life care, and I urge you to support it also.

Chair Orentlicher:
We will now go to Las Vegas for people in support. [There was no one.] Do we have anybody on the phone calling in support?

Johanna Koch, Private Citizen, Reno, Nevada:
I am a hospice and palliative care physician working for Summit View Hospice in Reno as well as working in California. I am a prescriber of medical aid in dying since 2017 in California. I feel as though the physicians and representatives who have spoken today have spoken from the heart and have spoken the truth as I see it and as I have experienced it. I had prepared some statements, but they feel redundant now. I just wanted to clarify two small points.

One is that in California, the requirement for reporting of a death is 30 days, just as it is in Nevada, which is a reasonable length of time for families to come to terms and physicians to get their paperwork done. The second is regarding the destruction of medication. As a hospice physician, when we have a patient who is prescribed medical aid in dying but does not take it, we take that medication back, and there are formal processes for destroying it. We do not leave it in a patient's home, and while it is in their home prior to ingestion, we always require that they keep it locked up, as was mentioned. Drugs are not left in a situation where they can be misused, misdirected, or in any other way used inappropriately. Thank you so much, and I am obviously in very strong support of this bill.

Emily Barney, Private Citizen, Reno, Nevada:
I am a co-founder of the Doula Co-Op of Nevada. I am also an end-of-life doula. Just as Dr. Koch has shared, all of the presentation of this bill and testimony before me urges the truth of this bill and what is needed desperately in Nevada and across the country for folks who are experiencing suffering at the end of their lives. I ditto everything everyone has said.

Illia Ludwig, Private Citizen:
I am calling in support of A.B. 346. I have personal experience with my uncle choosing to use MAID in Hawaii. His diabetes was going to end his life in a way that would cause him to suffer. He chose an option that allowed him to die peacefully and with dignity, and I am in complete support of this bill. [Exhibit D]

Tiara Flynn, Private Citizen, Las Vegas, Nevada:
I am a professional birth, postpartum, and full-spectrum doula here in Nevada. I am here to express my support and echo the sentiments of those prior to me for Assembly Bill 346. Although my work is centered around the beginning of life, I see undeniable parallels between birth and death. Both are deeply personal experiences that deserve compassion, dignity, and most importantly, autonomy. I recommend that this bill move forward without delay. No one should be criminalized for choosing a care path that feels right for them. Again, in closing, I urge you to support A.B. 346. Every person deserves the right to decide how they meet death with agency and peace. Thank you again, Chair and members, for your time and for everyone who shared their testimony today in consideration for A.B. 346.

Gina Schneider, Regional Campaign and Advocacy Manager, Nevada Compassion and Choices Action Network:
We advocate for legislation to improve the quality of life for terminally ill patients and affirm their right to determine their own medical treatment options as they mirror the end of life. We have been working with the people of Nevada since 2017 to authorize medical aid in dying. We support legislation that has authorized the time-tested practice of medical aid in dying safely for patients, their families, and loved ones, as well as clinical providers and coroners for decades. Compassion and Choices Action Network supports the original bill as written, and Compassion and Choices Action Network will have to review the additional amendments before we can comment on that.

[Exhibit E was submitted but not discussed and is included as an exhibit for the hearing.]

Ian McIntosh, Interim Executive Director, Not Dead Yet:
On behalf of members in Nevada and as a Canadian with disabilities living in America, I urge you to oppose A.B. 346. Unwitting ableism takes many—

Chair Orentlicher:
I am sorry; we are in support testimony, Mr. McIntosh. We will bring you back for opposition. Is there anybody else calling in support? [There was no one.] Before we move on, is there anybody else here in Carson City who wants to testify in support or anybody in Las Vegas? [There was no one.] Then, we can move to opposition testimony. We will start first in Carson City, and you can also get ready in Las Vegas.

Melissa Clement, Executive Director, Nevada Right to Life:
I am testifying in opposition to A.B. 346. States that have passed laws to legalize assisted suicide have followed a pattern of enacting legalization with supposed safeguards only to come back and claim they are barriers. State laws have been expanded by subsequent legislation, court action, and interpretation. Oregon, Washington, California, Vermont, Hawaii, and Colorado have passed legislation or used the courts to expand their laws to allow individuals less qualified than physicians to prescribe lethal drugs, reduce or eliminate waiting periods, and remove residency requirements. In Colorado and Oregon, physicians have interpreted their laws to allow the deaths of patients with anorexia, a mental health disability not envisioned when the law was enacted. California recently considered an expansion bill to remove the six-month prognosis requirement allowing dementia patients to request lethal drugs and allow self-administration of the drugs via IV infusion. The bill was withdrawn after one supporter stated it was moving too fast too soon, providing a vision of where proponents eventually want to go. Nevada legislators can rest assured that should Nevada enact an assisted suicide law, proponents will come back for more in a few years. Please vote against A.B. 346, not only to protect patients at the beginning but in the future.

Kirk Bronander, Private Citizen, Reno, Nevada:
I am testifying in opposition to A.B. 346. My testimony is my own. I am not representing my employer or the hospital where I work. I have been practicing in Nevada for 23 years. I am a hospital medicine physician in Reno, and I frequently deliver bad news to patients, give poor

prognoses, and explain end-of-life options. I am completely opposed to this bill for many reasons. Due to time, I am just going to highlight a few. Number one, the prognosis of a patient with a terminal condition is very difficult and we are often wrong in this prognostication. How do we determine whether a patient is likely to die in six months? It is an educated guess. Many people outlive that six-month prognosis on hospice, meaning that people who end their lives in this way could have lived for years. Former President Jimmy Carter lived almost nine years with metastatic melanoma in his brain. He would have been a candidate for medical aid in dying from the first time he was diagnosed. A study in the American Journal of Hospice and Palliative Care found that physicians are wrong in prognostication 50 percent of the time. [Exhibit F]

Number two, this bill also requires that an attending physician inform patients diagnosed with a terminal condition of this "option" as if this option is health care. The original Hippocratic Oath states, "I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan;" Yet this law insists that I violate my conscience and my oath and inform a patient I have just diagnosed with a terminal condition that they can take up this option. I should not be forced to do this against my conscience.

Jason Guinasso, Private Citizen, Reno, Nevada:
I am here as a private citizen representing myself and all my opinions and perspectives are my own and not any organization or employer that is attached to me. I come to you with over two decades of experience providing pastoral care to the dying. I understand the central premise of A.B. 346 is to alleviate suffering at life's end. I think this is a goal we all share. However, I want to emphasize that the means to that end matter profoundly. Proponents present this bill as compassionate, but true compassion does not abandon patients to death when they are the most vulnerable. True compassion walks in line with suffering people, addressing its root causes of suffering. Giving people the means to end their life rather than providing comprehensive palliative care is not mercy. It is abandonment. Assembly Bill 346 presents a false choice: either suffer unbearably or end your life. This is a failure of the medical system and our imagination.

Oregon has been cited a lot before you, though. Oregon studies, however, show that physical pain is not even among the top five reasons people request lethal medication. In fact, the Oregon health authorities report in 2003 on death and dignity says that physical pain is among the top five reasons for lethal medication. Instead, loss of autonomy, decreased ability to engage in activities, and loss of dignity top the list. These are all issues that we can and should address through holistic hospice care without resorting to assisted suicide. The fundamental question is not whether we should address suffering; it is really how. Will Nevada be a state that invests in palliative care, extended hospice access, and family support services, or will it take an expedient path of offering death instead of dignity? A holistic approach is what is required for a complexity of human suffering at the end of life, not lethal prescriptions. If hospice care and palliative care are a burden, then we should fix that if it is broken, not prescribe death. I urge you to oppose and vote against A.B. 346 and support other holistic options for compassionate end-of-life care.

Jason Luis, Private Citizen, Carson City, Nevada:
I am here on my own, and I am not representing my employer or anyone else. I am a survivor of terminal cancer. I currently have an uncle who is diagnosed with stage four [cancer], and he was given less than six months to live. He is currently, because of medical innovation, seven years past that point. The reality is the only one who benefits from this is the insurer, and to say that there is not a cost incentive is intellectually dishonest, and it is disingenuous. I see it every day in what I do for a living. I am in the worker's compensation arena, and I see how insurers delay treatment. I see the frustration that comes from that. I know firsthand what it is like to be diagnosed with a terminal illness—the fear that comes along with that and the depression. The first thing that goes through your mind is, Oh my God, I cannot put my family through this. Everyone would be better off if I was not here; the financial burden that I am going to potentially put on my family. Where the insurer comes in, all it takes, it is not them saying, You know what, this is what you need to do as a viable option. All it takes is delaying treatment. To say that there is not a financial incentive to do that, delay it when you are dealing with someone who is depressed when someone is in pain. All that does is present an option over here, where I do not want to put my family through something like this. I think it is dangerous. I think it is reckless, and I pray that you guys vote no on this and above and beyond that; I think this is something that is better off going to the voters than it is a legislative enactment.

Deidre Hammon, Private Citizen, Reno, Nevada:
I am a parent of a young woman with a disability, and now that I am becoming older, I also have a disability. I do want to say thanks to the Democrats who bring this bill up again and again and again. We have been here since 2009, when we convinced Bernice Matthews that this is not good for the disability community. This is a bad bill for the disability community. Now we have a Committee, and I think that is great in terms of addressing palliative care and hospice, but this bill needs to be withdrawn. It was so interesting to listen to Assemblymember Dalia because he gave us the answer. He did not even realize he was doing it. His father said that he did not want his dying to come at a cost to anyone else, and all change is hard; all loss is hard. Most of us struggle with thoughts of suicide, as we just heard.

In Nevada, we have an Office of Suicide Prevention, but this bill calls for us to create a separate office where disabled people who have been labeled terminal will be sent to be coerced to death without regard for their mental health or access to home and community-based services and case management to assist them with the adjustment. As disabled citizens who are so at risk from this law, we want you to understand that we have the right to be free from a danger created by the state to increase and encourage our suicide.

In addition, the bill removes compliance with many ordinary standards of care in medicine and shuttles people to doctors who cannot be held responsible for egregious actions or malpractice they might engage in, just like Dr. Kevorkian, who ignored Thomas Yoke as he begged him to stop. When asked later, Dr. Kevorkian said, [he] never could understand a thing that guy said. We asked the sponsors to pull this bill and proceed with the important work of strengthening hospice. [Exhibit G]

Chair Orentlicher:
We will go to Las Vegas.

Henry Rex Greene, Private Citizen, Las Vegas, Nevada:
I am board-certified in hematology, oncology, hospice, and palliative medicine, and I have nearly 50 years of experience caring for dying patients. I have given them aid in dying without handing out a lethal overdose. I have served on the ethics councils of the California Medical Association and the American Medical Association. Of the nearly 2,000 patients who have died under my care, yes, that is the number; a dozen requested enough pills to end their lives. None did so because simple counseling and a couple of doses of a mood elevator sufficed. However, there are terminal symptom crises, and I express my sincere sympathy with the Assemblymember whose father had such a terrible death. I wish I had been across from him at the poker table.

Now we hear from Oregon that they are doing this practice, which is euphemistically called MAID for anorexia, arthritis, blood diseases, non-lethal conditions, and non-terminal conditions. Oregon reports consistently at a 2.7 percent rate of referrals to psychiatry. In short, they have created a parallel medical universe in which a request for lethal drugs does not count as suicidality and is not even worth psychiatric evaluation. The range of outcomes in Oregon is from 1 minute to 137 hours. Think about that. Yes, the average is 2 hours, but 137 hours suggests that somebody performed a coup de grâce, and one minute suggests the patient could not possibly self-administer the medications per the terms of the law. The reasons for asking for this procedure were psychosocial issues known—

Chair Orentlicher:
You are over time.

Leslie Quinn, Private Citizen, Las Vegas, Nevada:
I offer my sincere condolences to the young man who spoke about his dad. I oppose A.B. 346. A 2018 article noted that the European country of Belgium has some of the most permissive laws regarding euthanasia of any nation in the world. Now, Belgium allows children of any age to choose euthanasia. Within two years of that article, three children, ages 17, 11, and 9, chose euthanasia. One child had cystic fibrosis, another had muscular dystrophy, and the third had a brain tumor. Doctors decided there was no hope for these children or reason for them to continue living, so their lives were ended at their request. That same year, over 4,000 Belgian adults, most of whom had cancer, chose euthanasia as well.

My dad passed a few years back. He had debilitating rheumatoid arthritis, amongst other issues. He was a Korean War veteran and served our country with everything he had. When dad was done taking his numerous pain medications, he courageously refused his medications to pass naturally. More recently, my mom has been in hospice for several months, suffering from debilitating dementia and Alzheimer's. Hospice had 42 different medications available to end her life, but none to help sustain it. During mom's final hours, she was offered oxygen to help her breathe but not water or an IV. Two-thirds of our bodies are made of water, right? Both mom and dad loved life. They wanted to live and not take

their lives; they respected how precious life is. Mom passed in February of this year. I was right next to her when she took her last breath, and she said, Yahweh Yahweh, the God of all creation, who she believed in with all her being.

Assembly Bill 346 is a doorway in support of people ending their lives at will. Simply put, it is murder under the guise of compassion. Why are we not a generation of people who encourage one another to live full lives and add value to one another? Each one of us has so much to offer others. We should not think of life as disposable. Legislators, if you honor life and humanity, please oppose A.B. 346. Fight for the sanctity of life before there is no turning back in the legislative justification of exterminating humanity. I oppose A.B. 346. It legislates others—

Chair Orentlicher:
You are over time.

Jesus Marquez, Co-Founder and Executive Director, American Christian Caucus:
We are a faith-based grassroots organization that works with dozens of churches in Clark County as well as northern Nevada. I want to begin by acknowledging the deeply personal stories shared here tonight, especially from those who experienced the pain of watching a loved one suffer. I honor your grief.

As a Christian organization, we believe in the sanctity of life, not just as a theology but as a lived value. Every life, no matter how fragile or dependent, has meaning and dignity. That said, I stand respectfully in opposition to A.B. 346. Though intended as compassion, this bill opens the door to abuse, legal conflict, and emotional pressure on those who are already vulnerable. We have seen how the elderly and disabled can feel like a burden. This bill risks reinforcing that lie. It could also cause family disputes over whether someone was truly of sound mind. In our communities, we walk with people through their final days. Those moments, though hard, often bring healing and even spiritual reconciliation. Assisted suicide cuts that short. True compassion does not rush people towards that. It walks with them, offering hope and dignity. For these reasons, I respectfully urge you to vote no on A.B. 346. Thank you, and may God give you the wisdom to decide properly.

Kerry Enright, Private Citizen, Las Vegas, Nevada:
I want to go back 2,000 years and read a passage from the Hippocratic Oath. With regard to healing the sick, I will take care that they suffer no hurt or damage, nor any man's entreaty prevail upon me to administer poison to anyone. Neither will I counsel any man to do so. This is a foundational document of Western civilization. We are the kindest, most compassionate, most merciful civilization on the face of the earth, and we have been that way for 2,000 years. This is not just another bill. This is a fundamental change in the direction of our civilization, and we should not go that direction.

Point number two: you do not know when life is going to end. We had a woman in our parish three years ago who publicly announced that she was expecting imminent death because she had stage four cancer. She is now living happily with her family in New Jersey three years later.

Point number three: the testimony in favor of this said this is going to be purely voluntary. Baloney. We had a very dear friend in Canada who was propagandized into MAID, and every time we talked her out of it, she kept on repeating the same propaganda over and over. We tried to say to her she was valuable to us, but she was totally brainwashed. This is not a voluntary thing. This is a propaganda thing. Finally, what is the whole reason for this whole thing? Well, one of the supporters of the bill spilled the beans. She said this costs the state nothing. Guess what? This is the reason for the bill. Let us kill this one more time. [Exhibit H]

Chair Orentlicher:
Before we continue, are you Miss Brianna Hammon? We are going to come back to Carson City and let Miss Hammon provide testimony.

Brianna Hammon, Private Citizen, Reno, Nevada:
Do you know how depressing it is to come here every session to try to prove I am human and deserving of life? I am sure by now you have all seen Elon Musk raising the Nazi salute and referring to me and those like me as the "parasite class." Then, President Trump seeking to cut $880 billion from Medicare and Medicaid. The purpose is no different than the Aktion T4 killing centers, where Hitler started with people who had disabilities.

Chair Orentlicher:
We will go to the phones.

Daniel Smith, Private Citizen:
I can appreciate the individuals going through difficult times with the elderly or those who have chronic or terminal illnesses. I came back from overseas, and my mother was terminal. As a matter of fact, the day I got back, hospice was brought in. Three days later, she had passed, and she was a survivor of cancer for eight years, but it came back. That afternoon, my mother and I prayed together, and I told her it is okay. You can go home to our Heavenly Father. That evening, she passed. She was on pain medications and so forth, but there was no way she was going to leave without seeing her grandchildren. I am a veteran. I have seen death. Right now, I have a rare autoimmune disorder. I am on a number of medications, but today, I am functional because of the technology and the research that has been done. I oppose this bill wholeheartedly for my personal reasons and my faith, and I heard someone who was supporting this bill saying this is not suicide. I believe it is, and in my faith and my understanding of my Lord Jesus Christ, my Lord and Savior, this suicide is a sin. I wholeheartedly oppose this bill. Thank you for letting me share, and God bless.

Katrin Ivanoff, Private Citizen, Las Vegas, Nevada:
I am here to express profound disappointment that, once again, this was proposed last time and is proposed again. We have so many problems that need to be solved, and we are talking about the same issues, and it is not a helpful bill. There are places that pass that bill, such as Canada, which is the closest to us in many ways. How about we wait another five or six years and see because so far, they have been literally killing their own population for no good reason. So far, there are those coming from Canada who are not very optimistic, and it is not something we should be bringing to our population. I am very disappointed with the legislature. They are thinking of everybody else but Nevada. They are passing a bunch of bills, trying at least, to support people from other states, to support illegal aliens; yet, when it comes to Nevada, they want to kill us. It is mind-boggling. I apologize, but I am very upset, and the testimony was quite long [unintelligible]. I hope you go back to Vegas. There are a lot of people in Vegas waiting to say something. I do not believe you are looking at NELIS. Over 90 percent of the people who testify in NELIS oppose this bill. Do you really care about our opinion because it sure does not seem like you do? Please oppose this bill. Do not let it out of Committee.

Brianna Cowan, representing Douglas County Republican Central Committee and Douglas County Republican Women:
We are speaking today to express our unwavering opposition to Assembly Bill 346. Assembly Bill 346 is not a compassionate measure. It is a deeply troubling piece of legislation that undermines the sanctity of life, erodes medical ethics, and places Nevada on a dangerous path of normalizing state-sanctioned death. At its core, this bill allows physicians and nurses to prescribe lethal medication to patients under the assumption that their lives are no longer worth living due to terminal illness. It turns a personal tragedy into a sterile, bureaucratic procedure masked in language like autonomy and choice. Let us be clear: A.B. 346 is not about autonomy. It is about surrender. It is about giving up on people at their most vulnerable. Instead of offering care, support, and counseling, this bill makes it easier to end life than it does to preserve it. It threatens the elderly, disabled, mentally ill, and those struggling through the dark moments of a terminal diagnosis. It places tremendous pressure on those who already feel like a burden to their families, society, and the health care system.

We must not open the door to quiet coercion where the path of least resistance becomes death itself. It erodes trust in medical professionals, and the public rightly expects their doctors will work to heal them, to ease their suffering, and not to end their lives. There are no safeguards enough to eliminate abuse; no form of protocol or checkbox will prevent vulnerable people from making irrevocable decisions in moments of fear, depression, and misinformation. Once a life is ended, no regret or clarification can bring it back. I urge you to reject this legislation. Nevada should be a state that champions life at every stage. We must stand for life, for dignity, and for true compassion.

Ian McIntosh:
On behalf of members of Nevada and as a Canadian with disabilities living in America, I urge you to oppose A.B. 346. Ableism takes many forms like legislatures that discuss real health care bills by deferring to authoritative organizations, but when talking about assisted

suicide laws, ignore the overwhelming body of opposition, which raises the incredulous idea that all national disability organizations with a position—the American Medical Association, the American College of Physicians, the National Council on Disability, and the United Nations Committee on the Rights of Persons with Disabilities and its treaty based on the Americans with Disabilities Act—that are in reception of all available verifiable data are wrong while you are right. That is definitional ableism, which requires limitless terminologically, elasticity, and camouflage, rendering words and promises meaningless, including terms like MAID, which intentionally cover assisted suicide and its intended iteration, euthanasia.

Jack Kevorkian had no problem calling it by what it is and noting it is not the era of eugenic origins as something positive, saying, I believe that there are people who are healthy and mentally competent enough to decide on suicide, and intense emotionalism engendered by the concentration camp atrocities of World War II has unfairly stigmatized this honorable concept.

Speaking of breathless comments to the Nevada compassion and choices representation that the goal is to improve the quality of life. Well, a CNCDDI advisor from Washington, D.C., said something different in a Maryland paper last year. Quote: I know in the black community, we are still fighting to live. We do not get adequate health outcomes to begin with, so it is hard to say, Okay, let me offer you this option when you have not been given the support you need to live. Precisely. Because it is an obvious moral failing to fight for people to kill themselves in a vacuum created by lawmakers who should be the loudest voices in the room fighting for them to live. On behalf of Not Dead Yet Nevada, please confirm your opposition to the idea that suicide is rational just because you have a disability by opposing A.B. 346.

Chair Orentlicher:
We will do one more caller.

Kenneth Wilson, Private Citizen:
I am here today to voice my opposition to A.B. 346 and also as a father of a child with a disability. Paying doctors, nurses, and pharmacists to kill our patients is absolutely the antithesis of health care. We are already seeing unscrupulous, low-standard doctors who will do any type of surgery and provide any type of treatment, no matter how unethical or controversial, so long as it pays. If we allow doctors and nurses to kill their patients or set up devices that will allow their patients to kill themselves, guess what? Hospitals are going to become places where people go not to be cured but to obtain the means to die. Doctors and nurses are not going to be people whom we trust for health but rather potential executioners who look upon their patients as dollar signs. This is already happening in some of our Nevada hospices as patients' deaths are hastened so that hospices do not have to repay the government for patients who live longer than a year.

Physician-assisted suicide has gotten so bad in the Netherlands that people actually carry a do not euthanize me card in their wallets because of mistrust for their so-called health care system. Couple this with people who have power of attorney over elderly and handicapped family members, and this is a recipe for disaster. Have we forgotten Terri Schiavo, whose parents in America watched helplessly and in horror as her husband withheld food and water from her until she died a horrific death two weeks later, thanks to legislation and litigation just like this bill? This bill suggests that physician-assisted suicide is not to be considered "mercy killing, euthanasia, assisted suicide, suicide, or homicide." But that is precisely what this is. Once again, legislators are attempting to rename the killing of people as something other than the killing of people, citizens of Nevada. We absolutely, and with healthy resolution, reject this bill.

Chair Orentlicher:
We have time for one more testifier in Carson City.

Kathleen Rossi, Private Citizen, Reno, Nevada:
I am a registered nurse. This bill claims to address two end-of-life concerns: pain and suffering and patient autonomy. However, I feel it fails on both accounts. Many who support these laws do so after a bad experience with the death of a loved one. I think it is important to acknowledge this sometimes is due to a misunderstanding of the natural dying process. I have seen this in my career, where certain breathing patterns and bodily changes can appear distressing but are not necessarily painful. A wise hospice nurse once said we labor into life, and we labor out. What looks disturbing to us is not always suffering. When real suffering at death does occur, and it certainly can, and I do not doubt for a minute Mr. Dalia's testimony, this is due to inadequate hospice care, not an inherent flaw in the dying process.

The answer is not lethal drugs but better-funded hospice and training for nurses. Having assisted four family members in the last five years through their hospice journeys, I can testify that hospice care varies widely and expertise varies widely. The answer is not to pass laws such as this. I believe they send a message to nurses that they would rather pay for a bottle of pills than invest in your expertise and time, and to patients, your care is too hard, too long, and we really need to speed up the process.

Remember, autonomy is only one of the four core medical ethical principles. The others being malfeasance, beneficence, and justice. We do not have time to go into how they are all held in tension, but true patient choice means having access to quality care and support. Ironically, once these bills become law, patient choice does become lost and given to those who pay the bills. This is not progress. I take issue with saying there is no escalation. That is simply not true.

Chair Orentlicher:
I am sorry, but I need you to wrap up.

Kathleen Rossi:
I just want to say one more thing. It has expanded. Last week, the United Nations Committee for the Rights of Persons with Disabilities urged Canada to roll back euthanasia. The fact that Canada is now combining assisted suicide with organ donation is beyond disturbing. I ask you, as lawmakers, to remember hard cases make bad laws. It is your duty to ensure that laws protect the vulnerable and not place them at greater risk. Please invest in true compassionate hospice care and not assisted suicide.

[Exhibit I and Exhibit J were submitted in opposition but not discussed and are included as exhibits for the hearing.]

Chair Orentlicher:
I am sorry that we do not have time for more, but I do want to get a count. If you wanted to testify in opposition and did not get a chance, please stand up. We will get a count also in Las Vegas if you could stand up. It looks like we have nine here. Sorry to those of you who did not get a chance to testify. You can submit written comments and we will certainly share them with the Committee members. There are 19 or 20 individuals in the room in Las Vegas. We have about 30 who were not able to speak, and we know there are a few more on the phone.

We now have time for neutral testimony. Does anybody want to testify in neutral here in Carson City? [There was no one.] Is there anybody in Las Vegas for neutral? [There was no one.] Is there anybody on the phones for neutral testimony? [There was no one.]

[Exhibit K was submitted in neutral but not discussed and is included as an exhibit for the hearing.]

Assemblymember Dalia, would you like to make any concluding remarks?

Assemblymember Dalia:
Thank you for a long, emotional night. We have heard a lot of opposition here tonight, but I think much of it overlapped the things we addressed at the outset. There are concerns about a slippery slope and other concerns that just have not come to pass in places where this is legal. I think a lot of care has been put into what this bill is. I think it was mischaracterized a few times tonight. I just ask the Committee to look at the facts, look at the language of the bill, look at the data, and please support this bill. It is going to help a lot of people.

Chair Orentlicher:
This concludes our consideration of Assembly Bill 346. We will now take public comment, also limited to two minutes, and please remember that public comment is not about the bill. It is about the general topic for the Committee.

Melissa Clement, Executive Director, Nevada Right to Life:
I do not want to talk about the bill. I do want to talk about the process. This is a select committee. From what I understand, you wanted to do a combination select committee that would have limited any kind of opposition to just a few people. This is a monumental decision you folks have in front of you. It would seem to me that it is worth listening to people who made the time today with very few days. What was it? Monday, we found out this was going to happen. This is a legislative process. You guys have such incredible power. I urge you to look at those people who are down there. They took the time. It seems to me that you could at least listen to them. You do not have to agree with them, but for gosh sakes listen to them. That is what your job is. You are elected to listen to them.

Chair Orentlicher:
Again, you may submit written comments. We would love to have more testimony, but please submit it in writing. If you did not get a chance or if you want to expound on what you said in your testimony, please submit it in writing, and we will look at it. Is there any public comment in Las Vegas?

Cristiane Mersch, Private Citizen, Las Vegas, Nevada:
I am a board member of Nevada Right to Life. I want to echo what Melissa Clement just said. It is very frustrating, this process, because we had a lot of people who arrived here at 4 p.m., one hour before we signed the sheet, we did everything according to the process. We had so many people via Zoom who were not even here in Nevada testifying. This is ridiculous. I am just upset. I am an immigrant in this country. I love that we can give our freedom of speech, and I feel censored. I feel censored because people took their time, and here we are again; we vetoed this bill years ago. Here we are again because this is a concern—the community. This is not about economics; this is not about doctors; it is the community, and you need to listen to your community.

Tim Underwood, Private Citizen, Las Vegas, Nevada:
I am a board member for Moms for Liberty, Clark County. I am a disabled Navy veteran who has been suffering from a debilitating brain injury since 2017. I have to say this. It is inappropriate for Committee chairs to threaten jail time for alleged false evidence presented to this Committee. You threaten us citizens of the great state of Nevada to intimidate us. This is a first when you say it is a misdemeanor to present false evidence to this Committee that evidence that opposes your false narrative is what actually is happening. And you quote this law about a misdemeanor. I want to ask, are legislators also subject to criminal penalties if they present false evidence to this Committee? Are they?

Chair Orentlicher:
Well, we have the same rule for everybody who speaks in testimony. Is there any other public comment?

Tim Underwood:
So, if I lie with false evidence, I can go to jail, and if you do, you go to jail too?

Chair Orentlicher:
I am sorry. This is not a question and answer. This is for you to make public comment. If you are finished with your comment, we can move to the next person.

Leslie Quinn, Private Citizen, Las Vegas, Nevada:
I am here to speak on the First Amendment. The First Amendment of the *U.S. Constitution* protects our five fundamental freedoms for all U.S. citizens: the freedom of religion, speech, press, assembly, and the right to petition. This is my public opinion, we are here to present—please do not weaponize your position as a legislator to silence—

Chair Orentlicher:
You may talk about the topic of this Committee. The First Amendment is not part of this Committee. Next, please.

Chris Marquez, Private Citizen, Las Vegas, Nevada:
You are asking everybody to come here and speak. You are limiting all of us. There is a whole room. There is about 30 people sitting here waiting. We all heard the time limits that you were going to give us to speak, and then you limit us. There was not enough time for all of us to speak. Why cannot we all speak? Do you have a whole opposition? There is a whole room of opposition. There are mothers here with their children. I came with my children here to speak on this particular bill. Why can we not have the time to speak? Can you answer that? Can you tell us why?

Chair Orentlicher:
This is common. I think everybody recognizes their time limits, and we would love to have all the time in the world, but we do not. And I am sorry. That is why we accept written statements. So please, all of you who did not get a chance to speak, send us your statements in writing, and we will read it.

Kimberly Johnston-Wednesday, Private Citizen:
I am a veteran. I am a parent. I am concerned about these issues and to be told this is not a First Amendment issue. I have waited here for hours with my newborn so I can discuss my feelings and opposition towards this bill. This is heinous to me. My whole family is down here so we can show support for what we, your constituents, believe. Get in NELIS, pay attention, read our comments. I feel extremely disrespected. I have witnessed people yawn, stretch, and look otherwise disengaged. As a voting member in this state, I am beyond myself that this is how we are being treated, and that is all I have to say.

Chair Orentlicher:
We look forward to seeing your comments in writing.

Grace Trujillo, Private Citizen, Henderson, Nevada:
I am a public health nurse, and I represent all conservative nurses. I am kind of disappointed; we prepared our speech. We took our time here, and you just gave us this false promise that you guys are going to read. I am 100 percent, you guys will not take time to read because you

did not even take time to listen to us. How much more reading? If you will not even take time to listen to us when we are here, why would we even believe that you take time to even read our notes? You guys are very hypocritical because what you are asking is respect from us, but you guys do not even respect the people who voted you in there. When you guys are putting laws that you guys are not even respecting the voice of people because you guys all have a motive, not for us, but for whatever motive, money-wise, you guys are doing. This is really disrespectful. If you want some respect, please respect the voice of the people of Nevada.

Chair Orentlicher:
I will remind you, we heard more testimony in opposition than in support. We do read. We are respectful of you, and we look forward to your written submissions.

Theresa Sharp, Private Citizen, Las Vegas, Nevada:
Ditto to what was just said. That was basically what I was going to say. May I suggest that public comment time be expanded moving forward? There are a lot of things that need to be said, and reading something on a piece of paper does not have the same effect as it does when you are in front of a microphone with your emotion and your passion about situations. So, please, I ask you if you would consider expanding time for when you want public comment on bills.

Danielle Evans, Private Citizen, Las Vegas, Nevada:
More of a question since there did not appear to be anyone who was neutral on the topic, and there was time allotted for neutral opinions, and there is time for public comment. Is it possible, since there are several people who have testimonies prepared in opposition to the bill, to translate that time instead for us to present our testimonies?

Chair Orentlicher:
We have used up all the time, I am sorry.

Danielle Evans:
Okay, thank you.

Chair Orentlicher:
Do we have any callers for public comment?

Katrin Ivanoff, Private Citizen, Las Vegas, Nevada:
I want to ask the Committee to really, really look into the NELIS results. To make it feel like you guys are listening to us because obviously, you hear the testimony, nobody you heard, nobody feels, and I understand you give more time for the people in opposition. But in comparison, we had a lot more people for opposition, and there was a lot to uphold on that bill. Honestly, can you please start making laws that are not restricting our constitutional rights, that are thinking about Nevadans, stop making laws that are beneficial for people from other states and people from other countries, and use our taxpayer dollars for providing benefits to people who did not pay into the system. I do not know. What do you believe your

job is? Are you guys serving the special interest people? I am really mind-boggled because if you really are there to support your constituent opinions, I do not see that happening. I am sorry; I am really upset with what is going on with this deal and the other deals. I hope you start listening to us. Thank you so much for staying that long.

Chair Orentlicher:
Next caller? [There was no one.] We have one more person here in Carson City.

Lisa Bedotto Laughlin, Private Citizen, Reno, Nevada:
I am glad I came down today even though I was not able to give my testimony in opposition, and I will submit it in writing, but I will say that the experience was a little disappointing that we did not get to speak and that the time that was allotted for neutral was not given to those in opposition. It felt disrespectful, and I heard something the other day on television, and today just made it so clear—everybody has a lobbyist except the people. No one listens to us. That is how it feels. Thank you for being here tonight.

Chair Orentlicher:
Thank you for coming. Before we wrap up, are there any comments from the members of the Committee before we adjourn. Thank you all for your participation. Seeing no further business before us, this meeting is adjourned [at 7:17 p.m.].

RESPECTFULLY SUBMITTED:

_____
Traci Dory
Committee Secretary

APPROVED BY:

_____
Assemblymember David Orentlicher, Chair

DATE: _____

EXHIBITS

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.B. 346	C	Elliot Malin, Private Citizen, Reno, Nevada	Conceptual Amendment
A.B. 346	D	Illia Ludwig, Private Citizen	Support testimony
A.B. 346	E	Various individuals	Letters of support
A.B. 346	F	Kirk Bronander, Private Citizen, Reno, Nevada	Opposition testimony
A.B. 346	G	Deidre Hammon, Private Citizen, Reno, Nevada	Opposition testimony
A.B. 346	H	Kerry Enright, Private Citizen, Las Vegas, Nevada	Opposition testimony
A.B. 346	I	Bradley N. Kehr, Government Affairs Director, Americans United for Life	Letter of opposition
A.B. 346	J	Various individuals	Letters of opposition
A.B. 346	K	Fred E. Avera, Private Citizen, Reno, Nevada	Letter in neutral