

**MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES**

**Eighty-second Session
March 14, 2023**

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:33 p.m. on Tuesday, March 14, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. [Exhibit A](#) is the Agenda. [Exhibit B](#) is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Fabian Doñate, Chair
Senator Rochelle T. Nguyen, Vice Chair
Senator Roberta Lange
Senator Robin L. Titus
Senator Jeff Stone

GUEST LEGISLATORS PRESENT:

Senator Edgar Flores, Senatorial District No. 2

STAFF MEMBERS PRESENT:

Destini Cooper, Policy Analyst
Norma Mallett, Committee Secretary

OTHERS PRESENT:

Annette Logan-Parker, Founder and CEO, Cure 4 The Kids Foundation, Division
of Roseman University of Health Sciences
Wiz Rouzard, Deputy State Director, Americans For Prosperity-Nevada
Erin Rook
Samantha Trad, National Director of Care Advocacy, Compassion & Choices
Action Network
Sara Manns, Compassion & Choices
R. J. Erickson
Corey Carroll, M.D., Compassion & Choices

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Clare Johnson, M.D.
Hanna Olivas
Dan Diaz
Lynda Brooks Bracey
Kim Mazeres
Herb Santos, Jr.
Kirk Bronander, M.D.
Kathleen Rossi
Theresa DeGraffenreid
Barry Cole
Melissa Clement, Nevada Right to Life
Janine Hansen, State President, Nevada Families for Freedom
Joy Trushenski
Cadence Matijevich, Washoe County
Joanna Jacob, Clark County
Lisa Parte
Jim DeGraffenreid
Leslie Quinn

CHAIR DOÑATE:

We will open the hearing with Senate Bill (S.B.) 221.

SENATE BILL 221: Revises provisions relating to Medicaid. (BDR S-951)

ANNETTE LOGAN-PARKER (Founder and CEO, Cure 4 The Kids Foundation, Division of Roseman University of Health Sciences):

I am the Founder and CEO of Cure 4 The Kids Foundation, and I am also the current Chair of the Nevada Rare Disease Advisory Council and have submitted my background presentation as ([Exhibit C](#)). I have been in Nevada for 25 years and have been in the healthcare industry the entire time.

Senate Bill 221 is a very simple solution to a complex problem that we have in southern Nevada as it relates to how children access care for pediatric oncology and other rare disorders [Exhibit C](#).

The history of Cure 4 The Kids Foundation is a direct result of my own experience with my son who had a catastrophic medical situation. Thankfully, he is healthy and productive now as a Clark County firefighter. Although our journey was a success in the end, it was full of frustration, heartbreak and pain

that lead to financial ruin. More importantly, it gave me an entirely new perspective on how children with cancer and rare diseases should be cared for.

We are here to talk about provider types found in my presentation ([Exhibit D](#)). Currently, the southern Nevada childhood cancer program is restricted to a Provider Type 20. We are hoping to amend the Medicaid Services Manual to include an additional provider type to add specific language for a billing guide and rate methodology for outpatient childhood cancer and rare disease centers. The goal of this bill is to ensure that the billing guide and associated administrative burdens are more in line with how kids with cancer are currently treated in today's environment. Currently, there are 16 specialty clinics listed under Provider Type 17 for Nevada Medicaid. This bill would add an additional provider type into a system that already exists and would allow us to create a billing guide and rate methodology that is better suited to the care provided in today's environment. It is a simple solution to a complex problem.

SENATOR TITUS:

Was a fiscal note submitted with this bill?

MS. LOGAN-PARKER:

Yes, there is a fiscal note that was submitted by Stacie Weeks from the Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (Medicaid). I have not had a chance to look at it, but can tell you that Richard Whitley, Director of the Nevada Department of Health and Human Services and the entire team at Medicaid, as well as the managed care organizations who manage Medicaid beneficiaries, are all onboard with having this new billing guide. Specifically, it would relieve many administrative burdens associated with it. I am happy to provide some of those examples.

CHAIR DOÑATE:

What are the frustrations you have encountered as an organization? It is essential for Committee members to understand that while we are trying to work through the fiscal process, it is important to convey how that plays down to your organization and why this is significant.

MS. LOGAN-PARKER:

Primarily, the rules that we must follow are based on what would be considered healthy children. For simplicity purposes, we give nephrotoxic chemotherapy in our center every day, which means that it is toxic to the kidneys. The billing

guide indicates that a urine analysis can be done within a certain period. We often do eight to ten urine analyses in that same period to ensure that we do not damage the kidneys, which could result in a kidney transplant or even end of life for that child. What happens is we either are denied, then appeal, and there is all this administrative back and forth. Another example is when the billing guide indicates that children with fee-for-service Medicaid are only allowed so many high-complexity visits within a period. Every time a child comes to our center, it is a high-complexity visit. It puts a huge burden on the State and the provider because we must go through the process of denying and appealing. A tremendous amount of labor expense is spent on both sides to provide the children with what is considered standard of care. I could provide more examples.

SENATOR TITUS:

This bill is trying to establish that if you change your provider type via Medicaid, you could get reimbursed for some of the cost of providing the care you already do.

MS. LOGAN-PARKER:

Yes, and to alleviate the back-and-forth administrative burdens, which are immense in our healthcare system.

SENATOR TITUS:

How many other agencies administer this type of care?

MS. LOGAN-PARKER:

We are the only ones in southern Nevada.

SENATOR TITUS:

There is no other agency in northern Nevada?

MS. LOGAN-PARKER:

In northern Nevada, childhood cancer is treated through Renown Regional Medical Center, which is more of an outpatient system. Care in southern Nevada is accessed very differently than in other parts of the Country.

SENATOR TITUS:

How many providers do you think it would affect?

MS. LOGAN-PARKER:

It affects Cure 4 For The Kids Foundation. We currently employ all of the practicing pediatric oncologists in southern Nevada.

SENATOR STONE:

Thank you for bringing this forward. We are talking about the pediatric population. You do not want to be caught in getting treatment authorization reviews and making sure the kidney function is sufficient for a nephrotoxic drug. I am in favor of giving you the latitude to have the appropriate billing codes and provider designations to provide this necessary service for our kids. We do not want any delays in therapy.

WIZ ROUZARD (Deputy State Director, Americans for Prosperity-Nevada):

We believe State-run health care, such as Medicaid and Medicare, should be limited and accessible to those who are most vulnerable in our society, I am presenting my written testimony ([Exhibit E](#)). We urge you to vote yes on S.B. 221.

ERIN ROOK:

I am here to testify in support of S.B. 221 as an individual. This bill will help to ensure that Medicaid covers children with cancer and other rare health conditions and have access to the care they need. We are lucky to have an organization like Cure 4 The Kids finding creative solutions to address the limited resources available to families struggling with these conditions. The least the State can do is to ensure that these critical services are appropriately reimbursed so that they can continue to be available to children who need them.

As an adult with a rare genetic health condition, I understand how difficult it can be to find a healthcare provider with the knowledge and experience to provide your care. I have a disease called epidermolysis bullosa (EB), a rare genetic skin condition that can be debilitating and even fatal for children who inherit two of the affected genes. I only have one of the affected genes and did not require specialized care as a child. However, even as an adult with a milder form of the disease, I have never seen a provider who is familiar with my condition. There is only one specialist in the entire Country who treats adults with EB, and he is not in Nevada. Until the State's healthcare infrastructure evolves to meet the needs of Nevadans, it is imperative that we use all the tools at our disposal to bridge the gaps in care. Passing S.B. 221 is an important piece of the healthcare access puzzle and I urge your support.

CHAIR DOÑATE:

Hearing no testifiers in opposition or neutral, we will close the hearing on S.B. 221. We will now open the bill hearing on S.B. 239, which will be presented by Senator Edgar Flores.

SENATE BILL 239: Establishes provisions governing the prescribing, dispensing and administering of medication designed to end the life of a patient.
(BDR 40-677)

SENATOR EDGAR FLORES (Senatorial District No. 2):

I am joined in my presentation by three additional individuals: Samantha Trad, Dr. Corey Carroll and Sara Manns. They are experts in this area and will provide a detailed breakdown of the bill along with additional anecdotal information about what is happening across the Country. They will also provide detailed testimony as to what is happening in Nevada with some of our constituents. I have had an opportunity in the last four years to speak with many folks who are passionately for and against this bill. I am incredibly respectful of everyone's position because I understand some individuals have passionate beliefs grounded and rooted in religion, and I respect that 100 percent. I have discussed this with my own family and engaged in that conversation for some time because it was also important for me to get buy-in from them.

Six years ago, I did not agree with this conversation. I had not yet gone through a personal encounter, an emotional relationship that focused me. It forced me to engage in this conversation in a way I had not done before. It was no longer anecdotal but was now personal.

I remember having this dialogue with my family. The question that was posed to us at that time was, how much suffering is too much? When we talk about suffering, who gets to decide? Is it we, the family, forcing a human being to suffer up to their very last breath? Does that serve our own egotistical desire to keep that individual for that additional second, regardless of how painful it may be? It was balancing that question with the second question, which is, are we engaging in the discussion of living versus dying? I argue that we are not. It is not deciding between living and dying but controlling your fate when you have a terminal illness. It is having the basic human opportunity and right to say, I will decide with this last breath how I will go out. That is incredibly important. I needed to get there and live through that experience to get to a place of comfort. I came to a very emotional stance in 2021. I have changed because

I allowed myself to attend conferences on palliative care. I thought that was important because I did not have that component in my own presentation, my own discourse when we talk about the end of life.

When I went to these end-of-life symposiums, it was important because I spoke to people who deal with palliative care every single day. Something that made me feel even more confident in engaging in this conversation is that they were talking about three key elements. First, the scenarios where individuals have a terminal illness and take many medications to numb their pain. They take so much medication that they can no longer have a coherent conversation with their loved ones. They no longer know who they are or who is in the room with them. They described the scenario of individuals that take so much medication to numb the pain that the medication itself ends up being what kills them. They talked about scenarios of individuals who suffer and are in so much pain that they are found in a bedroom with a gunshot to their head because they could not live another second with that suffering.

Second, they talked about another aspect of dying, which is directly in line with what we are talking about today. They said when you are at the very last second of your life, do you want to be in a cold room with doctors and nurses that you do not know, listening to the sounds of machinery to keep you alive just a little bit longer. Do you want smells you do not recognize, food you do not know, and not being surrounded by your loved ones?

Third, they talked about how palliative care has a responsibility of being compassionate and that those should not be your last memories. We need to make sure that folks are going back to their homes, that they are in their backyards and are surrounded by the people they love. They should have the food they care about, the smells they are familiar with and the voices they want to hear and remember.

I realized that we were going to engage in this conversation again in 2023. I want to debunk three issues we are going to hear today. One, is that we are choosing life versus death. When you have a terminal illness and you are suffering every single second, you are not choosing between life and death; you are simply choosing how you want to die. Two, palliative care has, in an indirect way, been part of this conversation for a long time. You will hear from individuals who will talk about family members who numbed the pain to the point they were no longer themselves.

Three, you will hear from individuals—and we will debunk this notion—that somehow doctors will find reasons to kill patients. That is not the case, and our experts will break that down in a detailed manner. They will provide all the anecdotal State and nationwide evidence to prove that doctors are not killing their patients.

Last, I say this to my own family who endured this conversation, I am grateful to them for giving me the opportunity, on behalf of our family member who had to go through a very horrible situation, to present this bill again on their behalf.

SAMANTHA TRAD (National Director of Care Advocacy, Compassion & Choices Action Network):

I first met Senator Flores at a symposium that was put on by the City of Hope. One in five Americans currently has access to this peaceful end-of-life care option, as shown in my presentation ([Exhibit F](#)). The first medical aid-in-dying law went into effect over 25 years ago. We have the good news that this law has been around for a long time, and we have data from many health departments. We have hard-based evidence to support this bill.

Currently, 11 jurisdictions have authorized medical aid-in-dying legislation as shown on the map in [Exhibit F](#). The dark blue states have all authorized aid-in-dying and people can access the law in those locations. The teal blue states are considering legislation, including Nevada.

What do I mean when I use the term medical aid-in-dying? You may know this as death with dignity. However, we do not call it death with dignity anymore because a dignified death is up to the person. It does not have to be medical aid-in-dying. This is one of many end-of-life options that are available to people. It is also not euthanasia or assisted suicide. There is no assistance in it, and it is not suicide; in fact, that is in the bill language. This is quite different from suicide. Medical aid-in-dying is a compassionate end-of-life option that a person can get if they are terminally ill with six months or less to live.

You will hear from two mothers who live in Las Vegas and have terminal illnesses. They desperately want the option of medical aid-in-dying in Nevada. Three out of four Nevadans support medical aid-in-dying. We live in an age where people cannot agree on anything, and if you look at these statistics, they are amazing. The majority of every demographic and most Democrats, Republicans and Catholics support the option of medical aid-in-dying. One thing

we all have in common, even though we do not like to talk about it, is that we are all going to die. People want to have the full range of end-of-life options available to them.

This is an incredibly important bill. Medical aid-in-dying is a widely supported end-of-life option that provides dying people with peace of mind and comfort during a challenging time. While only a small number of people will choose to use the option, it is a prime litmus test to patients of person-directed care. It exemplifies a medical system that respects patients by allowing them to assert their values and priorities as death approaches.

The main eligibility requirement to start the process is you must be an adult and must be terminally ill with six months or less to live. This is for people who are imminently dying. You must have the mental capacity to make informed medical decisions. This is something you must ask for repeatedly in the process and you must fully understand what it is you are asking for. You also must be able to self-ingest the medication. Again, there is no assistance provided. From all the data we have from departments of health and states that have this law, they have the same data point. About a third of the people who go through this entire process to get the medication never actually take it. Just having it gives the patients a huge sense of relief to know that they have this option should their suffering become unbearable.

I am going to talk about the steps from a patient's perspective and then we will go over what practitioners must follow. Beyond the eligibility requirements, a person cannot start this process unless the steps to qualify for the prescription are followed. The first step is an initial verbal request followed by a minimum of a 15-day waiting period. A second verbal request is made to the attending practitioner, who is the main prescribing practitioner. A consultation with the attending practitioner is conducted, and I will talk about what they are going to discuss with the patient.

The patient must then be evaluated by a second consulting practitioner. The patient will see two different practitioners, one of them two times on three different visits. A written request signed by a qualified witness, who must meet certain restrictions, is completed.

During the initial consultation, the attending practitioner goes over the diagnosis and prognosis with the patient. They will also talk about available methods of

treating or managing the terminal condition, including comfort care, hospice care, pain control, and the risks and benefits of each method. This is informed decision-making. I would want my doctor to review everything available to me so I can make an informed decision including the risks and benefits of self-administering the medication and the fact that death is the result.

The attending practitioner refers the patient to a consulting practitioner. They inform the patient that there is no obligation to take the medication. The attending practitioner does this a couple of times, and the patient can change or decide not to take the medication at any time. As we have heard from the statistics, a third of them do not take it. The attending practitioner instructs the patient against self-administering the medication in a public place. They refer the patient for comfort care, palliative care, hospice care, pain control or other end-of-life care if requested or as clinically indicated.

The consulting practitioner is the second practitioner that the dying person must meet with. They confirm that the patient has requested a medication designed to end the life of the patient. They confirm the attending practitioner's determination, considering whether the patient meets the requirements of the law. All end-of-life options in S.B. 239 are shown in my summary provided ([Exhibit G](#)). Again, the patient must be 18 years of age, diagnosed with a terminal condition with a prognosis of six months or less to live. The patient has made an informed and voluntary decision to end their own life, is competent in making an informed medical decision and is not requesting the medication because of coercion, deception or undue influence.

Other provisions of the law—including wills, contracts, insurance and annuity policies—are not affected. Medical aid-in-dying is not considered suicide or assisted suicide. No physician, healthcare provider or pharmacist is required to participate. No one must take part in this process if they do not want to. Healthcare providers receive civil and criminal immunity. Unused medication must be disposed of as required in Nevada. This is a terminally ill patient, so they will have many other medications that also require disposal.

Medical aid-in-dying is optional for the patient and optional for the doctors. No person is required to use it and no doctor is mandated to provide it. It is illegal to force someone to use it. Medical aid-in-dying improves end-of-life care. Studies show that medical aid-in-dying is part of palliative care. When people

receive their medication, it helps ease their fear and worry. They are not forced to go down the trajectory of their terminal illness. The people who are requesting medical aid-in-dying do not want to die, but their terminal illness has determined that path for them.

Medical aid-in-dying helps far more people than those who choose to use it. As Senator Flores said, we hear from people who tragically end their lives when they cannot access the option of medical aid-in-dying. This helps families and it helps the person have a peaceful end of life, if that is what they choose and they qualify.

Data show that over 10,000 people received prescriptions for medical aid-in-dying from 1997 to the end of 2021. This represents far less than 1 percent of the people who die in each jurisdiction. Very few people chose the option of medical aid-in-dying, but it is important they have that choice. Over one-third of people who went through the entire process and obtained the prescription never took it. They have peace of mind from simply knowing that if their suffering became too great, they would have the option. Most terminally ill people who used medical aid-in-dying, more than 87 percent, received hospice services at the time of their deaths according to annual reports for which hospice data is available.

Terminal cancer accounts for most of the qualifying diagnoses with neurodegenerative diseases, such as Lou Gehrig's disease or Huntington's disease, as the second leading diagnosis. On the way to this meeting, my Lyft driver told me that she has Huntington's disease. She asked me what I do for a living, and we had a conversation. She said that one of her biggest fears was that she was going to have to go to California to access their law. She knew all about medical aid-in-dying, which I was not surprised about. A lot of people know about this law. She has Huntington's disease and she wanted to come here to testify today, but she could not. She lives in Sparks, Nevada, and was grateful that we are presenting this bill, hoping so much that it passes. We cannot wait any longer. We need to pass it for people like Julia. Finally, over 90 percent of people who use medical aid-in-dying can die at home, which is where most Americans would prefer to die.

According to numerous studies over 25 years, there have never been substantiated incidents of coercion or abuse. This is not a new bill and is not a

new law. Countless people have had peace of mind by having the availability of this option.

SENATOR TITUS:

The person you spoke about with Huntington's chorea disease would not be eligible for this medication. I have taken care of many Huntington's chorea disease patients that have lived over a decade with this diagnosis. Within the scope of this bill, it is not a six-month diagnosis, just to be clear, and hopefully, you informed her of that.

Ms. TRAD:

I did inform her and said you must have six months or less to live.

SENATOR TITUS:

Section 4 of the bill talks about signing the death certificate. I have signed multiple death certificates in our State. We do them online now and there are multiple lines to complete including the immediate cause of death. Most of the time it is a respiratory arrest, a hemorrhage or a heart attack. Then it asks if there were other things affecting this death, such as diabetes, heart disease, and so on. Under this bill, we are obligated to say what their primary diagnosis was and that is counter to how we typically sign the death certificate. It also allows a physician assistant to sign the certificate.

Before I came today, I asked our legal counsel for clarification on the following. Senate Bill No. 227 of the 79th Session expanded who could sign the death certificate. That gave the authority to nurse practitioners but not physician assistants. This bill would dramatically change that. You are expanding the scope of a physician assistant to now sign the death certificate. You are mandating that if I was the attending physician, to falsify the record and say they died from something they did not die from, because that disease may have gone on for six months or more. Could you clarify those two things for me?

SARA MANNS (Compassion & Choices):

We reviewed this recently and the point that you raise about physician assistants not being able to document a death is correct. That was a drafting error, and we plan to correct it throughout. The other point that you raised, which is the death certificate question, is to think about the purpose of a death certificate. It is to legally document that the person died. It is to indicate

the cause of death so that epidemiology can study and prevent disease. That is the purpose of a death certificate.

As for the mechanism of death, if someone discontinued dialysis, you would not say that their cause of death was the discontinued dialysis. You would say they had renal failure. Similarly, what we are asking to do here is to have the death certificate reflect the underlying cause of death. That is the same terminal illness that makes the patient eligible to even ask for this option in the first place. The reason for that is the legal aspects that Ms. Trad raised about making sure that people's insurance can pay off and protect the patient, but it is also to protect the physician. This is extremely important because if we allow discretion in describing this practice of the patient self-administering a medication as suicide or potentially as homicide, it opens a realm of problems in the criminal arena where we do not want to go. That is the other reason. It is also to protect the physician to make sure they are covered with this practice.

SENATOR TITUS:

You mentioned the coroner's case and part of this bill says you cannot investigate that. How do we know it is not a homicide if we are not able to follow the accurate chain of events?

Ms. MANNS:

That is an excellent question, and we are working with attorneys at the National Association of Counties to determine how we can rework this language so that their concerns, which are the same ones you just raised, can be covered.

CHAIR DOÑATE:

The only request I have is when you make that determination, please communicate that to the Committee members because it is important for us to make sure of that clarification if the bill moves on.

SENATOR STONE:

Obviously, we want to ease the suffering of those that have been given the horrific diagnosis of a terminal illness. There are two questions that come to mind that scare patients. One, are they going to be in pain and are they going to suffer? Two, are they going to be a burden to their family?

As a pharmacist, I received my doctorate and specialized in pain control. I dealt with hospices and started a hospice in California. We have many resources. We have morphine and dilaudid, which is 7 times more potent; fentanyl, which is 100 times more potent; and pseudo fentanyl, which is 1,000 times more potent. You are right that people want to die in their homes and be surrounded by their loved ones. I am a huge fan of palliative care. I have seen it work and I want to ease the suffering. We should not use financial resources as a reason people should take their lives because they do not want to be a financial burden to their family.

This is a complicated bill. As healthcare professionals, we are not vetting the bill as carefully and comprehensively as we should. We have so many people that want to testify on this bill in Las Vegas and they cannot go to the Grant Sawyer Building to testify because all the roads are closed due to the President being in Las Vegas today. With that said, I am going to honor the one-question rule, but I have many. In section 24, subsection 1, paragraph (b) says that you must have a witness sign the written request for the medication for the end-of-life therapy. Can that witness be a family member and an heir to the estate of the future deceased?

MS. TRAD:

The written request for the medication must be signed by the patient and one witness who cannot be: related to the patient by blood, marriage or adoption; entitled to any portion of the estate of the patient upon death under a will or by operation of law; an owner, operator or employee of a healthcare facility where the patient is receiving treatment or a resident; the attending practitioner; or an interpreter for the patient. This language is from section 24, subsection 1, paragraph (b) of the bill.

SENATOR STONE:

Thank you for the clarification and that is an important protection. You stated there were no issues of coercion since the idea of patient-assisted suicide was enacted over 25 years ago. During my presentation in California on the same bill, I mentioned many examples of coercion that were prosecuted either by the state of Oregon or the state of Washington. I am going to try to find that information and will give it to the Chair to present to you. There were cases of coercion and that is why we need to vet this bill so that we can have an honest debate and make sure that we are getting our facts straight and understand what we are putting into Nevada statutes.

MS. TRAD:

There has never been a substantiated incident of coercion, so I would like to see that information. California's bill passed eight years ago, and we have about seven years of data from that state that is also evidence-based and shows this is a good bill that has been tested and has all of the evidence to support it. We also have peer-reviewed studies about pain management, but I can wait unless there is a specific question.

CHAIR DOÑATE:

If you can refer those documents to the Committee members, that would be great as a follow-up.

SENATOR NGUYEN:

We have such a limited time as part-time legislators and this is Senator Stone's first time going through the Nevada legislative process. There are thousands of bills that are introduced and during the Eightieth Session, there were about 539 bills that made it to the Governor's desk. We have limited time, but I appreciate and have spoken with Senator Flores, as I am sure the Committee members also have. They are truly willing to work to make sure this bill is heard, and they are listening. They are taking the comments from the Committee members, as well as the testimony of support and opposition and those questions that are proposed during public comment to make this the best bill possible.

CHAIR DOÑATE:

Senator Flores, can you give us an idea of how many times this bill has been introduced? Have you had a hearing before?

SENATOR FLORES:

We have had support and opposition now at least five separate times before the Nevada State Legislature. In fact, it has moved out of the Senate, and it has moved out of the Assembly. It has been in both houses, and we have done ample vetting. At one point, I was unsure if I supported this bill, and I have been here long enough and have discussed this for so many years now that I have had an opportunity to even shift my position. People that are going to be in opposition today have been in opposition four times already. I am respectful to our Senator's comments and understand that he has not had an opportunity to be here that long, but this conversation has been going on for many years, not just 30 minutes, but many years in this Legislative Body.

CHAIR DOÑATE:

We will move on to hear testimony in support, opposition and neutral. I will allocate 15 minutes to each of those. Each testifier will be allowed two minutes and if it goes over two minutes, I will need to stop you to allow other testifiers to make their comments. You are encouraged to send your written testimony, especially regarding this bill, to our Committee staff so we can accurately reflect your testimony.

R. J. ERICKSON:

I wish I were here under better circumstances. I am the proud son of Dr. John Marshall Erickson, former OB-GYN in Reno, Nevada who was a strong advocate of this bill. Tragically, he lost his life due to Stage 4 lung cancer two months ago to the day. I am here to not only speak on his behalf and advocate for this bill, but also in my personal experience in seeing his end-of-life journey shortly after the New Year. He asked my son, mother and me to begin this journey and, as selfishly as we wanted to hold onto him every minute we could, we did not want him to see him suffer, struggle, lose his dignity, and go through a tortuous path.

We began the end-of-life journey with hospice. Even though the hospice nurse was very gracious and empathetic towards our situation, the expectations that were set and laid out for us were not what we were expecting and certainly nothing that came to fruition. During his end-of-life journey, I was personally responsible for mixing his methadone and morphine. I was slowly killing my father. Over the five-day period before he finally went into a medicine-induced-coma, there were episodes of hysteria and delusion. The breaking point was after the fourth day, when he asked his hospice nurse under this delusion if they had found a cure for his Stage 4 lung cancer. It was not what I was expecting to happen. He wanted a peaceful and painless passing and this is not something anyone should have to endure. Being a physician himself, he would have loved a more peaceful passing to save his dignity.

COREY CARROLL, M.D. (Compassion & Choices):

I am here supporting S.B. 239. I am a board-certified family physician in private practice in Fort Collins, Colorado. In January 2022, I also began as a part-time National Medical Director for Compassion & Choices. I am one of the attending physicians that will prescribe this medication.

Over the seven years since the law passed in Colorado, I have personally helped 12 patients control their end. I have also had the opportunity to attend each death. I do not have time to go into all the individual stories, but in my experience as well as the stories I have heard from my colleagues, this compassionate medical intervention is not inconsistent with the practice of medicine, nor is it detrimental to the physician-patient relationship. I have had situations like we just heard; physicians have been in the hospital and watched the patients die. That is not humane, especially if there is another way out.

In June 2019, the American Medical Association (AMA) adopted a new policy. For the first time, the AMA affirmed that physicians could provide medical aid-in-dying without violating their professional obligations. The preceding year, the Academy of Family Practice changed its policy to be neutral on medical aid-in-dying. Despite multiple attempts to reverse that body's decision in the subsequent years, that policy remains. A polling of physicians in Colorado regarding medical aid-in-dying showed that 56 percent of the members were in favor while 35 percent were opposed. Last month, Dr. David Orentlicher and I made presentations to the Nevada Family Physicians at their annual meeting in Lake Tahoe. Physicians were very receptive to the presentations, and medical students and residents took that back to their institutions for more discussion. The previous week, I presented to the Nevada Medical ...

CHAIR DOÑATE:

Thank you so much for your comments. Unfortunately, we must move on to the next testifier. Please submit your written testimony to the Committee secretary.

CLARE JOHNSON, M.D.:

I am an emergency room physician and live in Reno with my husband and daughter. I see a great number of patients suffer at the end of their lives. I see patients lose their ability to eat as stomach cancer takes over their bodies. I have seen men who are 6 feet 2 inches, weighing only 130 pounds at the end of chemotherapy. I am relieved to know that Nevada is once again considering a bill that would honor the options of terminally ill people to decide how and when they die when death is inevitable. It has become evident to me that with great medical advances, we have also created great suffering. We live longer but often not better. It is our moral imperative as a society to give options that alleviate the suffering. We have embraced hospice. We must go a step further by passing this bill.

There is a common misconception that people die of natural causes in the last six months and often go peacefully. That is untrue. Some of us will die after days of dehydration and weeks of starvation as we lose our ability to swallow. That is how my dad died in 2020. A co-worker in California recently lost a family member after a battle with metastatic cancer. In the end, she could not eat and was bedbound. California, fortunately, has authorized medical aid-in-dying. She then died in the comfort of her own home with her loved ones by her side. I ask you to set aside your personal beliefs and consider passing this bill. We owe it to the diverse population of Nevada to provide diverse options at the end of life.

HANNA OLIVAS:

This is my third time speaking on the medical-aid-in-dying bill. I am currently a patient in Las Vegas, Nevada. I was diagnosed in 2017 with a rare cancer called multiple myeloma. I am a mother of 5 children, ages 10 to 30. This is a discussion I have had with my entire family since diagnosis. I was told I had five years tops for this incurable disease that I have. I have surpassed that. I have watched several other people with similar diseases utilize the bill in other states. Since I have been diagnosed, I must travel outside of Nevada to receive proper medical care because I have a complex cancer.

I have had open conversations with my family, friends, children and husband, who all support the decision that I would use medical aid-in-dying. What saddens me the most and what is the most important part about this bill is that this is such a personal decision and should be a personal decision between the patient, family and doctors.

It disappoints me that this is my third time testifying and I am currently going through treatment. I am coming here today to again plead with people who do not really understand a terminal diagnosis. If you did, you would hear what we are saying. This is not a suicide bill. This is us, as patients, asking perfect strangers to hear our voices and understand what we are saying. When that time comes and we have done everything humanly possible to fight the disease, and doctors are telling us that there is nothing left that we can do, then we should be allowed to utilize ...

CHAIR DOÑATE:

Thank you for sharing your story with us, however, we must move on to our next testifier. We appreciate it if you could please submit your written testimony to the Committee Secretary.

DAN DIAZ:

I am Brittany Maynard's husband. My wife died on November 1, 2014, and she was only 29 years old. Brittany experienced a gentle dying process only because of the option of medical aid-in-dying. Yes, my wife utilized the very program that we are discussing today. I am testifying in support of S.B. 239. Brittany's case received significant media attention because we had to move from our home in California to Portland, Oregon, so that she could access Oregon's law. Had we stayed in California at that time, the brain tumor would have tortured her to death. In contrast to the hypotheticals, and many times, the false narratives that the opponents tried to attach to the medical aid-in-dying, I have lived this experience. To be clear, a terminally ill individual that applies for this option is not giving up. They are not suicidal, and they are not deciding between living and dying. The option of living is no longer on the table.

Opponents seem to ignore that a terminally ill Nevadan that is in Brittany's predicament, has only one option and that is between two different methods of dying. One is gentle, the other can be filled with unrelenting suffering. Brittany felt incredibly protected throughout the entire process of applying for this option because getting through this process is not easy. Those safeguards are real.

I want to emphasize the importance of palliative and hospice care. At the end of her life, Brittany's team played a huge role in helping keep her comfortable, but modern medicine cannot control pain and suffering in all cases. Any assertion by anyone that they can control suffering in 100 percent of the cases is patently false. I can line up physicians, nurses and hospice care workers to refute such an arrogant claim. The people of Nevada deserve better than what Brittany had to endure. No one in Nevada should have to ever leave their home and move to another state to ensure a humane process.

LYNDA BROOKS BRACEY:

I am 57 years old and live in Las Vegas. I prefer not to die at this particular time. Unfortunately, even though I consider my age quite young, my diagnosis says differently. I have been diagnosed with metastatic pancreatic cancer. My

doctors and I have done all that we can do. I have been through numerous rounds of chemosurgery and everything else that could have been done. I am terminal. I very much believe that people in Nevada want and need S.B. 239. This bill may not become law in time for me, but I believe it should become law for those in need. There are many people in Nevada in need right now. I am a strong believer in the circle of life. I am a believer in God. I know that it is my time, but I do not think that my family or I should have to see me suffer.

I am a strong believer in hospice and palliative care, which I am currently on. They do a wonderful job. What they see and what they must go through as physicians in palliative care and nurses in hospice is unbelievable, and they do a phenomenal job. But, as others have stated, they cannot do everything, and they cannot guarantee a lack of suffering.

People say to me that I am interested in this bill now because I am ill. The reality is I became a widow very young. My husband passed away at age 38 from leukemia. My kids and I watched him suffer 20 years ago and not much has changed here in Nevada since that time. He had wonderful medical and hospice care in Nevada. Nonetheless, we watched a young man pass away in great pain because there were no other options. Most of us in Nevada, as in other states, want all the choices that are available. Senate Bill 239 gives us those options.

KIM MAZERES:

I am a retired executive from the utility industry, having lived in northern Nevada for over 40 years. My husband Steve loved life. He was a determined, intelligent and caring man, a devoted father and grandfather, a veteran who late in life went to law school, spending the best days of his career at the Washoe County District Attorney's Office.

Our wonderful marriage of 30 years took a drastic turn in 2017. Steve was in his fifties when doctors initially diagnosed him with chronic obstructive pulmonary disease. He spent years without disruptive symptoms until the spring of 2017 when he had a life-threatening event.

Steve's best hope was a lung transplant for which he opted. He did well for a year, but something kicked off chronic rejection and it was continually harder for him to breathe, but he continued treatments that could stop the rejection. During this entire process, Steve wanted the option to decide when enough was

enough. We had numerous conversations about his end-of-life wishes, including a potential move to Oregon to access the state's Death with Dignity Act that would allow him to die peacefully, without unnecessary suffering. I was angry about the idea of uprooting ourselves to establish residency in a state where we have no family—a place that was not home for either of us. I do not know if Steve would have used the medication to die peacefully, but simply having it as an alternative in hand would have eased both of our minds. That assurance would have lessened the stress and fear of his pain and suffering.

Steve's last 24 hours were horrific. He was in a tremendous amount of pain, and I scrambled to enroll him in hospice. His pain was unbearable without a more serious opioid. They let us know they could apply a fentanyl patch, but it was likely that he might not wake up once it was applied. Steve understood and agreed to move forward. Less than 5 hours later, my husband of 30 years took his last breath on June 9, 2020.

I urge you to support the End-of-Life Options Act so terminally ill Nevadans will have the option to shorten their suffering at the end of their lives.

CHAIR DOÑATE:

We will continue with testimony in opposition to S.B. 239. Just as we did for support, we will allocate 15 minutes and we ask respondents to please remain within the two-minute period. If you are not able to meet those time requirements, of course, you can always submit your written testimony to the Committee Secretary.

HERB SANTOS, JR.:

I was born and raised in Nevada and have raised my family in Reno. I am here to oppose S.B. 239 because this bill is bad for Nevada and has the potential to harm the most vulnerable in our great State. What may appear to be an act of compassion is really a pathway to a system that would expand assisted suicide to the disabled and vulnerable people with non-terminal debilitating conditions. In addition, insurance companies would have free rein to manipulate the rules by denying life-prolonging, pain-reducing medications, and directing people to the cheapest choice of prescription for death.

In my workers' compensation practice, I witness insurers denying treatment and pain medication almost every day and using out-of-state doctors to deny treatment, which delays recovery and sometimes makes them give up. It is all

about money over people and, in this case, profits over people. Assisted suicide is the perfect vehicle for insurance companies to deny or delay treatment and pain medications and pocket millions of dollars. When delays and denials happen, folks simply give up. There is no protection for the multitudes of Nevadans that this could affect. What is equally alarming is that any safeguard in this bill to protect the vulnerable is hollow. The proponents advanced safeguards while, at the same time, lawsuits are filed. Proposed legislation is advanced in the few states where assisted suicide is illegal to remove the very same safeguards, claiming now that there are barriers that must be removed.

Currently, they are seeking to reduce these barriers by shortening the waiting periods, supporting mail-order delivery of death drugs, expanding who can make the requests, and eliminating self-administration of the death drugs. Once this suicide bill has become law, removing the safeguards is the next order of business. I respectfully implore you to not let them get their foot in the door. This bill is bad for all Nevadans. I ask you to vote no on S.B. 239.

KIRK BRONANDER, M.D.:

I am a board-certified internal medicine physician and have practiced here for over 20 years. Senate Bill 239 is flawed legislation and I have submitted my written testimony ([Exhibit H](#)).

KATHLEEN ROSSI:

I am a retired registered nurse, worked in critical care and have taken care of hundreds of dying patients in my 36-year career. I am proud of the fact that I have helped people die well. It is disconcerting that this hearing was added to the agenda with only hours for us, the opponents, to get here. The disabled community was not able to show up today. I ask that you let them speak to you privately when they can. I left the bedside of my sister who is dying of a brain tumor as I speak. My sister was given 18 months to live and that was 14 years ago. This is another millionth example of doctors getting the prognosis of timing wrong.

The fact is when we are sure that a person has entered the dying process, we can be exceptionally good at taking care of them. Assisted suicide is not necessary for what these people are claiming it is needed for. What is needed is better funding for hospice and palliative care and not for this option, which will prey on vulnerable victims. Assisted suicide laws are based on the desire for patient autonomy, which is a high medical priority but is never the only one.

Laws should be based on the common good and its effects on society. The unintended consequences of these laws are no longer conjecture at this point. The slippery slope is occurring in Canada and Europe where euthanizing, not assisting death, is taking place. This is not for simple things, but a mental illness or someone who could not get the care that was due to them. Ethical boundaries in the medical profession have existed since ancient times for a reason. The power you think you are creating with this law, you are giving away to physicians and, in this bill, less educated physician assistants. The push to allow physician assistants to do this should be a huge red flag. I also want you to listen to the disabled community ...

THERESA DEGRAFFENREID:

I am a citizen lobbyist testifying on behalf of myself and all vulnerable citizens of Nevada that in the future may be faced with a decision like the one that you are proposing. I have submitted my letter of opposition to this bill ([Exhibit I](#)).

BARRY COLE:

This bill is flawed for two major legal reasons. First, it is an Americans with Disabilities Act violation. What do you do with the man with locked-in syndrome? What do you do with a man with a cervical cord injury? How do they self-administer? It is already discriminatory on its face.

Secondly, you have mistaken competence for capacity. As a psychiatrist, I determine capacity. I have no say about competence. That is assumed to exist until a judge takes it away from someone. I am an AMA Epic Trainer and was trained in 1999 to train other physicians in end-of-life care. I have taught many AMA classes to the American Academy of Pain Management, which I founded, along with the Academy of Hospice Physicians.

I have cared for over 300 people until their death, and I can assure you not one of them ever asked me to kill them. I have had a few family members ask how the dying process could be sped up, but not the patients themselves. They died comfortably. With boards in psychiatry, boards in pain management and a residency in neurology, I can usually keep people's pain well controlled. We have gotten better techniques through the years, such as blocks and interventional procedures. I understand what is motivating this, but 2,500 years ago, we wrote the Hippocratic Oath. The first thing I swore when I took that Oath is that I would not give people poison. That is a clear, bright line for me. Maybe not for other healthcare professionals, but it is for me.

MELISSA CLEMENT (Nevada Right to Life):

I am looking at the screen in front of us and it says thank you for considering this bill. Can you say that you are considering this important bill? Let me tell you what happened today. I woke up at 7:15 a.m. and before I got in the shower, I noticed nothing on the Senate Committee on Health and Human Services agenda today. Fortunately, when I got out of the shower, I got my personalized legislative tracking report, which is the only reason anyone is here today. That was the first time anybody heard that there was this important bill being heard today.

You do not see any disabled people behind me. They are one of the communities that are most impacted by this bill, and they are always at this hearing. I called them today, and they had no idea about today's hearing and needed 48 hours notice. Whatever happened to accommodation? On your own agenda it says you give accommodation. I also point out that when I found out that we would have testimony, we were only going to have a bit of time to speak, as opposed to what the testifiers on the other side got. I talked to the Committee staff and asked if we could turn in additional testimony. She said absolutely not, nothing will be accepted after this meeting, so I ask the Chair, please allow people time to turn in additional testimony.

CHAIR DOÑATE:

I can reset your time if you want to talk about the policy of this proposal.

MS. CLEMENT:

There are a number of problematic concerns that will impact our State: the fact that there is no physician requirement and no residency; no established relationship between a patient and a physician; and no screening for depression. If anyone has ever walked the walk with a loved one, like I have many times, depression is something they deal with. My dad was at the age of 88 when he was given a three-month diagnosis of terminal cancer. Ten years later, he passed away after sitting on the Assembly Floor and that was the greatest honor he ever had. Doctors do not know when the end is coming, and no one here is considering the real issue with depression. Suicide is something we have far too much of in our State. I oppose S.B. 239.

CHAIR DOÑATE:

Before we proceed, I did stop the clock very quickly. With no disrespect for this part of the opposition testimony, we are solely focusing on the policy options of

this bill. I would ask the community that if you are going to be talking in opposition or neutral as we go through this process, you refrain from comments that you have spoken to my staff and just focus on the sole policy of this proposal. We will ask that from everyone on all sides of this bill.

JANINE HANSEN (State President, Nevada Families for Freedom):

I have been a citizen lobbyist in this building for 50 years and I am appalled at the short notice that was given to us. My written opposition ([Exhibit J](#)) to S.B. 239 has been submitted.

JOY TRUSHENSKI:

I am a non-paid lobbyist, a Navy veteran and live in Carson City. I oppose S.B. 239 as it could be a slippery slope and lead to the murder of someone with dementia, depression or physical disabilities. Insurance companies and the government have supported assisted suicide to save money by pushing lethal drugs which are less expensive than treatment. It is money over people. Additionally, the real cause of death, assisted suicide, is not put on the death certificate. This will obscure the number of deaths by assisted suicide. Please vote no on S.B. 239 to protect the elderly, depressed, disabled and vulnerable populations.

CHAIR DOÑATE:

That concludes our rounds of opposition. We will now go ahead and offer the same 15-minute allocation for those who are neutral on this bill.

CADENCE MATIJEVICH (Washoe County):

My comments on the bill today are not about the policy of the bill. The Washoe County Board of County Commissioners has not taken a policy position on this bill, but I am here in a neutral position. I hope I am good with the rules because we do have some technical things that we think are important for the Committee to hear. I had an opportunity to speak with the bill sponsor earlier and have made him aware of these concerns. I made a commitment that we will work with him if the bill moves forward.

If it is the decision of this Committee to move this legislation forward, we have some concerns about the duties and authorities of coroners and medical examiners. Sections 3 and 4 of S.B. 239 partially address this, but unfortunately, did not get all the way there. A separate statute, *Nevada Revised Statutes* (NRS) 259.050, addresses the coroner's duty to investigate. There are

provisions within that statute that would need to be amended to come into alignment with this proposal. We ask that we be involved in those discussions if this legislation moves forward.

JOANNA JACOB (Clark County):

I concur with the comments from my colleague at Washoe County. I am also here on behalf of our coroner in Clark County with the same technical input on this bill. We also were able to speak with Senator Flores and the bill proponents on this. We are committed to working on these issues should this bill move forward. Again, these are the issues in sections 3 and 4 about the duties of the coroner. We may also be looking at the coroner's duties in NRS 259 because we investigate causes of death that may be unrelated to this decision by a patient. We want to ensure it conforms with the statute's duty. Again, we are not here on the policy of the bill, but more on a technical concern, therefore, we are neutral.

MR. ROUZARD:

I am testifying as a private citizen in neutral regarding S.B. 239. I applaud the bill sponsor for bringing this forward as it is an important discussion and a balancing act between individual rights and, more importantly, vulnerabilities. In section 23, subsection 1 it says a patient must be at least 18 years of age. My first question is why a minor has not been included, let alone a minor who has been emancipated.

Secondly, section 23 also says that a patient must have a diagnosis of a terminal condition and show competency. It is important to make clear how competency is determined and who makes that determination. In terms of the prognosis, the bill also states that the patient must be diagnosed with a terminal condition by two physicians. Why not three or four? Finally, in section 24, are there guardrails for individuals who might be indecisive? One minute they want it, last minute they pull out, next minute again they want it again, and then they pull out. Do we have any guardrails or processes to ensure that the individual is firm and competent in making the decision?

LISA PARTE:

My name is Lisa Parte and I am not neutral.

CHAIR DOÑATE:

We are currently in neutral right now. If there are any other individuals that would like to testify, we are currently in neutral testimony. If you would like to provide written testimony, either in support or in opposition, you can send it to the Committee staff.

Senator Flores, we heard patient privacy as a concern, and that is a valid concern with this legislation. There were concerns about the HIPAA Act. Is that something that has been raised in other states regarding patient privacy? Is there validity to that?

MS. TRAD:

The way that we protect patient privacy is by making sure that the death certificate lists the underlying illness so that they cannot be identified. That also helps the Centers for Disease Control and Prevention records so that people who are dying from different terminal diseases are rightfully counted in their collection of data.

CHAIR DOÑATE:

We talk about civil immunity for the physician that provides this service. Are there cases in other states where the patient is angry with the physician for not prescribing this medication because it is the physician's authority to do so? Have there been instances where they proceed forward with lawsuits and is that something that happens in other states?

MS. TRAD:

The law protects physicians, and they are allowed to opt out so patients cannot do that. If their doctor decides not to support the patient with their decision, then they must find a doctor who will.

SENATOR TITUS:

Contrary to what you just stated, section 37 distinctly says that the provider, if they are not willing to do this, must refer the patient to somebody who will. Does that mean I have to keep a list in my office of doctors, and if I do not refer the patient to a willing doctor, what will be the consequences? That is on page 17, line 7.

MS. TRAD:

The doctor is not required to support the patient through the process for medical aid-in-dying. It is important that a patient does not fall through the cracks and that they are able to be supported so that they can find a doctor who will support them. That is why the doctor should refer the patient to a doctor who will support them.

SENATOR TITUS:

This does not say that I shall or I am: it says I must refer them to someone. However, it does not clarify that if I am unwilling to do that, what is the civil liability if I do not support that patient's choices? Will they sue me for denying them access, and am I liable by the wording in this bill?

MS. TRAD:

I need to double-check our policy. I want to make sure I give you the right answer. I will research that and provide it in our written testimony.

SENATOR STONE:

I have tremendous empathy for those that have received a terminal diagnosis. I was with my mother until the very end, when at 57 years old, she died of metastatic breast cancer. I made sure my mom was comfortable until the end. Today, one of our testifiers mentioned what happens when somebody has a spinal cord injury and has no use of their arms or legs, or a person with Lou Gehrig's disease (ALS)? The legislation says you must self-administer the medications. How would somebody that has these disabilities self-administer?

MS. TRAD:

The eligibility requirements are important, and the patient must be able to self-administer the medication. There are three ways that can happen. One is the patient can drink the medication. Another is, if they have a feeding tube, they must be the one to push the plunger. They can also use an anal catheter if the patient is able to push the plunger. So that is how patients with ALS can access the law.

SENATOR STONE:

Who administers the liquid into the feeding tube? What if they cannot do it themselves and rectally it is unpredictable what your absorption is going to be? You can have a significant reaction where somebody has a prolonged death because they did not absorb the drug appropriately.

Ms. TRAD:

That is between the patient and the practitioner to talk about how they are going to do it. We do not want to legislate medicine either, because medicine changes. Every patient is different and there is not just one end-of-life medication. We need to make sure that the right medication is prescribed. We trust the practitioners to determine that with the patient.

SENATOR STONE:

You are saying that the cocktail that is going to end somebody's life is under the purview of the doctor. It can vary from doctor to doctor. It is not phenobarbital and atropine. It could be something else.

Ms. TRAD:

Yes, it is up to the practitioner; it is their responsibility. They are the ones who are treating the patient. To be qualified to be the attending or consulting provider physician, they need to be qualified to diagnose the terminal illness and the prognosis. They have that knowledge so they can do it. We also have a doc-to-doc consultation line. A doctor can talk to another doctor who has prescribed medical aid-in-dying, like Dr. Carroll who was here earlier and has supported many patients in this. There are many doctors who have a great deal of experience supporting patients in aid-in-dying whom we can connect doctors with, and they can mentor them if they have any questions.

SENATOR STONE:

In Oregon, they had a statistic a few years ago that between 15 percent and 25 percent of people did not die immediately and that it was a prolonged, torturous episode for a loved one to deal with. None of these formulas are 100 percent foolproof to extinguish somebody's life in a brief period.

Lastly, I wanted to bring up one example. A 64-year-old woman named B. Wagner from Oregon was diagnosed with breast cancer. A new drug came out that improved the efficacy and survival of breast cancer people by 30 percent. Oregon Medicaid had to be consulted because the cost of the drug was \$7,000 a month. The letter the patient received from the state of Oregon said that they would not cover this drug, but they would cover an assisted suicide drug. If this does pass in Nevada, I hope we do not send letters like that out to people and encourage them to commit suicide when there are viable treatments to save their life.

MS. MANNS:

This is a complex question as you and I have discussed about how State Medicaid formularies are determined and what would be driving that. I have sought care for my own rare cancer and insurance companies deny treatments constantly. This happens all the time. Unfortunately, when you are facing a serious illness, it is the worst time to have to fight about it. It is a serious problem in our system, and it has to do with the cost of prescription drugs more than anything. I do not think it has that much to do with this policy, and the idea that they sent that letter is shocking, but not surprising.

CHAIR DOÑATE:

We heard the discussion between competency and capacity. What is the feedback you have had in other states?

SENATOR FLORES:

I want to address competency in general. This is not something new to the medical community. People will talk about competency in palliative care, comfort care and hospice. What is competency? As an attorney, we have these conversations in court, whether somebody is competent to stand trial. There is no perfect formula to that but when we are talking about competency, the medical community will tell you there are varying definitions of that from doctor to doctor.

I am not pretending that there is a perfect definition and Senator Titus can speak to this; but in speaking with the medical community, there is a general discussion about whether somebody is competent or not. That is why it is important that we have two separate doctors because they are also making that assessment. They are not just looking at this individual and saying, does this patient have a six-month or less prognosis? Is there a terminal illness? They are simultaneously discussing whether this individual is competent to engage in the conversation. My point is that competency is defined, and our legal division can give us a specific section in the NRS. When a doctor realizes the individual is not competent, they are speaking with the family members or the guardian or speaking with many other individuals. That is a constant assessment that is always happening, not just in this dialogue, but always in the health community.

MS. TRAD:

Both the attending and consulting practitioner will work with the patient. They will go over competency. Like Senator Flores said, this is language we are

looking at in the bill. I do not know what happened with the drafting, but we are working on the language to make sure that it is correct before you vote on it. If there is any question about the patient's capacity or competency, they can refer the patient for a third evaluation by a mental health specialist. This is something that both the attending and consulting practitioners are qualified to evaluate. They are going to go through two different evaluations already and then, if there are any questions, they will refer the patient.

CHAIR DOÑATE:

Senator Flores, I am requesting from the people that helped you prepare for this bill presentation that it is important to address the instances of what Senator Titus alluded to, which are the obligations for a physician and the freedom that they also have in this capacity. That is something that must be addressed if you proceed with an amendment.

SENATOR FLORES:

We are working with people now on addressing some of the questions that were brought up, particularly in section 3. We are also working with the coroner's offices and are committed to ensuring that this bill comes out as clean as possible. There could be a hypothetical even in Senator Titus's question regarding what if no physician in Nevada wanted to do it. The intent here is not to create a harm for the physician, but to provide protection for the dying, suffering, human being to ensure that if one physician cannot help them, they are being referred elsewhere. What we do not want is for the dialogue to end there. That was the point of that section and why we put it there.

We understand that not everybody will agree with this discussion, and we are 100 percent committed to protecting the physicians' right to say no. Nothing in this bill requires any single human being to do anything. This is only creating an option for some human beings who will have a right to say when too much suffering is too much suffering. That is all this bill is aimed at doing.

CHAIR DOÑATE:

The hearing on S.B. 239 is closed. We will now move to public comment.

JIM DEGRAFFENREID:

I want to express my disappointment with the process and fairness of the process when hearings are scheduled on short notice well after the deadline for submitting written testimony has passed, and in conflict with other meetings to

give an advantage to supporters and make it as difficult as possible for opponents to be heard. It makes a mockery of the language in the bill that reads the people of the State of Nevada are represented in the Senate and Assembly. When only one side of the bill is represented, and are given an opportunity to participate, the results of the process will be suspect, and this benefits no one.

The lack of fairness and transparency is not limited to any bill or committee nor even to this Session. As we remember, numerous major bills in 2019 and 2021 were heard without notice and, therefore, did not receive fair hearings or proper vetting as well. I hope that this Committee and this Legislature will work towards a more transparent process that will foster respect for the results going forward.

MS. PARTE:

Thank you for allowing us to call in again for testimony. Again, my name is Lisa Parte and I am opposed ...

CHAIR DOÑATE:

I am sorry but we are currently in public comment. The time for commenting on the legislation has passed. We are no longer hearing testimony for S.B. 239. This is public comment. If there are other comments that you would like to make, now is the time.

LESLIE QUINN:

It is disturbing how our State, Country and government are becoming more immune to telling the truth and are okay with lying. I wish that we would stand up for honor and have more moral integrity in all things that we do.

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CHAIR DOÑATE:

We have received 8 letters in support of this bill ([Exhibit K](#)) and 11 letters in opposition ([Exhibit L](#)).

As there is no further public comment, the Senate Committee on Health and Human Services meeting is adjourned.

RESPECTFULLY SUBMITTED:

Norma Mallett,
Committee Secretary

APPROVED BY:

Senator Fabian Doñate, Chair

DATE: _____

EXHIBIT SUMMARY				
Bill	Exhibit Letter	Introduced on Minute Report Page No.	Witness / Entity	Description
	A	1		Agenda
	B	1		Attendance Roster
S.B. 221	C	2	Annette Logan-Parker / Cure 4 The Kids Foundation	Background Presentation
S.B. 221	D	3	Annette Logan-Parker / Cure 4 The Kids Foundation	Presentation
S.B. 221	E	5	Wiz Rouzard / Americans for Prosperity-Nevada	Written Testimony
S.B. 239	F	8	Samantha Trad / Compassion & Choices Action Network	Presentation - End of Life Options Act
S.B. 239	G	10	Samantha Trad / Compassion & Choices Action Network	End of Life Options Summary
S.B. 239	H	22	Kirk Bronander, M.D.	Written Opposition Testimony
S.B. 239	I	23	Theresa DeGraffenreid	Written Opposition Letter
S.B. 239	J	25	Janine Hansen / Nevada Families for Freedom	Written Opposition Testimony
S.B. 239	K	33	Chair Doñate	Letters in Support
S.B. 239	L	33	Chair Doñate	Letters in Opposition