Attachment K

Chairman Kagan and members of the committee, thank you for the opportunity to speak before you to you today. My name is Jeff Frant from Boulder County, and I am here to support HB16-1025"

I would like to make two points:

First, I find it helpful to look at the right of a terminally ill patient to chose medical aid in dying as a basic human right akin to those inshrined in the Bill of Rights of our Constitution: to freedom of speech, the press and religion, to equal protection of the laws, and to due process. HB 16-1025 would remove the myriad real world impediments a dying patient faces, those who want to live but, given their imminent death, seek doctor-prescribed medication to bring about a peaceful and dignified death at home surrounded by loved ones. To further explain this concept of choice at the end of life as a basic human right, I am submitting one of George Will's newspaper columns which appeared in the Boulder Daily Camera in 2015, wherein he discusses the Brittany Maynard case.

Second, I would like to address the objection to this bill raised by some that medical aid in dying is not necessary because, once patients who want to hasten their death get their symptoms controlled and their spiritual needs addressed, the overwhelming majority want to keep living. As a practical matter, access to cutting edge palliative care, to physicians highly trained and experienced in end of life counseling; to the hospice, and even to appropriate curative measures are often unavailable or ineffective for the dying person. The experience in California and Oregon is that just the existence of a legal medical aid in dying option has a positive effect on all components of the medical system as it relates to caring for patients at the end of life. To further explain this phenomenon, I am submitting a newspaper article which appeared in the Boulder Daily Camera in 2015 about the debate surrounding the passage of California's end of life options bill.

Thank you for your attention. I would be glad to answer any questions.

Commentary

Affirming a right to die

SAN DIEGO — Brittany Maynard was soon to die: The question was whether she could do so on her own terms, as a last act of autonomy. Dr. Lynette Cederquist, who regrets that Maynard had to move to Oregon in order to do so, is working with others to change California law to allow physician assistance in dying.

Maynard, a 29-year-old newlywed, knew that her brain cancer would fill her final months with excruciating headaches, seizures, paralysis, loss of eyesight and the ability to speak. Radiation and chemotherapy would have purchased mere months. "I'm not killing myself," she said. "Cancer is killing me." She would not put her loved ones through her cancer's depredations.

Advances in public health and medical capabilities for prolonging life — and dying — intensify interest in end-of-life issues. Reductions in heart disease and stroke have increased the number of people living to experience decrepitude's encroachments, including dementia.

"Dementia," Cederquist says, "is a whole different dilemma." Assisted suicide perhaps should be allowed only when survival is estimated at six months or less, but at that time persons suffering dementia have lost decisional capacity.

GEORGE WILL

Physician-assisted dying has been done surreptitiously "as long as we have been practicing medicine," says Cederquist, professor of internal medicine at the University of California, San Diego. Today, even in the 46 states without physician-assisted dying, doctors may legally offer "terminal sedation" — say, a life-shortening dose of morphine — when intense physical suffering cannot otherwise be satisfactorily alleviated. Some Catholic and other ethicists endorse a "double effect" standard: If the intent is to alleviate suffering but a consequence is death, the intent justifies the act.

Cederquist says the most common reason for requesting assistance in dying is not "intolerable physical suffering." Rather, it is "existential suffering," including "loss of meaning," as from the ability to relate to others. The prospect of being "unable to interact" can be as intolerable as physical suffering, and cannot be alleviated by hospice or other palliative care.

In some countries, doctors actively administer lethal injections. No U.S. jurisdiction allows doctors to go beyond writing prescriptions for life-ending drugs to be self-administered orally by persons retaining decisional capacity.

Almost 30 percent of Medicare expenditures are for patients in the last six months of life and about 16 percent of patients die in, or soon after leaving, intensive care units. Financial reasons should not be decisive in setting end-of-life policy, but Cederquist notes that reducing "expensive and inappropriate care" — costly and agonizing resistance to imminent death — "is the lowest-tech thing we can do in medicine." Hence the importance of "slow medicine geriatrics," avoiding a "rush to those interventions that build on each other" and thereby enmesh doctors and patients in ethical conundrums.

The American Medical Association remains opposed to physician assistance in dying; the California Medical Association has moved from opposition to neutrality. Litigation has been unsuccessful in seeking judicial affirmation of a right that California's Legislature should establish. Legislation to do this has been authored by Assemblywoman Susan Eggman, chair of the Democratic caucus.

There are reasons for wariness. An illness's six-month trajectory can be uncertain. A right to die can become a felt obligation, particularly among bewildered persons tangled in the toils of medical technologies, or persons with meager family resources. And as a reason for ending life, mental suffering itself calls into question the existence of the requisite decisional competence.

Today's culture of casual death (see the Planned Parenthood videos) should deepen worries about a slippery slope from physician-assisted dying to a further diminution of life's sanctity. Life, however, is inevitably lived on multiple slippery slopes: Taxation could become confiscation, police could become instruments of oppression, public education could become indoctrination, etc. Everywhere and always, civilization depends on the drawing of intelligent distinctions.

Jennifer Glass, a Californian who died Aug. 11, drew one. She said to her state legislators, "I'm doing everything I can to extend my life. No one should have the right to prolong my death."

The Economist reports that in the 17 years under Oregon's pioneering 1997 law, just 1,327 people have received prescriptions for lethal medications — about 74 a year — and one-third of those did not use them. Possessing the option was sufficient reassurance.

There is nobility in suffering bravely borne, but also in affirming at the end the distinctive human dignity of autonomous choice. Brittany Maynard, who chose to be with loved ones when she self-administered her lethal medications, was asleep in five minutes and soon dead.

Email: georgewill@washpost.com.

End-of-life option act

Laws accentuate need for palliative care

By Anna Gorman
Kaiser Health News

LOS ANGELES — More times than she can count, Dr. Carin van Zyl has heard terminally ill patients beg to die. They tell her they can't handle the pain, that the nausea is unbearable and the anxiety overwhelming.

If she were in the same situation, she too would want life-ending medication, even though she doubts she would ever take it. "I would want an escape hatch," she said.

This fall, California became the fifth — and largest — state to allow physicians to prescribe lethal medications to certain patients who ask for it.

Yet van Zyl can't see herself as one of those doctors.

"This is my life's work, to relieve suffering," said van Zyl, head of palliative care medicine at Los Angeles County-USC Medical Center. To her, that does not mean cutting short a life.

"I can't imagine pulling the trigger," she said.

Weeks after California Gov. Jerry Brown signed the "end-of-life option act" into law, palliative care physicians like van Zyl are trying to come to terms with what it means for them and their terminally ill patients.

It's not just a question of whether they support aid-in-dying or personally would ever help end a life. Palliative care doctors say the law underscores the need to raise awareness among doctors and patients about what they do and to expand access to high-quality programs.

Contrary to some patients' fears, they say, palliative care doctors are not there to hasten death. Their job is to help seriously ill people get relief from symptoms and stress and to improve quality of life for them and their families, regardless of how long the patients have to live.

The California law should be a "wake-up" call because it shows "how terrified patients are of what they will experience at the end of life," said Dr. R. Sean Morrison, professor of geriatrics and palliative care medicine at Mt. Sinai's Icahn School of Medicine in New York.

Morrison said that once patients who want to hasten their death get their symptoms controlled and their spiritual needs addressed, the overwhelming majority want to keep living.

"Their choice shouldn't be an assisted death or living with intractable suffering," Morrison said. "That's what laws allowing assisted suicide, in the absence of palliative care, present as a choice to patients."

Palliative care has become more widespread in recent years, and more doctors, nurses and social workers are being trained in how to provide it. In addition, recent legislation in California requires that Medi-Cal managed care plans ensure access to programs.


Heidi de Marco / Kaiser Health News
Dr. Carin van Zyl talks to patient Jose Garcia Flores on Oct. 13 about his treatment options for his advanced stage colon cancer.

But gaps remain. A recent report by the California HealthCare Foundation showed that residents in 22 of 58 California counties don't have access to community-based palliative care, and those in 19 counties don't have access to in-patient programs. Foundation researchers also found recently that specialists are in short supply and that there is no reliable way to pay for such care.

Dr. Ira Byock, a palliative care expert who opposed the California law, said its passage makes it more important than ever that all doctors receive more education on how to treat symptoms in seriously ill patients and talk with patients about what they want in their final months.

"As hard as illness and dying are ... people still have the capacity to experience the sense of well-being," said Byock, who heads the Providence Institute for Human Caring in Torrance, Calif.

Without palliative care programs, Byock and others say those conversations don't always take place. Only about 17 percent of patients have had end-of-life discussions with their doctors, though about 90 percent believe doctors should be doing so, according to a recent poll by the Kaiser Family Foundation. (KHN is an editorially independent program of the foundation.) In addition, research out of the Mayo Clinic found that only 12 percent of doctors had yearly end-of-life discussions with heart failure patients, and about 30 percent of the physicians had "little confidence" doing so.

Dr. Tony Back, who is co-director of the University of Washington's Cambia Palliative Care Center of Excellence, said that after a similar aid-in-dying law passed in his state, more doctors realized that they "couldn't just push it off on somebody else."

As van Zyl struggles with her own reactions to the new law, she continues to have those tough conversations with one patient after another, every day.

On a recent day, more than two dozen names were listed on a white board in her hospital offices — all of them patients referred to her team for care. A 33-year-old woman with metastatic breast cancer. A 50-year-old with pancreatic cancer that had spread to her lungs. A 20-year-old man with a fast-growing brain tumor.

One patient van Zyl visited that day was Jose Garcia Flores, a gaunt 60-year-old with advanced stage colon cancer. The former electrician had been diagnosed in the spring and was back in the hospital because of pain and nausea.

Van Zyl told him that there was a possibility that doctors would no longer be able to continue chemotherapy because of a complication. Van Zyl asked what he valued more — living longer, no matter what that looked like, or not living as long but being able to spend quality time with family at home.

"There is no right answer," she said, promising to do everything she could to ease his pain and control his symptoms, regardless of whether he wanted to continue treatment for his cancer.