Chair Representative Lindsey Daugherty and Vice Chair Representative Mary Young. My name is Dr. Cory Carroll, and I am a board-certified family physician who for 33 years has been and continues to practice medicine in Fort Collins. I am also a part-time medical director for Compassion and Choices. I speak in support of SB 068.

Since referendum 106 was passed and signed into law in 2016 I have been the attending physician for twenty-two patients seeking medical aid in dying and written prescriptions for nineteen. I have been at the bedside for all but one patient who ingested the medication and can tell you with certainty, those patients had good deaths. Seven years of experience by hundreds of Coloradoans demonstrates that the law works as intended.

Half of the patients who sought medical aid in dying were new to my practice. This was because their primary care provider chose not to or wasn't allowed to participate. Two weeks ago, a patient with end-stage COPD (emphysema) sought me out for MAiD. His primary care provider was a Physician Assistant. Although PAs are not included in this bill, Advanced Practice Nurses are, and allowing them to participate will lower this barrier.

Reducing the waiting time is critical. The patient described above asked his PCP and pulmonologist for MAiD months before finding me. On the 16th day after we established care he ingested the medications and had the peaceful death he wanted; at home surrounded by his wife, two adult children and their spouses. His wife shared that on three occasions during the waiting period she thought he was going to die of suffocation.

Finally, I care for patients who reside in Wyoming. Providing them with the end-of-life care they desire should not depend on their zip code. I do not restrict medical care to those patients, medical aid in dying should be no different.

SB 68 does not change the fundamental criteria or basic protections in the law. It simply addresses unnecessary restrictions that have made it harder for qualifying patients to access the care they want and need.

Thank you.

Cory D. Carroll, MD, Foothills Family Care, LLC

3213 Nelson Lane, Fort Collins Colorado 80525

cdc@drcorycarroll.com, office: (970) 221-5858, cell: (970) 2140787

COLORADO
CROSS-DISABILITY
COALITION

Dear Chair Daugherty and Committee,

I am submitting this testimony on SB24-68 on behalf of the Colorado Cross Disability Coalition and our nearly five thousand members statewide. CCDC is a statewide organization that advocates for social justice for people with all different kinds of disabilities.

We are testifying today in a neutral position.

As many committee members will likely recall, our organization and our community has had a long and uneasy - sometimes downright difficult - relationship with medical aid in dying. In a world where the needs of our community are routinely ignored, medical aid in dying is scary for many of us.

However, we recognize that Colorado's voters sent a clear message with the overwhelming passage of Proposition 106. Now that medical aid in dying is legal in our state, we see it as our mission to ensure that this option exists in the safest way possible and with the best guardrails as possible. Because of this, we are extremely supportive of the amendments adopted in the Senate, specifically the amendments that moved the waiting period in the bill from 48 hours to 7 days and the amendment that maintains the current statutory requirement that someone must be a Colorado resident to obtain a prescription. We also appreciate the amendment that clarified who can determine that a prospective patient is of sound mind. We believe that all of these amendments are fair compromises and with their adoption, CCDC officially moved our position to neutral.

We are incredibly grateful to the sponsors and the proponents for working with us on amendments and addressing the concerns we had about the bill.

Sincerely,

Hillary Jorgensen
Co-Executive Director
Colorado Cross Disability Coalition

Statement on SB24-068: Concerning end-of-life options for an individual with a terminal illness.

Charmaine Manansala, Chief Advocacy Officer, Compassion & Choices

House Health & Human Services Committee

Tuesday, April 2, 2024

Good afternoon, Chair and members of the Health and Human Services Committee,

My name is Charmaine Manansala. I am here today as a Colorado resident and a person living with a disability in support of medical aid in dying.

I have multiple sclerosis and was diagnosed in 1999. This debilitating disease has affected me physically with more than a dozen exacerbations, affecting my general wellness, mental health, energy, vision, speech, amongst others on and off over the last 23 years. It has also permanently taken away my use of my right hand and my mobility. I now use a wheelchair on a daily basis. Throughout my career, I have advocated on behalf of the community. Disabilities was amongst the issues in my portfolio as Senior Advisor to Speaker Nancy Pelosi when I worked in Congress.

I am also the Chief Advocacy Officer at Compassion & Choices Action Network. We are the nation's oldest and largest national consumer-based nonprofit organization working to improve the quality of end-of-life care. We advocate for legislation to improve the quality of care for terminally ill patients and affirm their right to determine their own medical treatment options as they near the end of life. On behalf of our Colorado supporters and terminally ill residents, thank you for considering this bill.

compassion & choices

Thank you for passing the Colorado End-of-Life Options Act, which has provided peace of mind to the terminally ill since it went into effect in 2016; and thank you for your consideration of SB24-068. We are here today and pleased to offer our support for these crucial amendments to the Colorado End-of-Life Options Act.

Holding true to the intent of the Colorado End-of-Life Options Act - to ensure that all terminally ill individuals have access to the full range of end of-life care options - the bill before you seeks to ensure eligible patients can access medical aid in dying by amending the law to:

- Reduce the current mandatory 15-day waiting period between the first and second oral requests to seven days.
- Allow attending providers to waive the mandatory minimum waiting period if the eligible patient is unlikely to survive the waiting period but meets all other criteria.
- Allow qualified Advanced Practice Registered Nurses (APRNs) to support patients in the option of medical aid in dying by acting as the attending and consulting providers in alignment with their scope of practice.

All of these amendments will reduce unnecessary burdens terminally ill individuals face when trying to access medical aid in dying.

Today, a few have testified or will testify about the risk and harm they believe medical aid in dying poses to people with disabilities. I understand their concerns. As a member of the community, I experience first hand the discrimination that people living with a disability deal with every day. However, the fears related to medical aid in dying are unfounded.

We now have over 25 years of data since Oregon first implemented its law in 1997, and eight years of experience since the law was authorized in Colorado, including annual statistical reports published by the Colorado Department of Public Health and Environment.

Let me share some facts. First, there is no data that suggests that people with disabilities represent a significant percent of the people seeking this option. Second, there have been no documented or substantiated incidents of abuse or coercion across the authorized jurisdictions since Oregon implemented the first medical aid-in-dying law. According to Disability Rights Oregon, there has never received a complaint that a person with disabilities was coerced or being coerced to make use of the Act. Also, people with disabilities overwhelmingly support having the option for medical aid in dying. A nationwide poll conducted in early 2023 by the disabilities organization Us for Autonomy found that 79% of people with disabilities support medical aid in dying.

If we truly value and respect people with disabilities, we need to acknowledge and protect their individual autonomy.

Members of the committee, I would not do this work as I have done for almost ten years if it put people with disabilities in harm's way. I urge you to let the evidence, experience, data, and strong public support for this end-of-life care option guide your policymaking. At its core, this bill is about alleviating unbearable suffering and increasing access to this option, all within the framework of proven safeguards.

Thank you again, Chair and Members of the Committee, for your leadership on this important issue.

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& choices

April 2, 2024

Committee Name:
House Health & Human Services

Sponsor(s):
Representative Kyle Brown

Hearing Item Title:
SB24-068: Medical Aid in Dying : Concerning End-of-Life Options for an Individual with a Terminal Illness

Submitted electronically to:
https://www2.leg.state.co.us/CLICS/CLICS2024A/commsumm.nsf/signIn.xsp

Dr. Ashley D. Fry
1601 N Nevada Ave
Colorado Springs, CO 80907
217-402-5105

Position on the Hearing Item: For
Representing: Organization - The Colorado Nurses Association

Madame Chair Daugherty and Members of the Committee:

Thank you for the opportunity to comment in support of this bill. I am representing the Colorado Nurses Association. My name is Ashley Fry and I am a board-certified adult-gerontology acute care nurse practitioner with advanced certification as a hospice and palliative nurse. I have been a nurse for 16 years, the majority of which has been spent working in hospice and palliative care.

We are a military family that moved to Colorado Springs in 2019. This is the first state I have lived in where medical aid in dying is legal, so I knew I needed to learn more about it so that I could talk to my patients as they explored all of the end-of-life options available to them here. What I was not anticipating was just how burdensome the process is for people.

Repeatedly, I have heard patients say to me that finding physicians who are willing to participate is time consuming, exhausting, and discouraging. On average for my patients who are able to secure the physicians, it can take 2-3 months. For those who receive health care services from religiously affiliated organizations in my community, they have to establish with new physicians. For my patients who live in rural communities, they often share that their primary care provider is an advanced practice registered nurse (APRN). APRNs have an independent practice authority in Colorado, and oversee care for our own patients, but currently cannot participate in this process.

This bill will help patients by reducing the barriers to accessing medical aid in dying, while keeping safeguards and qualifications for the process in place. Looking at examples from other states such as New Mexico, Washington, and Hawaii, we know that the amendments being proposed here in Colorado are realistic options that can help Coloradans who are interested in exploring medical aid in dying.[1] [2] [3]

Coloradans were clear when they voted in favor of medical aid in dying in 2016.[4] We should do what we can to make sure that there is equitable access to resources for those who want to participate - this bill would help do that. Please vote yes in support of this bill.

Thank you for your time and consideration.

Ashley D. Fry, DNP, APN, AGACNP-BC, ACHPN

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[1] End of Life Options New Mexico. (n.d.). *Steps for using the end-of-life options act.* https://endoflifeoptionsnm.org/end-of-life-options-act/steps-for-using-the-eolo-act/

[2] Washington State. (2023). *Death with Dignity Act - Various Provisions.* https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5179-S.SL.pdf?q=20230510092955

[3] Kokua Mao. (n.d.). Our Care Our Choice Act in Hawaii. https://kokuamau.org/our-care our-choice-act-in-hawaii/#:~:text=2023%20UPDATE%3A%20The%20Our%20Care,the%20Attending%20or%20Consulting%20Provider

[4] Death with Dignity. (n.d.) *Colorado*. https://deathwithdignity.org/states/colorado/

compassion & choices
Care and Choice at the End of Life

Colorado Campaign Manager, Gina Gentry,

SB24-068: Medical Aid in Dying: Concerning End-of-Life Options for an Individual with a Terminal Illness

House Health & Human Services

Tuesday, April 2, 2024, 1:30 p.m.

Dear Chair Representative Lindsey Daugherty, Vice Chair Mary Young, and members of the committee,

My name is Gina Gentry. I am the Colorado Campaign Manager for Compassion & Choices. We are the nation's oldest and largest national nonprofit organization working to improve the quality of end-of-life care. We advocate for legislation to improve the quality of care for terminally ill patients and affirm their right to determine their own medical treatment options as they near the end of life. On behalf of our Colorado supporters and terminally ill residents, thank you for considering improvements to the Colorado End-of-Life Options Act (EOLOA).

In 2016, Colorado voters overwhelmingly approved Proposition 106, "Access to Medical Aid In Dying," creating the Colorado End-of-life Options Act. Proposition 106 passed by 65% of Colorado voters in 2016. At the time, it was the widest margin of victory in Colorado history for a ballot initiative, with over 1.7 million Coloradans supporting this safe, compassionate medical practice. Compassion & Choices and the Compassion & Choices Action Network led the campaign for this critical ballot initiative in Colorado.

In the 7+ years since the EOLOA went into effect, we have worked with clinicians, health systems, hospices, and volunteers to ensure that the law was implemented well and that eligible dying people could access it. We have heard from many that it takes a dying person several weeks, if not several months, to get through all the steps in the request process, if they are able to complete it and obtain the prescription at all. This suggests that the request process, as currently constructed, has too many regulatory roadblocks for many dying patients to access the law.

After carefully evaluating how the current law is working and comparing it to other authorized jurisdictions, SB24-068, proposes modifications to the law that will allow more eligible patients to safely access this compassionate end-of-life option while still protecting medically vulnerable populations. This bill, based on data from decades of experience across states with similar medical aid-in-dying laws, half of which have made similar amendments over the years, seeks to update the Colorado law to better achieve its original intention of allowing eligible terminally ill people the option to end their suffering on their terms.

The proposed amendments maintain the same strict eligibility criteria. The improvements simply ensure the law's original intention is truly realized. Adults must have a terminal illness with 6 months or less to live, be mentally capable, and be able to self-administer the medication. This law does not allow healthcare providers, family, or anyone else, including the dying person, to assist or administer the medication by IV injection or infusion. Advanced age, disability, and chronic health conditions are not qualifying factors for medical aid in dying.

End-of-Life Options Act: Proposed Improvements

Reducing the 15-Day Mandatory Minimum Waiting Period and Adding a Waiver Provision

Even without a mandatory minimum waiting period between oral requests, it often takes weeks to months for many patients to get through the request process of being evaluated by two different providers, and submitting a written request signed by two qualified witnesses. Terminally ill patients don't have the luxury of time on their side. That is why it is critical to reduce or allow for a waiver of the 15-day mandatory minimum waiting period between the two oral requests a dying patient must make to their attending provider. It takes much longer than 15 days to get through the whole process; in fact, it can take up to 7-14 days just to fill the prescription.

According to data from Denver Health, one of the best health systems for ensuring that eligible dying people can access the law, nearly 1 in 4 of their eligible dying patients who wanted the option of medical aid in dying died trying to access the law[1]. If patients didn't have to wait for a minimum of 15 days, they would be able to get through the process faster and be able to access the law.

In 2023, the Hawai'i legislature passed a bill amending the Our Choice, Our Care Act to reduce the waiting period from 20 days to 5 days. For three years before that, the Hawai'i Department of Health's annual report to the Legislature repeatedly found some of the well-intentioned regulatory requirements – including the waiting periods – created unintended barriers for terminally ill patients. The 2021 annual report detailed that the 49 patients who died under the law endured an average waiting period of 41 days.[2]

California also recognized that waiting periods were posing an unnecessary barrier to terminally ill patients. In 2021, the legislature amended the California End of Life Option Act to decrease the waiting period between the two oral requests from 15 days to 48 hours.[3] The data from the California Department of Public Health shows that in the first year of the reduced waiting period, 47% more eligible dying people were able to access California's law and end their terminal suffering.[4]

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[1] Data from and with the permission of Denver Health. See Table 2 at the end of this testimony.

[2] Hawai'i Our Care, Our Choice Act Annual Report (2021). Available from: https://health.hawaii.gov/opppd/files/2022/07/corrected-MAID-2021-Annual-Report.pdf.

[3] *California SB 380 End of Life Option Act. Enacted October 2021.* Available from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB380

[4] California End of Life Option Act Annual Report (2016-2022) Available from: https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx.

In 2021, the New Mexico legislature passed its medical-aid-in-dying law. New Mexico requires just one written request, so there is no waiting period related to requests. However, the law requires a 48-hour waiting period between receiving and filling a prescription for medical aid in dying medication, but allows a qualified clinician to waive the waiting period if a person is going to imminently die.[5]

Based on years of practice, in 2019 the Oregon Legislature passed an important amendment to its law to better balance safeguards intended to protect patients and access to medical aid in dying. As long as a written request is provided and the attending qualified clinician attests that the otherwise qualified patient is likely to die while waiting, the amendment allows doctors to waive the 15-day waiting period between the two required oral requests and the 48-hour waiting period if they determine and attest that the patient is likely to die while waiting. The amendment was a direct result of evidence and data that clearly demonstrated the need for easier access for eligible terminally ill patients facing imminent death. The Oregon Health Authority annual reports in the years after the amendment show that 20% (2020) and 21% (2021) of patients required a physician exemption in order to make it through the process.[6]

These are only some examples of the many patients who are unnecessarily dying, deprived of a law that is supposed to bring compassion, as a result of an arbitrary mandatory minimum waiting period between the two oral requests. We urge Colorado to join Oregon, California, New Mexico, Washington and Hawai'i in modifying the needless suffering period.

Allowing Advanced Practice Registered Nurses (APRNs) to Participate Within Their Scope of Practice

The current law only allows for physicians and osteopathic physicians to act as the attending and consulting providers, even though APRNs have it within their scope of practice to do this important medicine.[7] This proposed amendment allows APRNs to participate as either attending or consulting providers.

This improves access for eligible patients and is particularly important in rural areas where there is a shortage of doctors. It is also important in areas with religious health systems that do not allow their doctors to practice medical aid in dying. Health systems, hospices, doctors, and APRNs will still be able to opt-out if they decide not to participate in the EOLOA.[8] Allowing APRNs to participate as providers

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[5] The Elizabeth Whitefield End-of-Life Options Act (2021), available at https://www.nmhealth.org/publication/view/general/8382.

[6] Oregon Death with Dignity Act, Annual Report (2020) Available from: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf. ; Oregon Death with Dignity Act. Annual Report, (2021). Available from: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf.

[7] Nurse Practitioner Practice Authority: A State-by-State Guide, Nurse Journal, Updated Nov 10, 2023. Available at: https://nursejournal.org/nurse-practitioner/np-practice-authority-by-state/.

[8] Nurse Practitioner Practice Authority: A State-by-State Guide, Nurse Journal, Updated Nov 10, 2023. Available at: https://nursejournal.org/nurse-practitioner/np-practice-authority-by-state/.

under the EOLOA is consistent with their scope of practice. It would help address the disparity in access to participating providers.

Closing

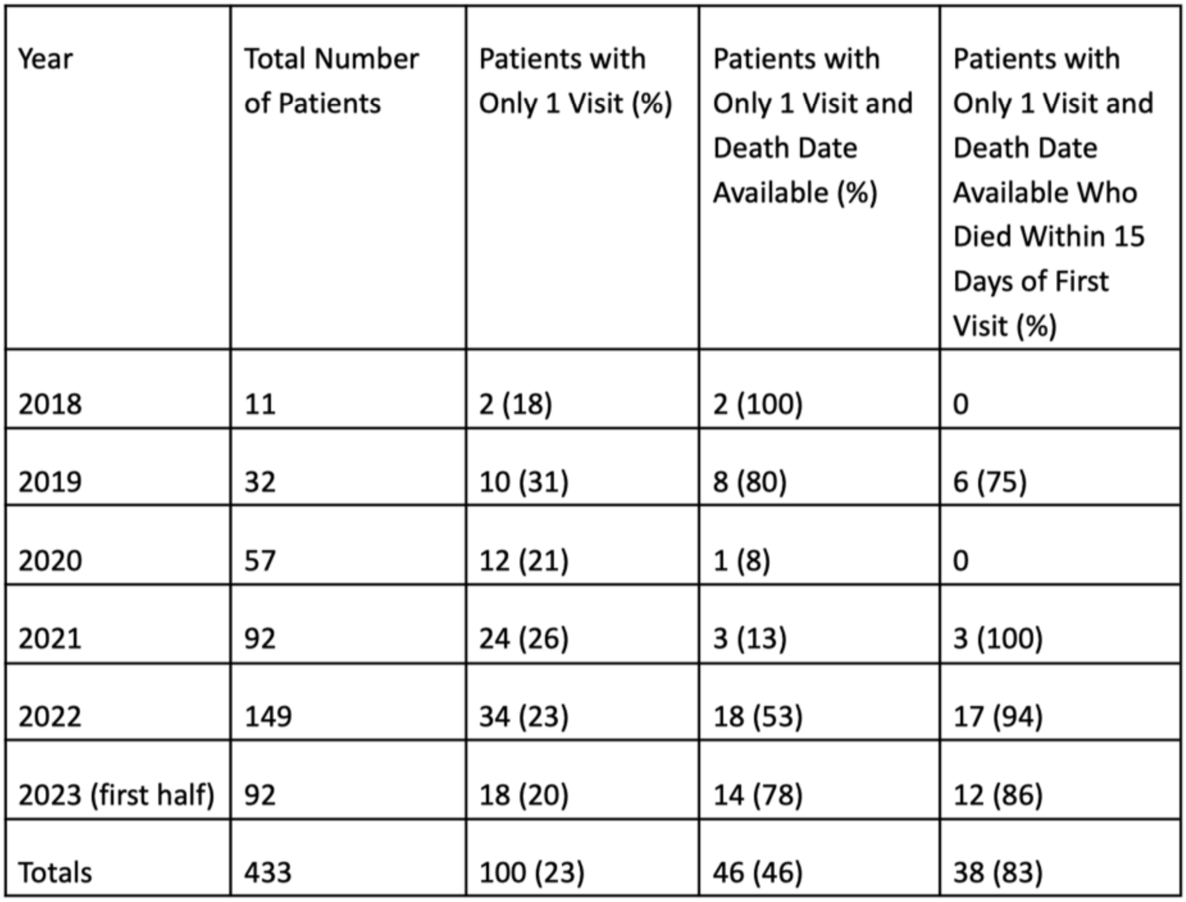
We are NOT recommending expanding the eligibility criteria or removing the core safeguards necessary to protect patients. We are simply requesting legislative fixes that will help us achieve a more appropriate balance between safeguards and access, so fewer eligible patients unnecessarily suffer. Thank you for your willingness to consider improvements that will extend the benefits of the law to more eligible terminally ill individuals while ensuring vulnerable populations are protected.

Sincerely,

Gina Gentry

Data from Denver Health

Table 2. Patients With Only One Visit Who Died Within 15 Days of First Visit



Year	Total Number of Patients	Patients with Only 1 Visit (%)	Patients with Only 1 Visit and Death Date Available (%)	Patients with Only 1 Visit and Death Date Available Who Died Within 15 Days of First Visit (%)
2018	11	2 (18)	2 (100)	0
2019	32	10 (31)	8 (80)	6 (75)
2020	57	12 (21)	1 (8)	0
2021	92	24 (26)	3 (13)	3 (100)
2022	149	34 (23)	18 (53)	17 (94)
2023 (first half)	92	18 (20)	14 (78)	12 (86)
Totals	433	100 (23)	46 (46)	38 (83)

Physicians for Compassionate Care
Education Foundation (PCCEF)

info@pccef.org www.pccef.org P.O. Box 7122, Bonney Lake, WA 98391 253-501-7011

Reasons to Oppose Colorado Reengrossed SB24-068

Sharon Quick, MD, MA (Bioethics)
President, Physicians for Compassionate Care Education Foundation (PCCEF)
House Health & Human Services
April 2, 2024

I am President of the Physicians for Compassionate Care Education Foundation (PCCEF), an organization without religious or political affiliation. We advocate for the terminally ill, who often have compromised capacity to choose, making them vulnerable to abuse. I have expertise in pediatric anesthesiology, critical care, and medical ethics. On behalf of our Colorado members, we urge you to oppose the reengrossed version of SB24-068.

- Eliminating the waiting period if a patient is thought to be near death is medically dangerous. Determining that death is near is difficult for experts.[1] This bill allows one practitioner, including a non-physician, without expertise or second opinion to assess prognosis of near death and decision-making capacity and provide immediate lethal drugs. Patients often begin to lose both mental capabilities and swallowing function a few weeks to several days before death with 90% lacking these functions within two days of death. Obtaining a valid consent and ingesting the lethal concoction are both unlikely at this time. Patients take anti-nausea drugs and mouth-numbing popsicles before drinking a bitter tasting, burning lethal drug cocktail. Risks include painful ingestion, nausea, vomiting, aspiration, seizures, prolonged death, and not dying. Complications, such as dying from choking on vomit, are more likely when patients are close to death. Supplying lethal drugs near death may be worse than natural death and demonstrates reckless disregard for patients. In addition, patient autonomy is violated by removing a chance for mind changes. Palliative care can do far better.
- Lethal drugs are never necessary for pain or symptom management, and shortening or eliminating the waiting period should never be done for this reason. Even a physician who advocates for lethal drug prescriptions admits this.[2] Patients rarely seek lethal drugs for inadequate pain control, but usually for psychological distress over new onset disabilities associated with terminal illness. Testimonies about patients with excessive pain or other symptoms at the end of life indicate that these patients had inappropriate palliative care. Unfortunately, studies show that doctors often lack knowledge about palliative care possibilities and fail to refer to specialists.[3,4] It is unethical to get consent for lethal drugs from patients in severe pain which compromises a person's decision-making capacity. Terminally ill patients frequently have psychological, spiritual, emotional, social, and family struggles, and they may find their pain and other issues reduced when these issues are addressed. In addition, the specialties of palliative care and pain management are not equivalent and may not be coordinated as well as they could be in end-of-life patient management.[5] The latter is anesthesia-directed, with a greater focus on interventions in addition to medications. Pain management may include regional anesthesia (e.g. epidurals), nerve blocks, acupuncture, and expertise in management of multiple medication types for unusual pain and pain syndromes.[5]
- Respect for patients' choices includes ensuring that they have the right to change their minds—this bill denies that option. When a patient says they want to hasten death, this often is a plea for help, not a real desire to kill themselves, and this wish usually abates with supportive care.[6] Lethal drugs are not usually sought for pain but for psychological distress over new onset disabilities. A patient who says they want to die might really mean "I'm afraid I'm a useless burden." Vulnerable patients make rash decisions out of fear, depression, compromised decision-making capacity, embarrassment, subtle pressure by a tired caregiver who makes them feel like a burden, etc. All may go unrecognized by doctors. Given time,

palliative care and mental health interventions, patients often change their minds, but this bill allows a bad day to become their last day. Fifteen days may be inadequate to do this but 7 days or eliminating it entirely for imminent death within 48 hours represents patient abandonment under a guise of "autonomy." It takes two weeks for anti-depressants to begin to work; 7 days is too short to ensure due diligence has been done.

- Shortening the waiting period has no advantages for patients and will only violate patient autonomy and increase discrimination against the most vulnerable. The terminally ill have frequent fluctuations in decision-making capacity, good and bad days, and often change their minds. By not allowing adequate time and sufficient expertise to assess what may be rash requests to hasten death in the midst of fear or depression, this bill not only infringes on patient autonomy by violating patients' rights to change their minds, but it allows injustice and discrimination, because the people most likely to be adversely affected by these changes are those with mental illness and disabilities. There is no scientific data or plausible reason to eliminate the safeguards of time and expertise—the risk of harms for doing so outweigh any benefits.
- This bill, unlike any other jurisdiction where lethal drug prescriptions are legal, does not require at least one physician to be involved in the process. This violates Medicare hospice regulations, which prohibit nurse practitioners from certifying a patient as terminally ill.[7]
- Patients in rural areas[8] and disadvantaged communities[9] have less access to hospice care. Making lethal drugs more available without ensuring hospice access and educating practitioners about pain management is unjust.
- Current law requires medical record documentation of participation in this act (Section 25-48-111) and the Department of Public Health and Environment has adopted rules for reporting.[10] Physicians are currently required to submit a list of information within 30 days of writing a lethal prescription and within 10 days of dispensing a lethal prescription. Hundreds of forms are missing that document that the patient was eligible for and voluntarily consented to lethal drugs, including 20% of patient consent forms, 15% of attending physician forms, and 22% of consulting physician forms. (See details in the Table below.) No investigations have been done or sanctions introduced, although noncompliant physicians are potentially guilty of a felony for not following the letter of the law. Why does this bill propose removing safeguards when current safeguards are not being followed and patient safety is in jeopardy?

References

1. White N, Reid F, Vickerstaff V, Harries P, Stone P. Specialist palliative medicine physicians and nurses accuracy at predicting imminent death (within 72 hours): a short report. *BMJ Supportive & Palliative Care* 2020; **10**(2): 209-12.
2. "[No] patient should take medications to die because they're receiving inadequate symptom management at the end of their life. Hospice care is a way of assuring that patients aren't forced to consider aid in dying because of inadequate end-of-life-treatment." Shavelson, Lonny. Medical Aid in Dying: A Guide for Patients and Their Supporters. American Clinicians Academy on Medical Aid in Dying, 2022. (p. 36)
3. Enguidanos S, Rahman A, Hoe D, Meyers K. Provider-Identified Barriers To Palliative Care For Medicaid Patients. *Innovation in Aging* 2019; **3**(Supplement_1): S689-S.
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5. Platt M. Pain Challenges at the End of Life - Pain and Palliative Care Collaboration. *Rev Pain* 2010; **4**(2): 18-23.
6. Chochinov H, Wilson K, Enns M, et al. Desire for death in the terminally ill. *Am J Psychiatry* 1995; **152**(8): 1185-91.
7. "No one other than a medical doctor or doctor of osteopathy can certify or re-certify an individual as terminally ill, meaning that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. Nurse practitioners and physician assistants cannot certify or re-certify an individual as terminally ill. In the event that a beneficiary's attending physician is a nurse practitioner or a physician assistant, the hospice medical director or the physician member of the hospice IDG certifies the individual as terminally ill." (Medicare Benefit Policy Manual, Sec. 20.1, p.5; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf)

8. https://reportcard.capc.org/state/colorado/
9. https://www.capc.org/blog/increasing-awareness-palliative-care-minorities/
10. Department of Public Health and Environment Reporting and Collecting Medical Aid-in-Dying Medication Information (https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7163&fileName=6%20CCR%201009-4)
11. See: 2022 Data Summary (https://drive.google.com/file/d/1DLML5hCvlI0Udvt0vCalCziN9g9Lhgf9/view?pli=1) and 2021 Report (https://drive.google.com/file/d/1fnWB83wb9nnr0mXlr30t2fFSkJ55Zi-h/view).

TABLE: CO Reporting Statistics[11] for Lethal Drug Prescriptions with Missing Forms

	2017	2018	2019	2020	2021	2022	2017-2022 Total (2022 Report)	2017-2022 Missing Forms[iii]
Patients prescribed lethal drugs	72	124	170	188	220	316	1090	
Patients to whom lethal drugs dispensed	56	, 85	137	150	164	246	838	
Patients who died	71	119	165	178	203	243	979	
Attending or prescribing physician form/ missing	63/**9**	108/**16**	146/**24**	160/**28**	188/**32**	260/**56**	925	165 (15%)
Patient's completed written request/ missing	50/**22**	93/**31**	130/**40**	157/**31**	185/**35**	258/**58**	873	217 (20%)
Mental health provider's confirmation	1	0	1	3	0	3	8 (0.7%)	
Consulting physician's written confirmation /missing	30/**42**	89/**35**	130/**40**	156/**32**	185/**35**	259/**57**	852 (849 actual)*	241 (22%)
Medication dispensing form	56	85	137	150	164	247**	839	
Death certificate[i]	71	119	165	178	203	243	979	
Totals Missing[ii]	73 (34%)	82 (22%)	104 (20%)	91 (16%)	102 (15%)	171 (18%)		623 (19%)

Note: Numbers in boxes represent those recorded in the most recent 2022 report from 2017-2022 except for the 2017 column from the 2021 report. Missing forms are in red print. Only 0.7% of all patients who are prescribed lethal drugs have a mental health consultation.

* Adding the final number in this row produces a sum of 849, but 852 is listed in the 2022 Report. Used 849 to calculate percentage of missing forms.

**Unclear why one more form received than patients to whom lethal drugs dispensed

[i] Note that death certificates are not documented for all the patients who received prescriptions for lethal drugs. It is unclear if these patients have not yet died—making their prognosis longer than 6 months in most cases—or if the death certificates have not been received or recorded.

[ii] Calculated using the added number of missing forms in each of three categories (attending, consulting, and patient request forms) divided by three times the number of patients prescribed lethal drugs for that year.

[iii] Calculated using the added number of missing forms in each row divided by 1090 (the number of patients prescribed lethal drugs from 2017-2022).

March 30,2024
House of Representatives

I have been in the end of life care field for the last 40 years. Over that time period I have seen many folks suffer needlessly at the end of their life.

Too many were like my neighbor, who was diagnosed with Alzheimer's. He (they) did not want their family members to spend the next decade or so caring for them and draining financial resources as they lost all ability to be themselves. My neighbor's wife was determined to care for her loving husband of 45 years at home where he was most familiar. But over time, with personality changes and aggressive behavior, she had to make several calls to the police because she was scared for her safety. This sweet, loving husband of 45 years was now aggressive, abusive, yet still strong enough to overpower his wife as she tried to keep him from leaving angrily in the middle of the night. So their last day together in the home they'd built together, ended with the police hauling her husband away, never to return home. Instead he stayed his remaining years in a care facility where they often told his wife he might be too aggressive to stay. Yes, it is possible for him to be "kicked out." He remained for many more years, miserable, draining the family resources.

Instead, he could have had the choice, and would have elected at the early diagnosis of Alzheimers, to use Medical Aid in Dying when he was still cognitively able to understand his decision. He could have had the opportunity to summon his family's support to have an intentional, loving, conscious and sacred gathering as he brought closure to his long marriage and life. IF the changes in SB1196 had been in place. And his family owed have been left with loving memories instead.

Another friend cared for her husband a full 20 years at home, after his original diagnosis of Lewy body dementia and Parkinsons when her children were teens. She was forced to quit work and care for her husband. This year he died. She has no life of her own now, and is left with almost no good memories after such a long illness. Had they had the choice SB1196 allows, they could have been left with loving memories, financial resources and agency over their lives.

Others who suffered needlessly went through all the proper medical channels for relief of their suffering, only to be told they had no other options. One such acquaintance, a spiritual and accomplihsed man who had access to many resources over his long life, had one last time, gone to the local ER for help. His suffering was unbearable and had been for too many years. When they sent him home with no relief of his suffering and no other options, he took a gun to his head in his own home. His wife of 53 years was left to find him, and his family is now left with public humiliation, guilt and fall out of his actions. Had he not been limited to needing a diagnosis of 6 months or less to live, he would have had the opportunity to die surrounded by family and friends in a supportive and loving way. Now his family is left with unnecessary trauma indefinitely.

Currently the only choices to use Medical Aid in Dying all involve the digestive tract in some way. Medication can be taken orally, rectally or through a feeding tube.

Complications can arise with folks who do not have a functioning digestive track, thereby eliminating them from this option. OR they may choose this option, and the process can take many more hours because the medication is not absorbed properly. Vomiting can also prevent many from having this option. Intravenous self-administration offers a quicker, more painless and compassionate way to die.

This bill has the potential to address ALL challenges we are seeing in those who are excluded from using MAiD currently.

I am so hopeful that SB1196 could set a new standard for compassionate end of life care going forward for ALL Americans. PLEASE do the right thing and support SB1196.

Sincerely,
Linda Wallace
Lafayette, Colorado 80026

House Health & Human Services

04/02/2024 Upon Adjournment

SB24-068 Medical Aid-in-Dying

Typed Text of Testimony Submitted

Name, Position, Representing	**Typed Text of Testimony**
Vanessa Johnston For themself	Dear House of Representatives Committee on Health and Human Services, My name is Vanessa Johnston from Littleton, and I am a volunteer with Compassion & Choices. I am also a death doula trained by the International End-of-Life Doula Association (INELDA) and the American Clinicians Academy on Medical Aid in Dying (ACAMAID). I am writing today in support of SB 68, the improvement bill for Medical Aid in Dying. I own Denver EOL Doula, LLC and have been working full-time as an end-of-life doula since 2015. At that time, Medical Aid in Dying was not yet legal in Colorado. My first client died from ALS and I saw the long, slow, debilitating physical decline that is the tragedy of that disease. There was so much suffering before his death and it could have been avoided if Medical Aid in Dying had been a legal option back then. In 2020, Medical Aid in Dying was an available legal option for another client who was suffering from cancer. However, she was unable to pursue this compassionate solution because her health declined too quickly while going through the eligibility process. While she was awaiting an appointment with a second doctor for approval of Medical Aid in Dying, her disease progressed quite rapidly. Unfortunately, she was no longer able to swallow the medication by the time she was deemed eligible by her doctors. The wait time had made self-administration impossible. I am also the Vice-President of the nonprofit group Colorado End-of-Life Collaborative. I often hear from folks in rural areas of Colorado who do not have access to prescribing physicians. I know that allowing Nurse Practitioners to evaluate and prescribe for Medical Aid in Dying would be tremendously helpful to those who do not live in the larger metro areas.

	The voters of Colorado wanted this humane option to be available to those who qualify without the obstacles that my clients have been encountering. Now is the time to make this empowering and compassionate option more accessible. When someone is dying, we should make it easier for them to find peace, not harder. I urge you to move the Colorado End-of-Life Options Act quickly and favorably out of committee. Thank you for taking the time to read my testimony. Sincerely, Vanessa Johnston 6089 S. Bemis Street, Littleton, CO 80120 (303) 241-3396 EOLDoulaDenver@gmail.com
Debra Belvill For themself	I am very much in favor of this bill - reducing waiting times, adding more people that can prescribe aid in dying medication, and removing residency requirem
Michael Dennis Against themself	Members of the Senate Health and Human Services Committee. I am personally opposed to SB 24-068. I am opposed to the state allowing people to die by the means of a prescribed pill from a medical professional. It is Colorado's intention to allow a pill to release a person from suffering instead of using our medical technology to help those in the final days of their lives.

	Colorado intends to simply offer death by a pill over compassionate hospice care. How is it that our technology can't ease the pain of a dying person? This subject is controversial because we are taught that life is valuable, and we should not engage in taking it or encouraging its end. I have serious reservations and disagree with Colorado government and their wish to legislate life in the womb and at its natural conclusion. I would not want a person to suffer needlessly but don't understand how Colorado government could advocate this type of idea. I thought government's task was to help people and not destroy them. For these simple reasons, I oppose this legislation. Thank you.
Barbara Klaus For themself	As a retired nurse practitioner, I support the changes to the Medical Aid in Dying law proposed in SB24-068. I believe that It is unfair to require that persons who are terminally ill wait for 15 days for the signature of a second health care provider to provide medical aid in dying, especially given the large rural population of Colorado. Additionally, since many of us receive health care from nurse practitioners rather than physicians (who are in short supply and often difficult to make an appointment with), nurse practitioners should be given the authority to sign medical aid in dying orders.
Donna Pyle For themself	My husband and I strongly support the Colorado End-of-Life Options Act SB24-068. We support any options that allow us to choose when and how to die. Once life has lost its meaning and pleasure, one should not have to endure more pain or more expense in an effort to stay alive. Please approve this bill.
Ardis Westwood For themself	My name is Ardis Westwood and I live in Denver, CO. When my husband died in 2018, he had been under hospice care for about two weeks. When he was in pain or agitated, I just had to call the hospice and they led me through the steps to administer morphine to relieve the pain or anxiety. When he died, someone came from hospice and took care of his body and let family members visit him individually. The hospice nurse

	then neutralized the morphine as we watched. We called the mortuary we had chosen and they took his body away. I know, though, that other's deaths do not go as well. A friend had had COVID which left him very debilitated, and he decided to use voluntarily stopping and drinking. It was not hard to stop eating but to stop drinking was more difficult. Because his mouth was dry, he would take a sip of water and swish it around in his mouth and spit it out. Two or three friends took turns sitting with him around the clock, and some friends visited and/or sent emails. It took him 9 days to die. I know that in Colorado a hospice facility can give as much medication as necessary to relieve pain, even if it causes death, if the motive is to relieve pain, so that is important. But I do believe that a competent person with a terminal illness should be able to request medication to hasten death without waiting 15 long days. Peace of mind and choice is a right we should all have.
Ellen Keckler For themself	I am offering testimony in support of SB24-068. As a retired social worker, I regularly encountered situations involving death and dying. As an individual, I have had direct experience with loved ones in the final stages of life. Based on both my professional and personal experiences, I strongly believe in human dignity as a crucial component in the death and dying process. One way of providing compassion and promoting the inherent value of human dignity is to allow people to retain some sense of control regarding the process of their own death in situations which meet the criteria for medical aid in dying. I have been with loved ones who have passed peacefully at home through voluntary stopping eating and drinking, and others who ran out of time to exercise free choice and passed amidst the chaos and flurry of a hospital emergency room. The contrast between the two is stark, and I believe to retain our dignity as human beings, we need to value and honor requests for medical aid in dying, allowing all people the right of self determination when it comes to this final stage of life. I applaud Colorado for being an early adopter of medical aid in dying, and at this time I support removing some of the barriers involved in accessing that opportunity. When someone already knows they are dying, why wouldn't we support that person in more easily accessing medical aid in dying if that is their choice? Medical aid in dying isn't the right choice for everyone, but for those who understand the process and are opting to follow through with medical aid in dying, we owe them the chance to access it without undue burden in initiating their choice. People who

	choose medical aid in dying deserve the right to exercise their judgment to proceed with medical aid in dying in a timely manner. There are already enough hoops through which dying patients need to jump, including the time delays built into the current system. I strongly urge you to support this bill on behalf of all Coloradoans and their families who are counting on the right to choose medical aid in dying as a viable end of life option. Thank you.
Sydney Leanna For themself	As a currently practicing medical aid-in-dying (MAID) pharmacist for a large health system within Colorado, I am in strong support of this hearing item. Expanding MAID prescribing to include advanced practice registered nurses would help increase Coloradan accessibility to this important end of life option, especially in rural areas where health care providers are limited. In addition, shortening the waiting period between oral requests from 15 to 7 days, with provider discretion to waive for actively dying patients is critical. Pharmacy lies at the end of patients' MAID journeys and being so, a strong sense of urgency can develop by that time for many patients with plans of ingestion. Those 8 days can make a big difference, especially given that pharmacists need time to compound MAID once dispense requirements have been met. A minimum of 72 hours is standard wait time to prepare MAID. This reduced wait time would alleviate stress and pressure on pharmacy as well as patients.
Philip Shimel For Cobalt	Thank you Madam Chair and members of the Committee for the opportunity to submit written testimony. My name is Philip Shimel and I'm representing Cobalt Advocates in support of Senate Bill 24-068, Medical Aid-in-Dying. Cobalt is a grassroots statewide organization that advances reproductive rights, including freedom from government interference in medical decisions. We have seen the disastrous and ongoing consequences from the politicization of healthcare decisions across the country and here in Colorado. These are decisions that are most appropriately made by the affected patients and their trained and qualified medical professionals in consultation with their medical peers and trusted organizations: not by politically- or ideologically-motivated untrained government officials. This bill will reduce the unnecessary obstacles facing patients and providers in giving healthcare in line with well-established medical standards of care and ethical best practices. We will continue to support removing arbitrary obstacles imposed on medical decisions. Last year Cobalt supported HB 23-1218, the Patients' Right to Know Act, that will increase transparency from medical facilities concerning nonmedical denials of care for services related to reproductive care, LGBTQ care, and end-of-life care. We believe in increasing patient access to

	healthcare services that reduce human suffering and adhere to medical ethics, regardless of whether those services are vilified for political gain. Cobalt respectfully requests a YES vote, thank you.
Susan Rhea For themself	I am an aging baby boomer who lost her spouse to cancer 8 years ago. I have worked in the Hospice community as a volunteer, bereavement counselor, and caregiver. I know the decision to choose MAID is sad and difficult, and often not made until very late. Helping anyone facing this choice with more compassion and assistance is the right thing to do. I support the work of Compassion and Choices network to improve the availability of compassionate life ending care, especially access to medical aid in dying. Please support this bill.
Annie Bridegroom Against themself	My name is Annie and I worked as a Physician Assistant in several Denver and Boulder area nursing homes in 2018-2021 and am now in chronic pain management. Physician-Assisted Suicide, currently considered incompatible with standard medical care per the American Medical Association, is more accurately considered experimental. Since Colorado has made it clear it wants to be part of this experiment, more regulations should be made to PAS rather than expanding access. Suicidal thoughts, whether in young people or at end of life, should always be taken seriously and ideally come under the care of a psychiatrist if not an astute primary care provider, not under the care of a nurse. Furthermore, reducing the time for suicidal drug administration does not realistically respect the time it takes to diagnose and treat the mental health imbalance that has brought someone to suicidal thoughts and should also not be further shortened based on the assessment of patient prognosis. Medical providers can be as smart as a whip, but no one can predict the future with 100% accuracy. This aspect of the bill allows wiggle room for abuse on the part of anyone involved in patient care, including medical providers and team, staff, family/friends/caregivers, and the insurance company. PAS already forces a duality in the role of the physician as someone who both heals and comforts and then switches gears to kill. It is unfair to the intricate and meticulous care of chronic and terminal disease as well as of mental health crises to speed up this process—essentially forgoing it altogether—in favor of a questionable solution that has an irreversible result. I urge all legislators to protect the vulnerable in our community by voting this bill down.
Lloyd Benes Amend themself	Amend SB24-068 – Lloyd Benes My Name is Lloyd Benes, and I represent myself. I have provided citations supporting the request for you to amend this MAID Bill visible in the printed material I gave you.

	Firstly, the original 2016 MAID law mandates medical record documentation. However, hundreds of forms are currently missing relative to indicating patients' eligibility and voluntary, uncoerced consent to lethal drugs. This includes 20% of patient consent forms, 15% of attending physician forms, and 22% of consulting physician forms (citation = tinyurl.com/46eazzmr, page 124). Without those forms, we cannot know if the law is working as intended and that coercion is avoided. Therefore, I support the amendment to 25-48-111 of the Bill because we need protection for Colorado citizens seeking MAID in the form of the proposed amendment wording, "(h) Failure to submit the required documentation to the CDPHE represents unprofessional conduct subject to sanctions by the Colorado Medical Board or Nursing Board." Secondly, also relative to documentation, the Bill should have the amended language suggested for 25-48-111 at the end of paragraph (c), "Document the reason the individual has decided to pursue MAID using a comprehensive list of potential reasons generated by CDPHE." Currently, the 2016 MAID law does not ask individuals what their end-of-life concerns are. By contrast, Oregon with 25 years history with MAID does ask clients about end-of-life concerns – revealing that only 28% of Oregon patients listed "inadequate pain control" as an end-of-life concern. And revealing that the primary worries were "diminished ability to enjoy life" (90% of patients), "loss of autonomy" (90% of patients), "loss of dignity" (72%), and "burden on family" (48%) [citation = tinyurl.com/baum3dy2]. With this information we could offer expanded mental health assistance and hospice to address our people's end-of-life concerns. Please vote yes on amendments protecting Colorado citizens
Jessica Koerner For themself	Dear Chair Daugherty, Vice Chair Young and members of the House Health and Human Services Committee: My name is Jessie Koerner from Denver, Colorado, and I am a death doula writing in support of SB 24-068. This bill will vastly improve access to medical aid in dying in Colorado. As a doula, I help empower people to envision and enact their end of life wishes. I love working in Colorado, where I can tell those I work with they have the option of medical aid in dying… most of the time. When my client, "Jane", began having strokes that would eventually cause her death, she decided she wanted to access the End of Life Option Act. The race against the clock began. The agony of finding doctors who would support her decision, and waiting, waiting, waiting for the 15 days to pass so she could be deemed mentally capable again with the second oral

	request was the most nerve-racking part of her whole death experience. The relief in the family once the medication was in hand was palpable. Reducing the waiting period is one way to reduce barriers to access to this medication, and reduce distress in those who are already facing death. This option should also be available through an advanced practice registered nurse. Finding a second provider should not be as difficult as it currently is in Colorado. SB 24-068 will make Colorado a better place to die. We should make every effort to embrace policy that makes dying according to our own values possible.
Thomas Jensen Against themself	Dear House Representatives, Thank you for allowing me to comment today on SB24-068 Medical Aid in Dying. My name is Dr. Thomas Jensen, I practice in the areas of Endocrinology and Metabolism with a focus on End Stage Liver Disease Patients, along with Cancer patients including pancreatic cancer, and pre and post transplant patients. I see many individuals near end of life due to those aforementioned conditions. I come to testify today over the concerns of easing access by decreasing wait times from 15 to 7 days and even as short as 48 hours days will target vulnerable patients limited decision making capacity It is quite shocking to me that here in Colorado <1% of patients were ever assessed for medical decision making capacity formally. And the reality is that terminally ill patients especially in the final days of their lives lack medical capacity to make such decisions. And physicians do a poor job identifying lack of capacity in terminally ill. A 2018 study from Am Journal of Geriatric Psychiatry of 55 Terminally ill cancer patients using the validated MacArthur Competence Assessment Tool for Treatment (MacCAT-T) to evaluate decision-making capacity found strong impairments in the areas of Understanding (44.2%), Appreciation (49.0%) and Reasoning (85.4%). Sadly Physicians believed that only 35.9% were impaired. Another 2013 from Journal BMC Palliative Care study found that in the last week of life 67% of patients have been found to have impaired decision capacity. It therefore should make us cringe to think we should hasten this decision in people with even as much as less than 48 hours to live given these facts and the fact hardly is ever a patient here in CO assessed for Medical Decision Making Capacity prior to MAID being granted. This Bill does not represent greater Medical Freedom, it represents irresponsibility and lack of concern. Why are proponents such as Compassionate Choices not simply focusing on earlier discussions with

	patients rather than targeting vulnerable patients in which rash decisions become last decisions? Instead we should be advancing legislation that ensures patient safety and the current law be followed now rather than simply easing access. Thank you for your time, Dr. Thomas Jensen

Senate Testimony HB24-068

February 29, 2024

Thank you Chair R. Fields, Vice Chair J. Ginal, and members of the committee, for this opportunity to provide some input into the legal process and advance the discussion regarding this quasi-taboo topic: end of life. It's certainly uncomfortable in our culture. In *Secrets of the Talking Jaguar,* Martin Prechtel describes living with Mayan indigenous people who among many differences seem to have an entirely different understanding of death; he describes a scene relating to ancestor worship, digging up ancestors' bones and showing them love. Our societal recoil from this reality—of death itself—appeared to be missing from their culture, though they certainly avoided *dying* as best they could.

My personal cosmovision has been informed by shamanistic traditions and also observations of the natural world, of which we are a part. For example, I've witnessed a wolfdog give himself self-mercy when dying, by way of exposure to the elements. There are stories of wild animals doing the same. They go off alone into the cold. The one I saw, soaked himself with water when there was a bitter-cold wind, and it was spitting snow. He was dying from lymphoma. The Innuits are a commonly-cited example, for at least in the 18th century they sometimes used ice floes to drift off and die from exposure.[i]

One other area that informs my views is that I've witnessed "natural death" and was left with questions about all the "died peacefully at home surrounded by loved ones" news we regularly see. Natural death looks like it can—except for sudden events like cardiac arrest, maybe—be miserable and protracted, with violent spasms, unmanageable pain, and a macabre death rattle (my data points). "Loving families" seem to—on close inspection—be riddled with vitriol, jealousy, and treachery, with some affection that admittedly does come out at surprising times. Maybe most of these people really are "surrounded by loving family" but a lot of people are in my situation—de facto orphans.

I'm rural, in my 60's, and have no family in my life. There's a partner that I see a few times a month, but she is death/illness averse (who blames her?) and likely will not be around for that rough chapter. There is no social safety net for me, in practice, apart from nursing home hospice/palliative care, should the time come. But in between the two—me maintaining my own home and me in a nursing home—there's a lot of distance that has zero coverage. There's a good chance I (and many, maybe you too?) would not survive that trek from here to there (the nursing home). Details to follow.

Further, even euthanasia (which is different from self-administered MAID, by the way) in dogs—as I have seen, repeatedly—is a solid three days of torture. That's my fault, because I give them three days to "rebound" or change their minds. They never do, though. The last time, the dog more mercifully went after two days because I changed the protocol.

This brings me to Colorado's existing laws. Consider that the current law requires a prognosis of less than 6 months to live; two doctors have to agree on this. This is problematic in multiple ways. Example: I've had a chronic, progressive, debilitating neurological disease since 1991. Guess how many specialists I have seen, and how many of them agree on a prognosis, treatment, or even specific diagnoses…? Each specialist has their own syntax and a different name for the piece of the elephant that they are touching. Some can be coerced to agree that Name X = Name Y (more or less). Prognosis: N*obody Knows.* Since cardiac involvement became a chronic thing back in September of 2022, there's a non-trivial chance that any day I could die. Not hyperbole. I was on a walk on February 5th, and a combination of SVT's and AV Block made it impossible for my Apple Watch to even count my heart beats: it had the pulse rate *greyed out.* I could feel the frenetic and irregular mamba dance on my throat pulse and had to creep home. If a cardiac event causes brain damage, for example, I'm confident it would be impossible to get two doctors to agree on a prognosis of less than six months, though that certainly could turn out to be the case.

Another thing about that six months…? You're not allowed to even fill the Rx until after a fifteen-day waiting period (the human equivalent of my "three day period"). Well, it turns out that time goes really, really slowly when you are being tortured. Gross debilitating injuries, and fast-moving diseases…can have you dead within that. Stats I have seen, is that some 24% of the time in Colorado MAID cases, the people do not make it past the fifteen days. I believe aggressive forms of lymphoma and other cancers can do that. It took the wolfdog in three *painful* weeks.

His attempted self-mercy was around two weeks, and he would not have been able to self-administer at that time (as a human) as he was too nauseous. It was torture after that.

Canada's laws seem excellent. As I understand it, the single guiding premise is: "Tenable Life." If your life becomes untenable, then you can—***if you choose***—pursue a claim for self-mercy. If people don't want you to leave this world, then perhaps they can prop up your life and keep it…*tenable*. Otherwise, they should shut up and let you make your decision, even be supportive. That's my belief.

What government *shouldn't do*, is funnel people toward MAID. Currently, our federal and state governments provide the worst of both worlds: they funnel people toward MAID but do not provide it as an option. The only way out of the *torture* is to endure it or do the equivalent of a "back-alley coat hanger procedure." You see, people who commit gruesome acts of self-mercy likely (in my opinion) were enduring worse or facing enduring worse.

This is not only a traumatic transition for the person, but also for First Responders, friends, and family. But, on the plus side, it permits governmental deniability or splash-back. The government can't be accused of funneling people toward MAID if they do not allow MAID, right? However, they *can* be accused of contributing toward making life *untenable* and then de facto torturing people to death, all legal like.

Hyperbola? Well, maybe. In my case, here's what track I'm on. After owning a house plus this land for 25 years, I'm on track to default on the mortgage *this year.* My crime: the disease progressed and I had to early retire from my livelihood in September of 2022, barely of age to collect Social Security. However, Social Security is currently about $1,000 short to sustain my life. It won't pay the mortgage, the property taxes, house maintenance, gasoline to enjoy socialization with others, etc. Land around here saw a 50% increase in appraised value a few years ago; another 25%-30% jump in property taxes is being discussed for this year. Total overall inflation for last three years' I've seen estimated as high as 40%. Meanwhile, Social Security's COLA increase to cover the huge inflation of last few years, not counting property taxes: ~$60/month. I'm losing ground and my life is becoming: untenable.

What happens when I (or others) lose the house? Well, I'm homeless, with a debilitating disease. I'm doing that long trek to the nursing home, but not yet eligible to get in there. The *pricey* infusions I take three times per week have bulky IV supplies that must be kept sanitary and refrigerated. So, those infusions go away—a major medical support. Of note, if I *could* drop those infusions to twice a week, the savings of product would be somewhere between $17,000 and $34,000 *per month*, enough money to pay off my mortgage *in a few months.* I'm grateful for the infusions and unfortunately, at the lower dosage it would be out of the therapeutic range for me—but my point is that it amazes me how much is being spent on my health (MUCH GRATITUDE), but keeping a home *is not considered essential for health*. This is how government funnels toward MAID: "Social Security" is anything but.

I've been homeless before, and don't want to do that again. I can't survive it. Further, I can't do the stress of living in a crime-infested apartment complex that perhaps the government would provide—though the wait here in Colorado for government housing is 1-4 years. (By then, I would be long gone—but good luck getting two doctors to agree on that.) It would have to be *fully* subsidized, too, for my tiny Social Security to be enough to keep me in the tenable category. Likely, I would be paying same or more as my subsidized mortgage, so I would *still be unable to afford it*. If I endured the torture of homelessness long enough, maybe I would arrive at the nursing home for a meaningless stay I would never choose for myself. No, I would choose self-mercy, *given the option.* That is what *funneling* looks like. What would you do? Because, you or loved ones may be called upon to decide that one day.

Another example. My beloved neighbor. She was older than I and actually grew up living next door to our family ranch near Hayden. Her family and mine go way back. I considered her extended family. Her family ranch is also still there to this day. Her health diminished and the day finally—begrudgingly—came when she had to go into assisted living, as that was *the only option she had.* She was a proud rancher and when her husband died in early 2000's, she continued to *run her neighboring ranch on her own*, a recognized pioneer of women in ranching, in that regard. She loved that land. I can't speak for her, but I did talk to her shortly before she went into assisted living in town. She did not want to go, but had no options. She was dead within a few months. Would she have chosen MAID if she could have? I don't know. But, I would have been honored to be at her side through that process if she did so choose. Bonus: It was during the height of Covid; once she was in assisted living, there was no leaving. She could not visit her land nor could she be visited. She died in confinement, which I suspect was psychological torture for her. In talking with her on the phone, her day consisted of staying in her room and she did not like it. "But what can you do?" or words to that effect was what she told me, once. I have no idea how that sacred event of her passing presented itself in the facility, but I would have wished for her peace and dignity…and mercy…on the land she loved, truly surrounded with friendship and family…if that was an option.

How else does government funnel us? Well, I saw that $450B+ is being spent on illegal aliens or possibly that is only on housing for illegals, it was not clear. Our state leadership in Denver is in alignment with that policy. Ditto for the hundreds of billions going to Ukraine and other countries. Then, there is the push to take away full-agonist opioids for the treatment of chronic pain. You see, it is the removal of all supports: *that is how* you funnel people to MAID, all legal-like. Take away homes, take away pain management, take away a person's ~~reason~~ *ability* to live. But don't make MAID accessible, or the optics will be bad. In fact, charge people $850 for the Rx, and don't permit insurance to pay that. That way, you can get the last cash they might have—that's right, extort $850 out of them, as a parting tribute, but claim clean hands: "We'll stop torturing you…for eight-fitty. You did this. Neither we nor the insurance agencies had anything to do with it." Well, that's not entirely true: *funneling.*

If my tone sounds "spicey," please appreciate it's merely meant to be assertive and not euphemistic, to shine light on the absurdity of how seniors/veterans/disabled are treated in contrast to illegal aliens and other countries and political ambitions. These are horrible policies that have deeply impacted the entire nation. I believe rural Colorado shares my opinion towards self-serving, short-sighted, governmental policies. We *all* should be angry at what is happening to the nation and world, and this debate is only a tiny part of the larger.

For example, that money spent on welcoming and supporting illegals…could go a long ways towards ***housing for seniors/vets/disabled***. We could be fully exempt from paying property taxes, too. Incentives for employers to hire seniors/vets/disabled could be enhanced. But there is no political hay to be stacked in those fields. Those groups have little political upside, it seems. They're a burden. That political narcissism is the ugliness rural Colorado (in my opinion) would have me underline in passing, without politely "churching it up."

Look, I can only speak of my experience. But…from all the Facebook groups and Twitter (X) people…? There are *a lot* of people in the same boat, with neurological/autoimmune/autonomic diseases alone. A lot. Covid arguably has greatly amplified those numbers. As a group, it's hard for us to contribute. Hard, but largely not impossible. For a good portion, it's impossible. I can contribute. Here I am, writing this to you folks *for free*. People tend to expect our stuff to be free, which is problematic, for one thing. I can do software work but require a lot of flexibility and low hours. I can write. I can research. But no one will hire on the terms I need. It sucks, also, that our GDP-based society would demand seniors work until they die—no leeway given to illness and disability.

It's the types of accommodations we need. They simply do not mix with the predatory/competitive corporate culture we have. Our economic engine literally forces us to be part of someone's wealth funnel to have permission to live. [Unrelated, there is another economic engine available, but no one wants to hear about it.]

What I, and (I suspect) this larger group in general need: "Low-stress, meaningful work, mentorship to get you up-to-speed in three-to-six months. Friendly environment, flexible hours, 10-15hrs/week, remote work valued, where our people are valued for who they are. Growth in responsibilities and duties as your skills naturally grow. We are a *no striving zone*." In other words, there are high-level contributions I could still make…but that scenario simply does not exist in my industry, the computer industry. My productivity is being wasted. Government could stop the funneling plus focus on providing what we need to be effective, to stay in the *tenable zone*. Then, government can truly say "We had nothing to do with this," when people choose self-mercy.

Opposing Arguments: People will abuse the system and unlive themselves unnecessarily. Well, ok, but they do that already—again, using the "back-alley coat hanger approach." If someone does this, isn't it fair to say they in general—unless an impromptu act of passion (which the proposed 48hr waiting period would prevent)—must have had a good reason? My experience with beloved dogs, is that they *always* know when it is their time. If anything, they hang in there too long, for the benefit of their humans. My suggestion would be to not make it gruesome to bail out, but instead—this is crazy talk, I know—for government to actually seek the well-being of the planet and humanity over their bottomless lust for wealth and influence. You know, make the world a non-toxic place to live and thrive. I remember the days when everyone in town could leave their homes unlocked, day or night. Oh, there was gossip, adultery, drama, bigotry, negative human nature, sure. But fact remains: doors unlocked day and night. We've gone the wrong direction.

Fun Fact: If you all live long enough, all these issues will apply to you and those you love. We all will eventually be left to contemplate the terms for how we leave this world; be careful what world you help co-create for yourself, those you love, and your constituents. This bill is a step in the right direction.

Regards,

Richard Warner

Bio: Colorado 4th Generation Native. Family ranch in Hayden area was de facto “Ponderosa-sized” back in the day. Patent App for underlying tech enabling augmented reality & VR goggles, etc., (was first to reduce Intangible Reality to practice, aka invented it). Writer who has published eight books plus articles in MacTech, Radio-Electronics, Far Cry Literary Magazine, South American Explorer, and Ibn Qirtaiba (now-defunct literary website for Australian Mensa Society). Attended Rose-Hulman I.T., University of Montana, and Colorado State University. Ecologist and computer scientist by training. Former GS-13 Computer Scientist for federal government, plus contractor to Hewlett-Packard, EDS, and Bureau of Census. Developed concept of Hope Now Project for incentivized conception control to reduce global poverty and overpopulation at the same time, plus a different economic engine (based on per capita GDP instead of GDP) that can grow personal prosperity economy in down-trending population. Developed five simple things that if everyone globally and en masse did them, could halt biospheric destruction (fossil fuels and meat did *not* make the Top 5, as they are dealing with secondary issues rather than root or primary ones). Has traveled substantially in Latin America and South Pacific. Lives in rural Larimer County.

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[i] https://www.straightdope.com/21343302/did-eskimos-put-their-elderly-on-ice-floes-to-die

Colorado State House of Representatives

Department of Health and Human Services

Amendments to the Medical Aid in Dying Improvement Bill

From Sunny Weber

Thank you for this opportunity to speak. I wish to testify on behalf of shortening the wait time for MAID assistance.

May 1st, 2023 my mother died at age 94. Her name was Ruthie. She was once a lithe, red-haired beauty who could have doubled for the actress Barbara Stanwyck.

After years of decline, Ruthie made her first request to the Colorado Medical Aid in Dying process to end her life. She had been in hospice six months.

Every organ in her body had shut down—kidneys, liver, bladder, intestines. As bodily toxins built up, she likened it to “forever flu.”

She was blinded by macular degeneration—wet in one eye, dry in the other. She suffered end stage COPD, chronic bronchitis, and was on full time oxygen. She woke up nights gasping in panic for breath.

Ruthie was chronically dehydrated because fluids put pressure on her congestive heart failure that resulted in crushing chest pain. She could not defecate without laxatives. She had vertigo. Severe arthritis in every joint froze her body into a hunched, paralyzed lump.

Despite $6,000.00 hearing aids, she could not hear. She could not walk. Despite years of wasting away that erased all quality of life, and countless ER trips, nothing ever quite killed her.

Despite all the losses, Ruthie remained cognitively lucid. She knew she was imprisoned in a useless body.

Always a fastidious self-groomer, Ruthie lost the ability to maintain her own hygiene. A shy, religious girl, she had become dependent on strangers for the most intimate of bodily care. She was mortified as she lost control of every private function.

A devout Catholic, Ruthie struggled with waiting for “God’s will” to release her. She couldn’t understand why He would require such suffering. On top of all her other losses, she lost her faith.

When the compassionate counselors of MAID, reassured her that she wouldn’t go to Hell if she chose to die, she made her decision.

During the two weeks delay between the first and second mandated requests for aid in dying my mother suffered not only from her physical ailments but just as greatly from the emotional trauma of having made her decision—the only thing left in her power—but knowing she was blocked by unknown “Powers That Be.” Impersonal legislation kept my frail mother from ending her suffering on her own timeline.

During the wait, pain and illness forced Ruthie to submit her alert brain and courageous spirit to the fog of mind addled drug induced semi-consciousness. She no longer qualified for MAID. She was forced to linger in pain. She lay unconscious waiting, waiting, waiting.

Once a person has made the decision to end their own life in a humane and peaceful way, they should not have to wait. For what? For a miracle of some sort of fantasy recovery?

Over and over, my mother begged. She just wanted to “go to sleep and never wake up.”

I have worked with animals all my life and we have NEVER allowed the suffering my human mother underwent. We show far more compassion, respect, and love to our nonhuman companions.

Please pass this bill.

Good afternoon, fellow Colorado citizens. My name is Cathryn Bauer. I am a retired court reporter, and I live in Durango, Colorado, Senate District Six, House District 59. I am here today to urge your full support for SB 24-068 which would increase access to Medical Aid in Dying.

My late husband, Theodore Kahn, suffered from liver cancer, leaving this world on November 8, 2022. Liver cancer is painful, debilitating, and incurable once it has metastasized. I remain deeply grateful for the peaceful and dignified end that MAID provided him. However, his last weeks and months were made even more difficult because of the difficulties we encountered in locating a practitioner who would provide us with MAID services.

When Ted first requested that I find out about MAID for him, I contacted Compassion and Choices in Portland, Oregon. Their representative spoke with us at length about legal requirements, the rigorous screening process, and other aspects of the MAID journey. I was given the name and contact information of two physicians in the Durango environs whom they believed would offer MAID services. However, neither of them even saw fit to return my phone calls. An appeal to Compassion and Choices gave us the name of another physician in a Denver suburb. Colorado MAID laws required two visits with her as well as a psychiatric consultation. One doctor visit and the psychiatric appointment could be held over Zoom. However, the second physician visit was required to be in person. This doctor referred us to a psychiatrist and said that she would bring the drugs needed for MAID with her to the required face-to-face visit. Since Ted was too weak to travel from Durango to the Denver area, we had her fly from her office to our home. Her transportation and fees amounted to approximately $4,000. Allowing advanced practice nurses to screen patients seeking MAID and prescribe the necessary drugs would eventually shorten and ideally eliminate this grueling ordeal of seeking out a physician, particularly in rural areas.

I wish that I were allowed to show you the video that was taken a few moments before Ted's death. It would show the stress our difficulties in locating this physician caused us and the negative effect the struggle had on Ted's already-deteriorating condition far more effectively than any other way that I could provide. So I will quote from this video: "What people don't understand is just the crap that one has to go through to figure out the end of life…the amount of work it takes to do to get to the end is just amazing." Later, he emphasized, "And yet, it's a Colorado right as a citizen. And, you know, they really do a disservice. Get the hell out of the way. You know, just let people do – have the freedom to exercise the rights they've been given. That would be more beneficial than anything they're doing." He spoke of the expense of the various evaluations, the high cost of the drugs, and ancillary charges: "If we didn't have the means to do this, it would have been out of our reach." Ultimately, our total costs reached nearly $7,000. None of these expenses were covered by insurance, nor were they tax-deductible. We were fortunate in that we were able to liquidate investments to pay for these services out of pocket. It is a given that others are not so fortunate. Thus, the painless and dignified death that is their legal right is out of their reach. SB 24-068, if voted into law, would eliminate this outrageous injustice. Fellow Colorado citizens, I urge you to vote yes on SB 24-068.

DR. JENNIFER CURRIN-MCCULLOCH

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Regarding: Health and Human Service Committee Bill SB24-068

Chair Representative Lindsey Daugherty and Vice Chair Representative Mary Young and Committee Members

March 29, 2024

Dear Chair, Vice Chair and Committee Members of the Health and Human Service Committee,

My name is Jennifer Currin-McCulloch and I am a concerned palliative care social worker, resident of Weld County and health/mental health researcher. I am testifying on how the current Colorado End-of-Life Options Act has created exhaustive psychological and physical barriers for those choosing to seek a medically assisted death. The area that I would like to focus my testimony is on how the current legislation excludes our states most vulnerable terminally ill individuals – those who are the most physically compromised and those who live in our rural and frontier communities.

Having worked for almost 30 years as a palliative care and hospice social worker and social science researcher, I have had the opportunity to witness the death and bereavement of countless families. Before moving to Colorado in 2019, all of these scenarios took place in states where a medical aid in dying was not authorized. Thus, I saw people experience physical and emotional dying processes that were meaningful, and also witnessed visually graphic and audibly arduous deaths where no amount of pain medication could relieve suffering, including my own father's excruciating 11-year fight with metastatic prostate cancer.

I choose to move to Colorado for my academic job so that I could be in a state where aid id dying was authorized. Since arriving, I have chosen a course of research that allows me to talk with families facing a terminal illness who have chosen medical aid in dying. Through my research with Coloradans, I have garnered extensive insight into how the current legislation offers options at end of life; however, these options are available only to a few selected people who live in metro communities with access to doctors and those who have a predictable, slow terminal disease progression.

I spent a week living in rural eastern Colorado visiting with patients and healthcare providers to learn about dying experiences of residents of these communities. I remember well visiting with a nurse practitioner practice in Holly where two APRNs served the healthcare needs of their communities. I overheard them talking with patients about their farms, how they were dealing with hardships, and exchanging inside jokes. I asked the APRNs about how people die in their community and if they choose medically assisted deaths. The APRNs' expressions changed to more sullen looks and one shared, "*We try our hardest to provide the best care to patients as they die. They have been with us their whole lives and the way our law stands, we have to abandon them at their most difficult final moments. We only have a physician visit our office once a month from his practice in Kansas. There is no way that people who are on their death bed can wait a month for a doctor to write the prescription for assisted dying meds. We basically have to watch our patients suffer and feel helpless in not being able to address their physical and psychological distress. We have been a part of their family and essential to their physical and emotional wellbeing and now we have no way to relieve their terminal suffering.*" The APRNs shared how having the ability to write prescriptions for assisted dying meds would enable them to maintain the medical home they want for their patients and be there for them at each pivotal life transition.

Echoing throughout the stories of patients pursuing a medically assisted death and their family members were exasperated narratives of how the 15-day waiting period has caused undue psychological harm to them or their family member. With most terminal illnesses, there is no clear indication when the individual will become so ill that they cannot self-ingest the assisted dying medications. This uncertainty leads people to live in a constant state of bodily surveillance and anxiety with fear that they will lose ability to move their limbs, to speak, swallow, or think clearly – legal requirements for the self-ingestion of assisted dying medications. The 7-day waiting period, and in some cases, the 48-hour waiting period, precludes our most vulnerable (e.g., those with terminal neurological illnesses such as ALS, brain cancers, and those in the final days of life) from having this end-of-life healthcare option. I talked with a nurse about her own father's death from cancer and how he died on day 13 waiting, 2 days before his scheduled second doctor consult to be approved for aid in dying medications. She shared "*I wish I could have been able to help him make his dying wish come true but we couldn't get his second doctor visit in time before he died.*"

By passing the proposed legislation (SB24-068), you can help Coloradans to expand the option for all terminally ill residents, and not just those living in metro areas or with predictable slow declines. Specifically, I suggest revising the bill to (a) allow Advanced Practice Registered Nurses (APRNs) to practice within their scope of work and prescribe aid-in-dying medication to qualifying patients; and (b) to reduce the mandatory waiting period between verbal requests for medical aid in dying from 15 days to 48 hours – including the provision for prescribing providers to waive the mandatory waiting period if the patient is unlikely to survive more than 48 hours and meets all other qualifications

Thank you Representative Daugherty and Young, and members of the Health and Human Service Committee for reading my testimony. I hope that you will consider my testimony and the suggestions I have offered from my perspectives as an expert in end-of-life care and mental health, and a concerned Colorado resident. Your consideration of these matters and solutions is very much appreciated.

Respectfully,

Dr. Jennifer Currin-McCulloch

Dr. Jennifer Currin-McCulloch

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Dear Chair Representative Lindsey Daugherty and Vice Chair Representative Mary Young

Thank you for the opportunity to provide written testimony. I support SB24-068. I am a long-term resident of Colorado, a retired social worker, and I have enjoyed supporting my community as a volunteer for Compassion & Choices since 2016. I collected and delivered signatures for our ballot measure, and I was present the day Proposition 106 passed with a
65 percent of Colorado voters saying yes. In 2017, I began providing education about the Medical Aid in Dying law and end-of-life options to Hospices, community groups and organizations as well as to individuals and their families. I also provide general information about end-of-life support and options to Coloradans at educational events in my community.

As a volunteer, I have had the honor of meeting with Coloradans who are exploring their end-of-life options, and they often want to share their stories. What is shared in my community is that it is difficult for individuals to find a physician willing to write a prescription for medical aid in dying. It can sometimes take weeks or months and when they finally find the physicians, they have to wait another 15 days before they are eligible to receive the medication. They may not survive that waiting period. For patients and their families, this has caused additional physical and/or mental suffering. Changing the waiting period from 15 days to 7 days, with the option of waving the waiting period if the patient is not expected to live through it, would help to eliminate additional suffering. As Coloradans, we have the option to request medication to take control at the end of our lives if we meet the criteria, but it’s difficult.

I had the opportunity to discuss medical aid in dying and end-of-life care to a group of people in Basalt, Colorado, along with another volunteer. For that group, as well as many rural locations in Colorado, they have limited access to physicians. Allowing APRN’s to prescribe medications would increase access for those in rural Colorado.

Whenever I provide educational presentations I always tell my audience I’m not sure if I would use Medical Aid in Dying but I’m glad I live in a state that allows me to make that choice.

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April 1, 2024

Chairman Lindsey Daugherty
Chair, House Health and Human Services Committee

Remarks of
Michelle Richart
Midwest Regional Liaison
United States Department of Defense-State Liaison Office

Support of: SB24-018– Physician Assistant Licensure Compact

Testimony

The Department of Defense is grateful for the opportunity to support policy changes proposed in Colorado SB24-018 regarding the Physician Assistant Licensure Compact, a measure to reduce barriers to physician assistants and employment in Colorado.

My name is Michelle Richart and I am the Midwest Regional Liaison for the Defense-State Liaison Office, operating under the direction of Under Secretary of Defense for Personnel and Readiness. We represent the Department and work with state leaders across the country who are concerned for troops and their families' welfare by harmonizing state and federal law and regulation on policy problems of national significance. These are identified by the Office of the Secretary of Defense, the Military Departments, and the National Guard Bureau as areas where states can play a crucial role. I am also a licensed professional and military spouse residing in Colorado.

The Department of Defense has advocated for improved licensure and career portability for military Service members and their spouses for several years. Military spouses are disproportionately affected by state-specific professional licensing requirements that can cause delays and gaps in employment, with thirty-six percent requiring a state license to practice in their professions and an annual cross-state relocation rate more than ten times higher than their civilian counterparts. Accordingly, military spouses experience unemployment and underemployment at significantly higher rates than their civilian peers.

State policies enacting interstate licensure compacts, such as the Physician Assistant Licensure Compact, relieve one of the many stressors of frequent military moves by enabling military spouses to transfer their licenses more quickly across state lines and obtain employment as soon as they relocate to a new state. These policies facilitate greater career sustainability for military spouses, improving their families' financial security and overall resilience.

Interstate licensure compacts benefit not only military spouses, but also apply to all eligible professionals to include active-duty Service members, members of the reserve components, veterans, and civilians. By continuing to enact these beneficial policies, Colorado can expand the opportunity to increase its workforce available to serve the local community while continuing in its great tradition of providing an extraordinary degree of support to our military families as they move into and out of the state.

In closing, the Department of Defense is very appreciative of Colorado’s ongoing commitment and efforts to support members of the military and their families who sacrifice much in service to our country. Thank you to Representatives Amabile and Winter for their sponsorship and to the committee providing me the opportunity to provide comments in support of this policy proposal.

Please feel free to contact me with any questions you might have.

Very Respectfully,

Michelle B Richart

MICHELLE RICHART
Midwest Regional Liaison
Defense-State Liaison Office