Vermont Written Testimony, Kim Callinan

S.74 Improving the Patient Choice at the End of Life Act
Senate Committee on Health and Welfare
January 12, 2022, 9am - 10am EST

Introduction

Good morning, Chairwoman Virginia "Ginny" Lyons, Vice Chair Senator Ruth Hardy and Members of the Committee.

My name is Kim Callinan. I am the President and CEO of Compassion & Choices, the nation's oldest and largest national nonprofit organization working to improve care, expand options and empower everyone to chart their own end-of-life journey. 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; and I am here today on behalf of our Vermont supporters and terminally ill residents. Thank you for considering improvements to the Patient Choice at the End of Life Act (S.74).

Compassion & Choices has played a leadership role in the passage and implementation of most of the medical aid in dying laws across the country. We partnered with Patient Choices Vermont to advocate for bringing this option here in Vermont. Additionally, as these laws are passed, we are allies with the community-based organizations, such as Patient Choices, to help with implementation by raising awareness of the medical practice and providing education and training to providers and health systems on how to administer medical aid in dying.

In my role as CEO, I see first-hand how the freedom and autonomy of medical aid in dying brings profound comfort, peace, and relief to dying people as well as those who love them.

Of course, medical aid in dying laws must be written, enacted and implemented with great care and reason. And here in Vermont you have done just that, and as pioneers I might add. While Oregon, Washington and Montana implemented their medical aid in dying laws before Vermont, their laws were all authorized via citizen initiative or court decision. Vermont was the first state in the nation to implement a medical aid in dying law through the legislature; since then a half a dozen other state legislatures have followed your lead.

In doing this, you did exactly as you should have. You put in as many regulatory requirements as possible into the law to protect vulnerable populations. And of course, protecting vulnerable populations remains of utmost importance.

However, considerable time has passed since the Vermont legislature authorized its law. We now have 24 years of experience in Oregon and additional years of experience across the other 10 jurisdictions to draw on. We know that with a few minor adjustments to the Vermont law we can continue to protect vulnerable populations, while allowing more of the eligible population to be able to access the law. On behalf of our Vermont supporters, thank you for considering these minor amendments to the Patient Choice and Control at the End of Life Act.

Connection to COVID-19

This year, the COVID public health emergency brought about a deeper understanding of the fragility of our lives, the tragedy of people dying alone without the care and comfort of loved ones, and the limits of modern medicine to relieve suffering at life's end. It also reinforced the need to modernize medical aid-in-dying legislation to better reflect the realities of the current practice of medicine. While the law is benefitting some eligible terminally ill residents, far too many eligible residents are robbed of the promise of the law because it includes unnecessary regulatory roadblocks.

Facts About Medical Aid in Dying

In 2013, lawmakers in Vermont heard the voices of their constituents and voted for passage of the Patient Choice and Control at End of Life Act. Since that time, the law has directly benefited those who have used the law and indirectly benefited all terminally ill residents. Evidence suggests that the passage of aid-in-dying laws result in

- improved conversations between physicians and patients,[1]
- better palliative care training[2] and
- improved enrollment in hospice care.[3]

Since the Patient Choice and Control at the End of Life Act has been implemented, there has not been a single proven incidence of abuse or coercion.

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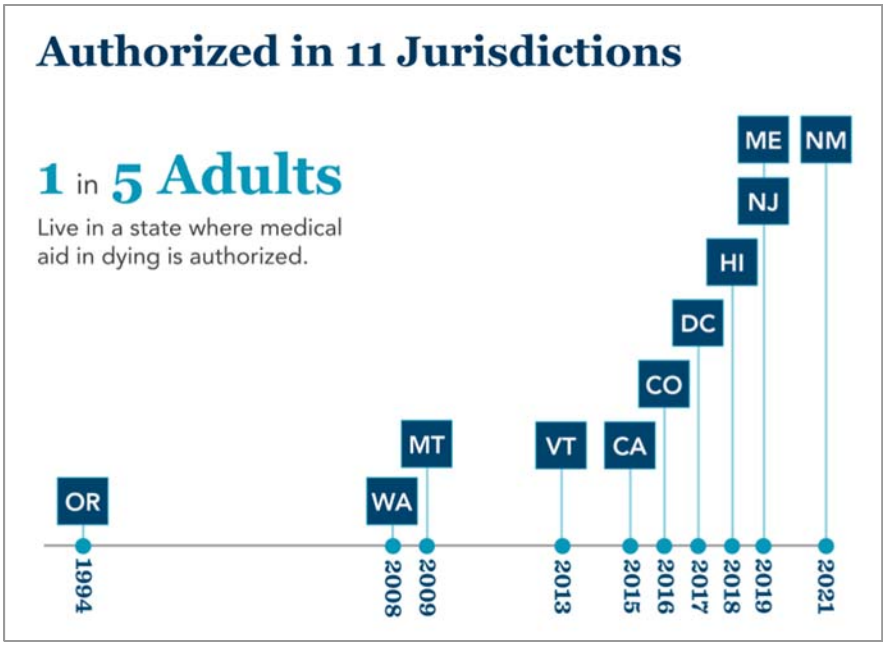
[1] *Geographic Variation of Hospice Use Patterns at the End of Life.* Journal of Palliative Medicine, S.Y. Wang, M.D, Aldridge, C.P. Gross, et al. (2015). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4696438/

[2] *Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death with Dignity Act.* JAMA. L. Ganzini, H.D. Nelson, M.A. Lee, D.F. Kraemer, T.A. Schmidt, M.A. Delorit, (2001). Available from: https://pubmed.ncbi.nlm.nih.gov/11343484/

[3] *Oregon's Assisted Suicide Vote: The Silver Lining*. Annals of Internal Medicine, M.A. Lee, S.W. Tolle, (1996). Available from: https://www.acpjournals.org/doi/10.7326/0003-4819-124-2-199601150-00014?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed

The Growing Movement

Today, more than one in five people, 22%, live in a jurisdiction where medical aid in dying is authorized either through statute, ballot measure or court decision. Oregon (1994, ballot initiative), Washington (2008, ballot initiative), and Montana (2009, state Supreme Court decision) were the first states to authorize the medical practice. After Vermont passed its law, six states and Washington, DC, followed: California (2015, legislation), Colorado (2016, ballot initiative), Hawaii (2018, legislation), New Jersey (2019, legislation), Maine (2019, legislation), and New Mexico (2021, legislation).



The growing support for medical aid in dying is attributable, in part, to the fact that it is a compassionate and time-tested end-of-life care option. We now have close to 25 years of experience since the law was first enacted in Oregon and years of experience from the laws passed in the 10 other authorized jurisdictions. None of the dire predictions that opponents raised have come to fruition. A few facts:

- There has never been a single substantiated case of misuse or abuse of the laws.
- A 2015 report from the Journal of the American Academy of Psychiatry and Law noted there is “no evidence to support the fear that assisted suicide [medical aid in dying] disproportionately affects vulnerable populations.”[4]
- Disability Rights Oregon (DRO) former Executive Director Bob Joondeph confirmed in a letter written on Feb. 14, 2019 that: “DRO has never to my knowledge received a complaint that a person with disabilities was coerced or being coerced to make use of the Act.” The evidence

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[4] Gopal, AA. 2015. Physician-Assisted Suicide: Considering the Evidence, Existential Distress, and an Emerging Role for Psychiatry. Journal of the American Academy of Psychiatry and the Law. Vol 43(2): 183-190. Available from http://jaapl.org/content/43/2/183.

confirms that medical aid-in-dying laws protect patients while offering a much-needed compassionate option.

How Many People Use the Law

In addition to Vermont's report issued just a week ago,[5] public health departments in eight other authorized jurisdictions have issued reports regarding the utilization of medical aid-in-dying laws: Oregon,[6] Washington,[7] California,[8] Colorado,[9] Hawaii,[10] the District of Columbia,[11] Maine,[12] and New Jersey.[13] Vermont's data parallels that of the other jurisdictions, which cumulatively shows:

- Far fewer than 1% of the people who die in each state will decide to use the law each year. This amounts to 5,171 people cumulatively across all years and all authorized states.[14] In Vermont, based on the report published by the Vermont Department of Health just a week ago, 116 people in 8 years have accessed the law.

State	OR	WA	VT	CA	CO	DC	HI	NJ	ME
Data Period	1997 - 2020	2009 - 2019	2013 - 2021	2016 - 2020	2017 - 2020	2017 - 2018	2019 - 2020	2019 - 2020	2019 - 2020
MAID Deaths	1,905	1,435	116	1,662	*508*	2	47	45	1

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[5] *Vermont Patient Choice at the End of Life Data Report* (2022) Available from: https://legislature.vermont.gov/assets/Legislative-Reports/2022-Patient-Choice-Legislative-Report.Final.pdf

[6] *Oregon Death with Dignity Act Annual Report* (2020) Available from: https://oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

[7] *Washington Death with Dignity Act Annual Report* (2019) Available from: https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf

[8] *California End of Life Option Act Annual Report* (2020) Available from: https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPHEndofLifeOptionActReport2019%20_Final%20ADA.pdf

[9] *Colorado End of Life Options Act Annual Report* (2020) Available from: https://drive.google.com/open?id=1-gPiQos0ezHQrL6nMI1FZL8J3ODNkwRV

[10] *Hawaii Our Care, Our Act Annual Report* (2020) Available from: https://health.hawaii.gov/opppd/files/2020/01/OPPPD-Our-Care-Our-Choice-Act-Annual-Report-2019-1.pdf

[11] *District of Columbia Death with Dignity Act Annual Report* (2018) Available from: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/DWD%20Report%202018%20Final%20%20%208-2-2019.pdf

[12] *Maine Patient Directed Care at End of Life Annual Report* (2020) Available from: https:/maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/Death-with-Dignity-Legislative-Report-050420.pdf

[13] *New Jersey Medical Aid in Dying for the Terminally Ill Act* (2020) Available from: https://nj.gov/health/advancedirective/documents/maid/2019_MAID_DataSummary.pdf

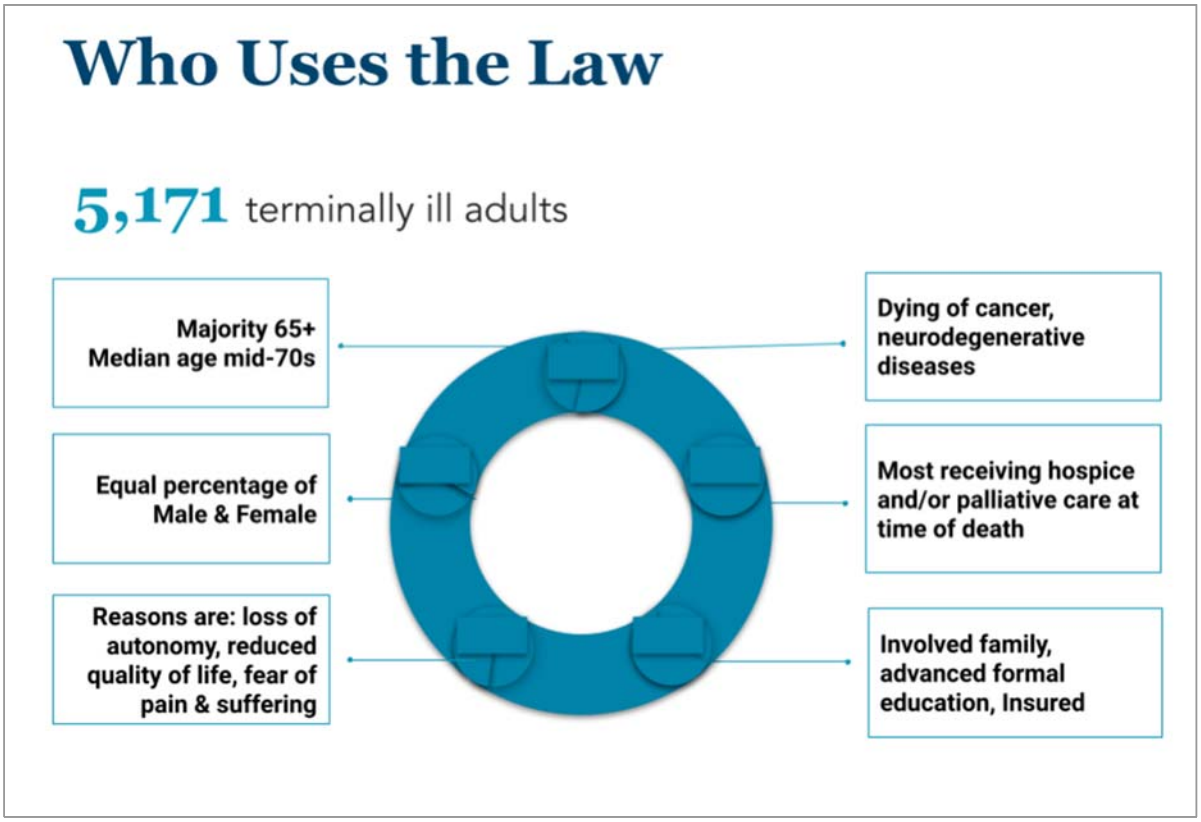
[14] Colorado data reflects all deaths identified among individuals prescribed aid-in-dying medication, whether or not they used this medication. As a result, this cumulative number may be slightly lower when taking this into account.

- One-third of people who go through the process and obtain the prescription never take it. This is certainly true in Vermont — of the 29 confirmed deaths between June 1, 2019 and June 30, 2021:
    - Close to two third of the patients (59%) used the aid-in-dying prescription
    - One third (34%) — as is the case with the other authorized jurisdictions — died from their underlying disease

Who Uses the Law

Across the authorized states:

- The majority of people who use the law are older than 65 years of age; equally male and female.
- The vast majority of terminally ill people who use medical aid in dying — more than 86% — received hospice services at the time of their deaths.
- Nearly 90% of people who use medical aid in dying are able to die at home, which according to various studies is where most Americans would prefer to die.
- The reasons terminally ill people are choosing medical aid in dying include loss of autonomy, reduced quality of life, and fear of pain and suffering.



Who Uses the Law

5,171 terminally ill adults

Majority 65+
Median age mid-70s

Equal percentage of Male & Female

Reasons are: loss of autonomy, reduced quality of life, fear of pain & suffering

Dying of cancer, neurodegenerative diseases

Most receiving hospice and/or palliative care at time of death

Involved family, advanced formal education, Insured

Vermont does not publish data on these variables; however, they do list the underlying diagnosis of the patients who have used medical aid in dying:

- Terminal cancer accounts for the vast majority of qualifying diagnoses with neurodegenerative diseases, such as ALS or Huntington's disease, following as the second leading diagnosis. This holds true in Vermont as well — since 2013, when the law was enacted, 77% of patients who used medical aid in dying had cancer and another 16% had a neurodegenerative disease, such as ALS. (The other 7% were listed as other.)

Legislative Overview

Vermont and the other U.S. jurisdictions that have authorized medical aid in dying through legislation modeled their bills after Oregon's Death With Dignity Act. They each include the same strict eligibility criteria and practice requirements to ensure the highest standard of care, as described in the clinical criteria and guidelines published in the prestigious, peer reviewed Journal of Palliative Medicine.[15]

To be eligible for aid-in-dying medication in Vermont and all other states, an individual:

(1) must be a mentally capable adult,
(2) must be terminally ill with 6 months or less to live,
(3) must make the request on their own behalf,
(4) must be educated by their qualified medical provider on all other end-of-life care options,
(5) may be allowed to withdraw their request or decide not to use the medication and
(6) must be able to self-ingest the medication.

Medical aid in dying does not allow for the administration by lethal injections by any person including the physician or patient.

Advanced age, disability and chronic health conditions are not qualifying factors for medical aid in dying.

The Vermont law also requires a dozen steps, including two physicians to confirm the person meets eligibility criteria, as well as two or more witnesses. Each of the laws, including S.74, establish the following core safeguards:

- The attending medical provider must inform the terminally ill adult requesting medical aid in dying about all other end-of-life care options. These other options include comfort care, hospice care, pain control and palliative care;

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[15] *Clinical Criteria for Physician Aid in Dying.* Journal of Palliative Medicine; D. Orentlicher, T.M. Pope, B.A. Rich, (2015) Available from: https://drive.google.com/file/d/1Uno90VkE2JcUVC-Wp5lbZ7hYiXdUbJmC/view?usp=sharing

- The attending medical provider must inform the terminally ill adult requesting medical aid in dying that they can change their mind at any time. This patient right to change their mind includes deciding not to take the medication once they have obtained it;
- The attending medical provider must also offer the individual an opportunity to rescind their request.

These core safeguards ensure that individual patient preferences, needs and values are honored, and guide all clinical decisions, including the decision to use medical aid in dying.

In addition, medical aid in dying is being regulated within the practice of medicine with established clinical guidelines and a recognized standard of care. In addition, all the education, training and oversight in place to protect patients undergoing any other medical procedure, also exist to protect patients accessing medical aid in dying. While some additional procedural safeguards may be appropriate, too many are unnecessary and will defeat the law's very purpose.

The Patient's Choice at End of Life Act: What Would Be Different

The improvements being proposed evolve from 24 years of experience since the law was first enacted in Oregon and years of experience from the laws passed in the 10 other authorized jurisdictions.

Telehealth

Vermont's current law requires that a patient make both oral requests for medication in the physical presence of a physician. The law also requires the prescribing physician to conduct a physical examination of the patient to determine that the patient is suffering from a terminal condition. It is the only statute among the 10 authorized jurisdictions that specifically requires requests be made in the physical presence of the provider.

This requirement makes it so that Vermont physicians are not able to use telehealth in an appropriate way to support their patients in accessing medical aid in dying. During COVID this requirement forced dying patients looking to access the law to be exposed to a disease that could result in a faster and lonelier end than they already faced.

This choice is unnecessary. Telehealth is being regularly and effectively used by providers in other jurisdictions where medical aid in dying is authorized. The concern that adding telehealth as an option will increase coercion and abuse is unfounded. In nearly 50 combined years of medical aid in dying in authorized jurisdictions, including two decades of rigorously observed and documented experience in Oregon, not a single instance of abuse or coercion has ever been substantiated. Telehealth is routinely used across most of the other authorized jurisdictions. The laws work as intended, with none of the problems opponents predicted prior to Oregon's law passing in 1994 or in the nine other jurisdictions (Washington, Montana, Vermont, California, Colorado, Hawaii, Washington, D.C., Maine, and New Jersey) that have authorized the practice since.

The proposed changes to the Vermont bill simply align it with the other authorized jurisdictions by removing the requirement for an in person visit. Under existing laws, audio-only telephone calls between clinicians and patients may not be used exclusively to meet all of the requirements of medical aid in dying. And while video-calls are allowed to be used for the entire process, it does not mean that video calls will replace in person visits in all circumstances; it simply means that physicians would have the flexibility to practice medical aid in dying using the existing standard of care and telehealth laws to provide their patients with the best care possible.

- Because doctors are allowed to opt out of participating, some patients may have received their terminal diagnosis from several doctors before they find one who will support them.
- Other patients know for years that they want the option of medical aid in dying, and they have established care with a doctor who they know will support them with this option when the time comes. They may get a terminal diagnosis from their oncologist and seek medical aid in dying from their primary care provider, and that doctor is comfortable given the pre-established relationship and years of clarity from the patient in supporting them via a video call.
- In other circumstances, a doctor will feel like an in-person visit is necessary either to confirm the prognosis and/or to ensure that abuse or coercion is not occuring.

By removing the requirement that providers be in the physical presence of the doctor you are simply allowing doctors to use the standard of medical care to dictate how medicine should be practiced, rather than having another legislative roadblock get in the way of patient care. This standard of care is consistent with the recommendations of every major professional healthcare advocacy group and association.[16]

48-hour Timeframe

Vermont has one of the longest overall timelines for getting a prescription out of all the authorized states. Most of the other authorized states require a minimum of 15 days between the initial request and writing the prescription. Vermont's law requires 17 days. It includes a 15 day time period between the first and second request for medical aid in dying. In addition, it requires the physician to delay writing a prescription for 48 hours after the last of the following events have occurred: the patient's written request for medication; the patient's second oral request; or the physician's offering the patient an opportunity to rescind the request.

While the legislation mandates a minimum of 17 days from first request to the writing of the prescription for most patients the time frame is far longer as patients need to find supportive doctors, schedule appointments, and get the prescription filled. And as is the case with medical care in general, rarely does this all happen perfectly sequentially.

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[16] AMA Policies, Coverage of and Payment for Telemedicine H-480.946, The Promotion of Quality Telemedicine H-160.937

The longer timeframe has proven to be a barrier for individuals seeking medical aid in dying rather than a necessary safeguard. Data from the authorized states suggests that it takes weeks to months for most patients to get through the 13 step process. Unfortunately, a third to half of patients die suffering during the legislated delay. States across the country are recognizing that the legislated delay ends up being an unbearable suffering period for a terminally ill patients and adjusting their approach accordingly:

- In 2019, the Oregon legislature updated its Death With Dignity Act and now allows a physician the ability to waive the 15-day period if a person is going to imminently die. In the first year of implementation, 20% of patients-- that's 75 people--were given exemptions;[17] this is an astounding demonstration of just how many patients are unnecessarily dying -- deprived of a law that is supposed to bring compassion -- as a result of this provision.
- In March, the New Mexico legislature passed their medical aid in dying bill, with a 48 hour waiting period and a physician waiver for patients who are likely not to make even that reduced period.
- The California legislature, just last year, amended it's bill to reduce their 15-day timeline to 48 hours. It went into effect January 1.
- The state of Washington is considering reducing its 15-day timeline to 72 hours.

S. 74 would shorten the timeline for access to medical aid in dying by 48 hours, while maintaining the 15-day timeframe between the first and second request. This change would bring the Vermont law in line with the original laws in most of the other authorized jurisdictions.

Extending Immunities

Vermont's current law provides immunity to physicians only, leaving pharmacists, nurses and others who participate in medical aid in dying at risk. All states, with the exception of Maine, extend immunities to any person, which helps to improve participation rates among providers such as pharmacists and nurses.

S. 74 would expand immunity for anybody who participates in and acts in good faith for medical aid in dying. Extending the immunities gives protections to providers, pharmacists, administrators and others who participate in the practice of medical aid in dying.

The immunities in this act are similar to the immunities across the other authorized jurisdictions. They don't prevent anyone from suing a doctor or other provider if they have violated the law and committed malpractice. Under no circumstances would malicious intent satisfy the "good faith" standard under the law. These immunities simply allow doctors or other providers to make the decision to provide, or

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[17] Oregon Health Authority, Oregon Death with Dignity Act: 2020 Data Summary, February 2021. Available from: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

respectfully decline, going through the process of writing or filling a prescription under the law without fear from baseless lawsuits that have nothing to do with the standard of care.

Support Is Strong

Among the Public

Public opinion polling from a variety of sources, both nationally and at the state level, demonstrates that the American public consistently supports medical aid in dying, with majority support among nearly every demographic group. About 60-70% support in May 2020 — as measured by national independent polling outlets such as Gallup.[18] State-by-state polling also indicates majority support that cuts across demographics.[19]

This broad support spans nearly every demographic, from age to ethnic group, and from religious to political affiliation. In 2016, LifeWay Research, a historically conservative, religious organization, released a survey that concluded national support for medical aid in dying stood at 67%, even though the questionairre used the biased term “assisted suicide” to describe medical aid in dying.[20] The survey also demonstrated that majority support spanned a variety of demographic groups, see figure below.

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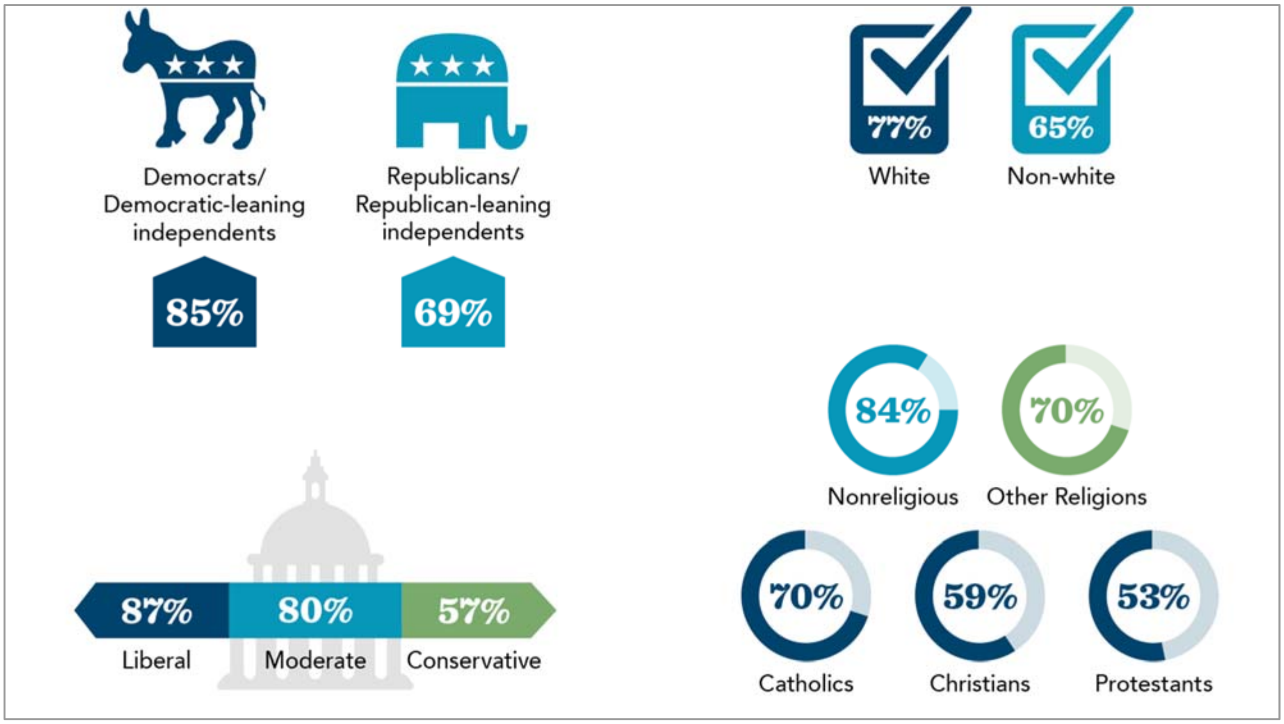
[18] Prevalence of Living Wills in U.S. Up Slightly. June 22, 2020. Available from: https://news.gallup.com/poll/312209/prevalence-living-wills-slightly.aspx.

[19] Compassion & Choices. National and State Polling Data. Available from: https://compassionandchoices.org/resource/polling-medical-aid-dying/

[20] *American Views on Assisted Suicide.* LifeWay Research (2016) Available from: http://lifewayresearch.com/wp-content/uploads/2016/12/Sept-2016-American-Views-Assisted-Suicide.pdf



Support for medical aid in dying is high among demographic groups.

Within the Medical Community

Among U.S. doctors, support for medical aid in dying is also strong. A 2020 Medscape poll[21] of 5,130 U.S. physicians from 30 specialties demonstrated a significant increase in support for medical aid in dying from 2010. Today, 55% of physicians surveyed endorse the idea of medical aid in dying, agreeing that "Physician assisted death should be allowed for terminally ill patients." Another Medscape poll[22] conducted in June 2017 found that some 62% of doctors who practice in states that do not allow medical aid in dying said they had been in a situation in which they wished the patient could have been able to exercise that right. Additionally, 56% of doctors who responded said they thought the passage of medical aid in dying laws was a positive development.

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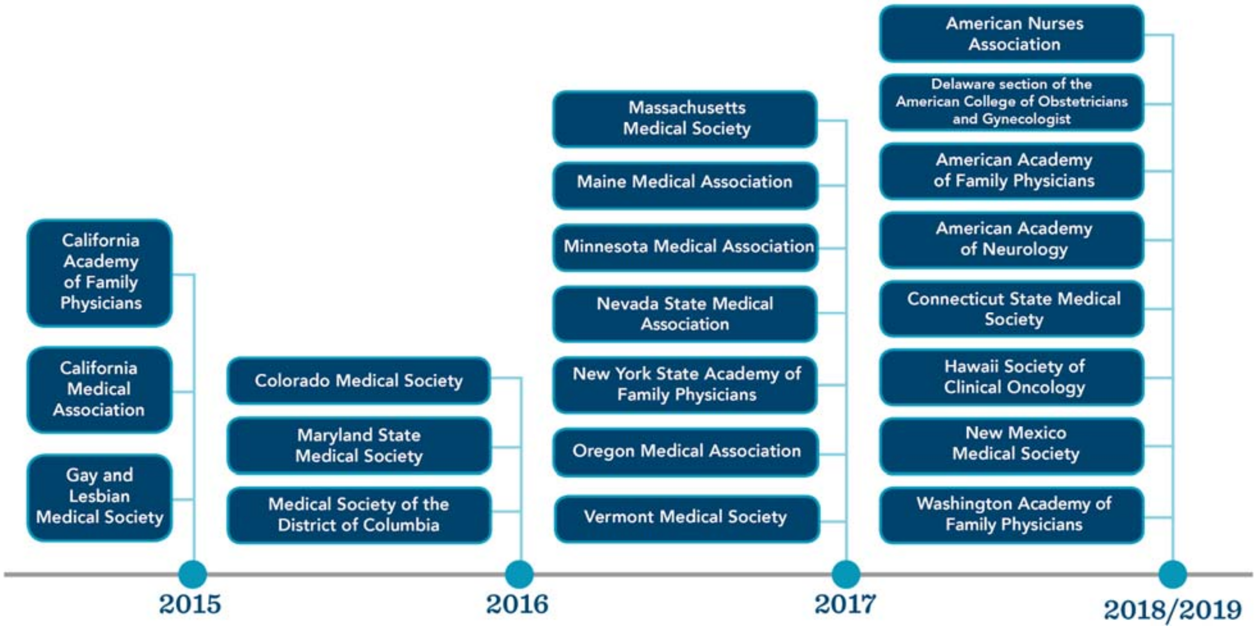
[21] Medscape Ethics Report 2020: Life, Death, and Pain, November 13, 2020. Available from: https://www.medscape.com/slideshow/2020-ethics-report-life-death-6013311#2.

[22] *Medscape Poll, June 2017, Physician Assisted Death: Where do you stand?* (2017) Available from: www.medscape.com/viewarticle/874341

Most of the medical associations in authorized jurisdictions currently have neutral positions on medical aid in dying, including the Vermont Medical Society,[23] as well as that of Oregon[24], California[25], Colorado[26], Hawaii,[27] and Maine[28].



Professional medical societies have dropped their opposition to medical aid in dying.

Six national medical organizations have taken positions supporting medical aid in dying:

- American College of Legal Medicine[29]

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[23] Vermont Medical Society, Position on Medical Aid in Dying, (2017). Available from: http://www.vtmd.org/sites/default/files/2017End-of-Life-Care.pdf

[24] Oregon Medical Association. Available from https://oma.informz.net/informzdataservice/onlineversion/ind/bWFpbGluZ2luc3RhbmNlaWQ9NjU0Mzk3MSZzdWJzY3JpYmVyaWQ9ODc4MzYwNjk3.

[25] California Medical Association. Excerpted from: CMA changes stance on physician aid in dying, takes neutral position on End of Life Option Act. June 2, 2015. Available at www.cmanet.org/news/detail/?article=cma-changes-stance-on-physician-aid-in-dying.

[26] Colorado Medical Society, Statement by CMS President-elect Katie Lozano, MD, FACR, regarding Ballot Proposition 106. Available from: www.cms.org/articles/statement-by-cms-president-elect-katie-lozano-md-facr-regarding-ballot-prop.

[27] *Hawai'i Society of Clinical Oncology Position on Medical Aid in Dying* (2018). Available from: https://www.accc-cancer.org/docs/ossn-network/hi/pdf/advocacy/hsco-maid-statement-on-letterhead.pdf?sfvrsn=d348ccab_0

[28] MMA Board Withdraws Opposition to Death with Dignity Legislation. May 1, 2017, http://newsmanager.commpartners.com/mainemed/issues/2017-05-01/index.html.

[29] American College of Legal Medicine, Excerpted from: Policy on Aid in Dying. October 6, 2008. Available from https://aclm.memberclicks.net/assets/docs/Policy_On_Aid_In_Dying.pdf.

- American Medical Student Association[30]
- American Medical Women's Association[31]
- American Public Health Association[32]
- GLMA: Healthcare Professionals Advancing LGBT Equality[33]
- National Student Nurses' Association[34]

Six national medical organizations have adopted neutral positions:

- American Academy of Family Physicians[35]
- American Academy of Neurology[36]
- American Academy of Hospice and Palliative Medicine[37]
- American Nurses Association[38]
- American Pharmacists Association[39]
- American Society for Health System Pharmacists[40]
- National Association of Social Workers[41]

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[30] American Medical Student Association, Excerpted from: Preambles, Purposes, Principles: Principles Regarding Physician Aid in Dying. 2008. Available from http://www.amsa.org/wp-content/uploads/2015/03/PPP-2015.pdf.

[31] American Medical Women's Association, Excerpted from: Position Paper on Aid in Dying. No date. Available from https://www.amwa-doc.org/wp-content/uploads/2018/09/Medical-Aid-in-Dying-Position-Paper.pdf.

[32] American Public Health Association, Excerpted from: Patient's Rights to Self-Determination at the End. Policy # 20086. October 28, 2008. Available from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/29/13/28/patients-rights-to-self-determination-at-the-end-of-life.

[33] GLMA: Healthcare Professionals Advancing LGBT Equality, Letter in Support of Assembly Bill X2-15, October 2, 2015, https://compassionandchoices.org/wp-content/uploads/GLMA-Letter-in-Support-of-CA-End-of-Life-Option-Act-2015.pdf.

[34] National Student Nurses' Association, NSNA Resolutions 2018, Pg. 57. Available from https://compassionandchoices.org/wp-content/uploads/National-Student-Nurses-Association-NSNA-Resolutions-2018-Pg.-57.pdf.

[35] American Academy of Family Physicians COD Addresses Medical Aid in Dying, Institutional Racism. October 10, 2018. Available from: https://www.aafp.org/news/2018-congress-fmx/20181010cod-hops.html.

[36] Lawful physician-hastened death AAN position statement. February 7, 2018. Available from http://n.neurology.org/content/90/9/420.

[37] American Academy of Hospice & Palliative Medicine. Excerpted from: Statement on Physician-Assisted Death, February 14, 2007. Available from http://aahpm.org/positions/pad.

[38] *The Nurse's Role When a Patient Requests Medical Aid in Dying,* American Nurses Association, 2019 Revised Position Statement. Available from: https://www.nursingworld.org/~49e869/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements/social-causes-and-health-care/the-nurses-role-when-a-patient-requests-medical-aid-in-dying-web-format.pdf.

[39] American Pharmacists Association, Actions of the 2015 APhA House of Delegates, Available from: https://www.pharmacist.com/sites/default/files/files/2015%20Report%20of%20the%20APhA%20House%20of%20Delegates%20FINAL.pdf

[40] American Society for Health System Pharmacists, *Board Report on the Joint Council Task Force on Pharmacist Participation in Medical Aid in Dying*. Available from https://www.ashp.org/-/media/assets/house-delegates/docs/hod-board-report-on-task-force.ashx.

[41] *National Association of Social Workers, NASW Standards for Palliative and End of Life Care*, Available from: https://www.socialworkers.org/LinkClick.aspx?fileticket=xBMd58VwEhk%3D&portalid=0.

There is growing recognition within the medical profession that patients want, need and deserve this compassionate option at the end of life; and this growing recognition is burgeoning into collaboration. As more jurisdictions authorize medical aid in dying, the medical community is coming together, and providers are sharing their experiences and fine-tuning their collaborative efforts to better serve dying patients.

Closing

We are NOT recommending expanding the eligibility criteria or removing the core safeguards necessary to protect patients. We are simply requesting minor legislative changes, all of which are already in practice in other authorized states, to better achieve the original intention of the bill.

Thank you for your willingness to consider improvements that will extend the benefits of the law to more eligible Vermont residents while ensuring vulnerable populations are protected.