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Representative **STEWART**: Thank you, Mr. Speaker. I think I want to make a Point of Order here because, do we have to back up the previous position of the House in order to do that? That's a parliamentary question and I'm not sure what the answer is there.

The SPEAKER PRO TEM: The Chair would answer in the negative. The previous motion in front of us was acceptance of the Majority Ought Not to Pass Report and the motion to send back to committee can be made over that motion pursuant to House Rule 503-A. So, when a question is under debate, a motion may not be received except a motion to, one, adjourn, two, table and assign, three, the previous question, four, commit, five, to table to a day certain, six, to amend, or seven, to postpone indefinitely. So this is the fourth in those lists of motions that are allowed.

Subsequently, the Resolve and all accompanying papers were **COMMITTED** to the Committee on **HEALTH AND HUMAN SERVICES** and sent for concurrence

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HOUSE DIVIDED REPORT - Majority (10) **Ought to Pass as Amended by Committee Amendment "A" (H-293)** - Minority (3) **Ought Not to Pass** - Committee on **HEALTH AND HUMAN SERVICES** on Bill "An Act To Reduce Youth Cancer Risk"

(H.P. 940) (L.D. 1297)

TABLED - May 21, 2019 (Till Later Today) by Representative HYMANSON of York.

PENDING - Motion of same Representative to **ACCEPT** the Majority **OUGHT TO PASS AS AMENDED** Report.

Representative O'CONNOR of Berwick **REQUESTED** a roll call on the motion to **ACCEPT** the Majority **Ought to Pass as Amended** Report.

More than one-fifth of the members present expressed a desire for a roll call which was ordered.

The SPEAKER PRO TEM: The Member may proceed.

Representative **O'CONNOR**: Thank you, Mr. Speaker, Ladies and Gentlemen of the House. Although all of us would like to prevent cancer in children, we'd like to prevent cancer in everybody, that would be our goal. However, what this bill does is it disallows parents to sign for their children under the age of 18, even if they sign to allow their children under the age of 18 to go into a tanning bed, they will not be allowed. This will prohibit that. And there are some cases where this is actually good for children, children who have psoriasis or acne, and basically this takes away parental control. Thank you.

The SPEAKER PRO TEM: A roll call has been ordered. The pending question before the House is Acceptance of the Majority Ought to Pass as Amended Report. All those in favor will vote yes, those opposed will vote no.

ROLL CALL NO. 141

YEA - Ackley, Alley, Austin B, Babbidge, Babine, Bailey, Beebe-Center, Berry, Blume, Brennan, Bryant, Caiazzo, Cardone, Carney, Cloutier, Collings, Cooper, Corey, Craven, Crockett, Cuddy, Daughtry, Denk, Dodge, Doore, Doudera, Dunphy, Evangelos, Farnsworth, Fay, Fecteau R, Foley, Gattine, Gramlich, Grohoski, Haggan, Handy, Hanington, Harnett, Hepler, Hickman, Higgins, Hobbs, Hubbell, Hymanson, Ingwersen, Jorgensen, Keschl, Kessler, Kornfield, Landry, Madigan C, Marean, Martin J, Mastraccio, Matlack, Maxmin, McCrea, McCreight, McDonald, Melaragno, Meyer, Moonen, Morales, Nadeau, O'Neil, Pebworth, Peoples, Perry A, Perry J, Pierce T, Pluecker, Reckitt, Riley, Roberts-Lovell, Rykerson, Schneck, Sharpe, Sheats, Stanley, Stearns, Stover, Sylvester, Talbot Ross, Tepler, Terry, Tipping, Tucker, Verow, Warren, White B, Zeigler, Madam Speaker.

NAY - Andrews, Arata, Austin S, Bickford, Blier, Bradstreet, Campbell, Cebra, Costain, Curtis, Dillingham, Drinkwater, Faulkingham, Fecteau J, Foster, Griffin, Hall, Hanley, Harrington, Head, Hutchins, Javner, Kinney, Kryzak, Lockman, Lyford, Martin T, Mason, Millett, Morris, O'Connor, Ordway, Perkins, Pickett, Prescott, Reed, Rudnicki, Sampson, Skolfield, Stetkis, Stewart, Strom, Swallow, Theriault, Tuell, Wadsworth, White D.

ABSENT - DeVeau, Dolloff, Grignon, Johansen, Martin R, McLean, Paulhus, Riseman.

Yes, 93; No, 47; Absent, 8; Excused, 2.

93 having voted in the affirmative and 47 voted in the negative, with 8 being absent and 2 excused, and accordingly the Majority **Ought to Pass as Amended** Report was **ACCPETED**.

The Bill was **READ ONCE**. **Committee Amendment "A" (H-293)** was **READ** by the Clerk and **ADOPTED**.

Under suspension of the rules, the Bill was given its **SECOND READING WITHOUT REFERENCE** to the Committee on **Bills in the Second Reading**.

Under further suspension of the rules, the Bill was **PASSED TO BE ENGROSSED as Amended by Committee Amendment "A" (H-293)** and sent for concurrence.

By unanimous consent, all matters having been acted upon were **ORDERED SENT FORTHWITH**.

HOUSE DIVIDED REPORT - Majority (7) **Ought to Pass as Amended by Committee Amendment "A" (H-305)** - Minority (6) **Ought Not to Pass** - Committee on **HEALTH AND HUMAN SERVICES** on Bill "An Act To Enact the Maine Death with Dignity Act"

(H.P. 948) (L.D. 1313)

TABLED - May 21, 2019 (Till Later Today) by Representative HYMANSON of York.

PENDING - Motion of same Representative to **ACCEPT** the Majority **OUGHT TO PASS AS AMENDED** Report.

The SPEAKER PRO TEM: The Chair recognizes the Representative from York, Representative Hymanson.

Representative **HYMANSON**: Thank you, Mr. Speaker, colleagues in the House. I am rising in support of this motion.

This is a difficult issue to spend time in the session with. Death is a part of life and this bill honors control over life. Through my 32 years practicing medicine as a physician and neurologist in inpatient and outpatient settings, I have witnessed people dying from many different diseases in different ways. For ten years, I chaired the Medical Ethics Committee at Portsmouth Regional Hospital, a hospital with highly complex services. Families and the patient, if they were able, would come together to talk about their values, goals, wishes, ideas of what happens after death, have conversations and try to come to some understanding of what the patient, him or herself, wanted. One added benefit of this law that we're talking about now in other states is that end-of-life conversations have become more open and comprehensive between patients, their families, their physicians and their providers. Sometimes the answer was, do everything you can do, sometimes it was keep me comfortable, surrounded by things I love. We would talk about whether the enemy was death or was it suffering. At that point, some people talked

about wanting personal control at the time of impending death. It is for these people, my patients, that this bill is before you.

I want to share some statistics about similar legislation that currently exists in the United States and then review the bill itself. Oregon, California, Colorado, Vermont, Washington, Hawaii, Washington D.C. and New Jersey have enacted laws like the one before you. This bill is modeled after Oregon's law was passed in 1998, 21 years ago. Importantly, though, this bill has been modified to reflect past public hearings in Maine. In Oregon, 79% of patients who utilized the law had cancer and 8% had neurologic disease like amyotrophic lateral sclerosis, ALS. Ninety-three percent died at home and, importantly, 90% had hospice services at the same time. Data and studies collected by the states show the safeguards in the law work as intended and I refer to articles through peer-reviewed journals, the Journal of Medical Ethics, about evidence concerning the impact on patients in vulnerable groups. Over more than two decades, Oregon's law has, quote, “showed no evidence of heightened risk for the elderly, women, the uninsured, people with low education status, the physically disabled or chronically ill, people with psychiatric illnesses including depression, or racial or ethnic minorities compared with populations”, end-quote. Additionally, there has been no slippery slope in laws or evidence of insurance companies that have paid for this process and withheld treatment. The bill before you safeguards against someone with dementia, mental illness, inability to understand or who is coerced to use this process. The public hearing, over a hundred testimonies for this bill was heartfelt and large. People in support and opposed, spoke from their hearts about themselves and their loved ones. What came across so clearly from everyone was how personal this issue is, and it is. That is why we should all have as much control over our death as we have choices.

The bill itself has many safeguards. The patient must be diagnosed within six months of death, the same standard used for hospice, the patient must be competent and voluntarily make two verbal requests and a written request with a waiting period in between of 15 days. Two witnesses must confirm the patient is acting voluntarily, not coerced and is competent. One must not be related. If there is any indication that the patient is not of sound mind, they must be referred to a mental health professional for evaluation. The patient must take the medication themselves without assistance, two physicians must confirm the patient meets the requirement of the law, no health professional can be forced to participate, and all health professionals can opt out. The patient can rescind any request at any time.

I diagnosed and treated a 36-year-old man from Kittery with amyotrophic lateral sclerosis, ALS. He told me when he couldn’t get out of bed on his own, he would see no point of living longer. When his hospice nurse called me one day to tell me he couldn't get out of bed on his own, I went to his house to see him. He cried to me that this was his life and he wanted his own death to honor his life. Using this law would've allowed that honor and freedom with humanity. Thank you for supporting this bill.

The SPEAKER PRO TEM: The Chair recognizes the Representative from Knox, Representative Kinney.

Representative **KINNEY**: Thank you, Mr. Speaker, Men and Women of the House. First, I want to begin with the fact, I rise in opposition to the pending motion.

Currently, the way that this bill is created is it's going to create a perfect crime. Title 17-A, Subchapter 2140, a patient's death certificate pursuant to Section 2842, must list the underlying terminal disease as the cause of death. We have seen in states where this legislation has been passed where doctors, caregivers, family have pushed to have the patient request this act of suicide. We've been told that this is for people that are within six months of death, so a person with a terminal disease expected to result in death within six months, but it's interpreted to include chronic conditions such as diabetes and because six months is determined without treatment. However, with treatment, in this case insulin, such persons can have years or decades to live. Family members will push their family in order to get things like life insurance policies, which we can't guarantee that they're going to continue to pay out for this. This is suicide. It's murder on the part of the doctor, in a lot of ways.

There are fears that lead someone to consider assisted suicide and they're real and they're legitimate. However, each fear has a corresponding life-affirming answer. For many people who are lonely, suffering, and/or possibly dying, the prospect of death by lethal injection or, in this case, in Maine we're doing a prescription for pills, gives them a feeling of control over their helplessness. There's no reason for a person to suffer uncontrolled pain or to feel they are a burden on family or other caregivers. They should not feel abandoned in their time of greatest need. They shouldn’t fear receiving unwanted medical treatment without consent.

You need to know a few certain facts. Intentionally killing a human being is always wrong. It erodes respect and equality of every human being and establishes killing as a solution to problems best solved by caring options. It destroys the trust relationship between medical professionals and patients. People will fear for their life when they're actually in need of help. It threatens the lives of those experiencing depression, the most common factor in suicide attempts. Many requests for assisted death will be granted when help is truly what the person requires. It threatens the lives of people with disabilities, the elderly, and the chronically ill who may be vulnerable to friends, family members or medical caregivers who question their quality of life. People may be pressured into choosing death without giving informed consent. One person's freedom to choose death may be the only choice offered to someone else. Elder abuse and abuse of people with disabilities is a prevalent social scourge and safeguards will never protect the vulnerable person. If killing is an exceptional solution for one problem, what other problems will killing be a solution for?

There is fear that they're going to experience uncontrollable pain, being abandoned, left alone in their final days. They fear receiving unwanted medical treatment without consent, being a burden on family members and other caregivers, fear living with a terminal illness and losing abilities or personal autonomy. They fear the process of dying naturally. Euthanasia and assisted suicide are not necessary. Everyone has the right to refuse unwanted medical treatment. Withholding or withdrawing medical treatment is legal and a common medical practice. Withholding or withdrawing medical treatment is not the same as assisted suicide. Pain management and palliative care can effectively control almost all types of physical pain. Proper palliative care or hospice care provides relief from pain and other distressing symptoms. It affirms life and regards dying as a normal process. It neither hastens nor postpones death. It integrates psychological and spiritual aspects of patient care, offers a support system to help patients live as actively as possible until death, a support system for the family. At this point I got to put a shout out to Androscoggin Home Health Care and Hospice at the time

when my father was dying 20 years ago from complications from lung cancer. They were wonderful for the entire family, not just for my father, and they attended his funeral when he passed. These are wonderful, caring people; caring, not killing. They use a team approach to address needs of patients and their families. It enhances quality of life positively throughout the course of the illness. And it's applicable early in the course of illness in conjunction with other therapies intended to prolong life, includes investigations needed to better understand and manage distressing clinical complications. This hits very close to me, as I lost my 45-year-old cousin on May 9th of this year due to complications from pancreatic cancer. On May 10, 2018, he was given three months to live, without treatment, and he was still very active at the time and aside from the pain that was caused by the cancer, which was how they identified what was wrong, he was relatively healthy. Because he chose treatment over suicide, he was able to celebrate a year's worth of unfortunate lasts with his family. He was the sole breadwinner in his family of five, including three children still in high school. He continued to work up until about a month before he passed. Because of this, he was able to go through a year's worth of bill paying and, again, this was something that was entirely on his shoulders, but now he was able to work with his wife and make sure that she understood what needed to be done after he was gone. He did at one point consider suicide and realized that would've been devastating to his family, would've cost them financial stability at the cost of his life insurance. And I can attest he suffered at the end of life. I was able to visit him just 15 days before he passed away. However, it was not unbearable thanks to the wonderful medical care he received not only through hospice, but through the hospital where when fluid was building up in his abdomen causing pain, they drained it and all of a sudden he kind of came back to life and wanted to start walking around again. One thing, though, that he didn't lose was his mind and continued to help his wife navigate all the idiosyncrasies of running a household with three very active teenagers. Had he taken his life at diagnosis, he would not have been able to coach his kids' softball teams one more time. He wouldn't've had one more Father's Day, Thanksgiving, Christmas or Easter with his family. They knew they were his last, and they made sure they were also the very best. Please vote against the pending motion. Thank you.

The SPEAKER PRO TEM: There are ten Members in the queue.

The Chair recognizes the Representative from Cape Elizabeth, Representative Carney.

Representative **CARNEY**: Thank you, Mr. Speaker, Members of the House. I rise in support of the pending motion.

As many of you know, I am a lawyer and I've looked through LD 1313 very carefully, and I really appreciate the careful process that it lays out for people who are terminally ill and facing tough decision-making. It contains clearly-written steps for a patient and attending physician to follow to ensure that a patient has made an informed decision.

But I'm speaking today not as a lawyer, but as a family member who has suffered a significant loss in the last eight months. Many of you know that in March, my father passed away, and in April, my mother passed away. Some of you also know that in the fall, my brother, Chris, died after suffering from substance use disorder for a long period of time. Each family member's death was so different for them and so different for my family as we helped them through the process. In each case, it was intensely personal in a way I've never experienced before. My brother's death was anguished, my father's was serene and stoic and I would say that my mother's was peaceful and brief. I don't know if my dad or my brother would have sought out information about death with dignity or would have followed the process to obtain the medication to end the suffering they experienced in the last few weeks of their lives. As a sister and a daughter, I would have liked for them to have the option this bill provides. I would like my loved ones and others here in Maine to have this option. My recent experiences have shown me just how personal death is.

I support LD 1313 because it gives those who will soon die of a terminal illness more control over this intensely personal process of suffering and dying. This vote is about empathy and compassion. Thank you for listening, and I urge you to support the pending motion.

The SPEAKER PRO TEM: The Chair recognizes the Representative from Vassalboro, Representative Bradstreet.

Representative **BRADSTREET**: Thank you, Mr. Speaker, Ladies and Gentlemen of the House. I rise today in opposition to the pending motion.

I concur with the words of the Good Representative from Knox fully. First of all, I believe that God is the author of life, only God can give and only God can take it away. But I also believe that other people who have probably more hands-on experiences with this should be heard as well, and I'd like to read the testimony of a friend of mine who is a pharmacist. He says; I am deeply confounded with the predilection of many legislators' focus on enhancing or facilitating opportunities to participate in killing human beings. From the unborn to now the seemingly incurable, there is such a strong movement to participate in the termination of these lives. As a pharmacist, I have spent my career trying to help cure, and when cure is not possible, to do my best to be supportive and assist with palliative treatments that will hopefully lessen the suffering. Having lost many family members to cancer or other chronic illnesses, I saw firsthand that hospice care was not only available, but that it was extremely effective at supporting end-of-life care. And by effective, I mean that I know for a fact that there's no single dose of drug that will easily end someone's suffering. Even when manufacturing the death of a condemned inmate in a prison, many times it just doesn't go quietly or to plan and at the very least dignity is not a word I would associate with the process. So families at home without support of hospice type care have no idea what can go wrong with self-administration of a suicide dosage. I've even read cases from Oregon where family members admitted to administering the drugs because the patient was unable and probably pending imminent death, anyway. What happens when seizures occur? What happens when the patient vomits after receiving the medication? Where's the dignity if there is not healthcare providers there with the supportive medications often needed to really make sure that the last moments of life truly are dignified?

Television shows and movies have given many of our citizens just the wrong perception about the reality of what happens in death. That is why hospice care is truly a blessing for those families, because there's a good chance that the trauma of watching a relative go through a self-inflicted death is often troubling and it can be haunting for their lifetime. Most folks have no idea what is really possible and could go wrong, and they are not trained or prepared to be aware of the consequences. Although on the flipside this bill would prevent the prescriber from being present so at least we will spare them from the potential ways a process can go sideways, do patients really self-administer? Are relatives that are heirs to the estate allowed in the room? At the point that these patients

finally assume they would self-administer, the reality is that they may already be past the point of self-directing their suicide. There are stories out there of family members admitting to finalizing the administration. Do we know that the patient had really decided at that point? Maybe their final moments were not as troubling as they believed they would be and are in a complete, somewhat peaceful death. You're asking unprepared folks to believe that this process is just so simple and easy and pleasant. First, do no harm. There's no guarantee of dignity in this process at all. Thank you, Mr. Speaker.

Representative STEWART of Presque Isle **REQUESTED** a roll call on the motion to **ACCEPT** the Majority **Ought to Pass as Amended** Report.

More than one-fifth of the members present expressed a desire for a roll call which was ordered.

The SPEAKER PRO TEM: The Chair recognizes the Representative from Jay, Representative Riley.

Representative **RILEY**: Thank you, Mr. Speaker. Mr. Speaker, Men and Women of the House, I rise to speak in honor of my long-time friend, Chris Tridor, his late wife, Karen, in support of LD 1313.

Mr. Speaker, my son was born with a catastrophic form of muscular dystrophy. From the outside, it looks a lot like ALS, Lou Gehrig's disease, with symptoms becoming noticeable in the elementary ages. Brian stopped walking at the age of 12 and today, at age 19, he's barely able to lift his hand from his lap. He requires around-the-clock care. He's on heart medication and he's trying to adapt to life with a ventilator, which he will need increasingly in the days to come. More times than I can count, I've held strong to ease him through unfathomable grief as best I can the loss of autonomy, physical pain, social separation and cruel indignities. Let me assure you, Mr. Speaker, when this disease is at its full scale, my best is laughably inadequate. But, Mr. Speaker, my son's life is a life worth living. Brian has always been a joiner; the robotics team, the math team and Leo's Club. He plays saxophone in the school band and in the community band. Two years in a row, we honored him in this chamber as a member of the State Championship Envirothon team. He couldn't play sports so his gym teacher gave him a whistle and taught him to officiate. He won the school Geography Bee and represented the district at the State Championship and his SAT scores made the Johns Hopkins Honor Roll while he was still in middle school. Most summers as a kid, he not only went to the summer camp specially designed for kids with mobility impairments, but also to the former Maine Conservation School where they teach shooting and boating and outdoor skills of every type. When he aged out, they invited him back as a counselor in training and he'll be there again this summer. This kid rocks.

I've spent every day of my life since his diagnosis early in 2002 plotting how best to support him, and in return I have the daily delight of living with this splendid creature. He's taught me to hold strong, to use patience, and the elemental weapon of humor in a battle against a living nightmare. But his disease is progressive and it keeps devouring muscle until there is nothing left to devour. We cannot win. I have always known I cannot win.

Mr. Speaker, of all the difficulties that Brian and I have been through together, by far the worst is having to hold strong for him in the dark moments when we reel from the ways that this disease robs him of his autonomy. There is no level of care, no drug, no alternative plan that can ease that stark reality and we know it is only going to get worse. So, today, Mr. Speaker, I hold strong for him once again and I vote in favor of a bill that might one day give him that last measure of autonomy and I hope that you'll follow my light.

The SPEAKER PRO TEM: The Chair recognizes the Representative from Carmel, Representative Reed.

Representative **REED**: Thank you, Mr. Speaker, Ladies and Gentlemen of the House. I also rise in opposition to LD 1313.

I rise today once again and ask that some of you stand with me in opposing this bill. There is nothing that can dignify the taking of one's life by suicide; not now, not ever. As a matter of fact, I can't think of anything more undignified than this bill. As I stand here today, I am somewhat amazed that so many have become so fixated on enhancing and facilitating ways to participate in the taking of a human life in the twilight of his or her years. We all want to die with dignity, don't we? What exactly does that mean? I suppose the best way to die would be to live to a ripe old age, to be in excellent health and to just go to sleep and never wake up. But not everyone is allowed this manner of death. Some will have to deal with debilitating diseases while others will face other forms of terminal illnesses that will require constant care. Is hastening death by ingesting pills more dignified than dying under hospice care? If so, why do we invest so much money teaching caregivers how to provide the best care and the most tenderness in the final stages of life? It is also my understanding that we are not talking about taking just a pill and going to sleep, but rather in some cases taking many pills. Is it possible that the medication might be rejected or expelled? If so, what happens then? I also wonder if the person's personal physician is required to be on hand or the physician who prescribes the medication or if anyone at all will be present in the room after the medication has been taken. And on the ensuing death certificate, how will it be recorded? Will it read death by drug overdose or by whatever the terminal illness was? Certainly you couldn't claim death by cancer or heart failure and be honest about it.

What prompts one to support a bill like this? I am sure it is the thought or the experience of sitting at the bedside of a loved one and watching them suffer and slip away. Yes, this is extremely hard to endure and we all wish we could avoid it. We have all been there and more than likely we'll be there again sometime in our future. But is this the way to make it easier on our loved ones or us? No matter how noble or honorable this might seem to be, in my opinion it is morally wrong. To everything there is a season, a time to every purpose under Heaven. A time to be born, and a time to die.

This used to be called a mercy killing, but it was illegal and it usually resulted in an arrest and incarceration so they had to dress it up with a new title to show more sensitivity and one that now has wider appeal and acceptability, so they came up with death with dignity. I remember back in the 1970s when talks of abortion burst on the scene. It was back then that sooner or later it would eventually get around to taking the lives of the elderly and the terminally ill. Now here we are, and many are convinced that it is good, that it's humane, that's it's a dignified thing to do. This bill suggests that if we are terminally ill, it is better to ingest pills to bring on an early death rather than die a natural death. And in this bill, does terminal illness mean anything that's incurable? Does it mean a death will occur within six months with or without medical attention? Does it include liver disease, heart disease or diabetes? Some live a long time with some of these diseases and especially now that so many people have elected to become organ donors. I'm concerned that a physician-assisted death might become an option when an elderly person has an insurance

company whose coverage comes into question and rather than be a burden on the family, he or she might see this as a way out. And I also worry that if this becomes commonplace in Maine, insurance companies because of costs might elect not to provide a life-saving procedure and might offer instead as an alternative physician-assisted suicide.

For years we have heard of situations which an heir to a fortune has engaged in something underhanded to get rid of a rich relative to gain access to an inheritance. Is it possible that this could happen legally should this bill be passed? What happens if the heir is also the Power of Attorney for the family? What about a misdiagnosis of a patient as terminally ill when, in fact, that person's terminal illness might be reversed by a new drug or by a new advanced procedure yet known to exist? And what about just a simple mistake? Doctors can't predict any certainty as to a person's life expectancy. If they have been known from time to time to leave sponges in patients, I guess it's conceivable that they could make such a mistake. Remember a few years ago when Jimmy Carter had a cancerous portion of his liver removed and he was told that the cancer had advanced to his brain? He even resigned his Sunday School class because he believed that he only had two or three weeks to live. A few months later, he was told that his cancer was totally gone. It wasn't long before he was back with Habitat for Humanity, going as strong as ever. What if a physician had convinced him that suicide was a way for him to alleviate a lot of suffering? Now wouldn't that have been a serious loss for humanity? And what about the idea that physician-assisted death, as just being bad medicine? Doctors have always been seen as healers. They have always offered hope to those who had no hope. If a physician is allowed to offer the option of suicide to one struggling with a serious health issue, it would become extremely difficult to see him as one who exudes hope to the hopeless. When a similar bill was being considered in the year 2000, a letter appeared in the Bangor Daily News that summed up the law in this way. As the years pass and vigilance wanes, our society's most vulnerable people will be judged fit or unfit for their place in the world by physicians, unchecked by the law nor by their charge to first do no harm.

Today, here in this House, let's do the right thing. Let's kill the bill, not the patient. Thank you, Mr. Speaker, and thank you, Ladies and Gentlemen of the House.

The SPEAKER PRO TEM: The Chair recognizes the Representative from Yarmouth, Representative Cooper.

Representative **COOPER**: Thank you, Mr. Speaker, Ladies and Gentlemen of the House. A number of years ago there was a referendum on this question. At that time, I voted against it. Since then, I have changed my views on the subject and it arises primarily through having witnessed a bad death. It is said that that's what it takes to see the worth of this legislation; a bad death. It was the son of my next-door neighbor and friend. He was 26 at the time, he had brain cancer. And I'd like to read to you a letter that my friend, Sarah Witte wrote to the committee as testimony for why she supported LD 1313.

"In 2009, my son, Andy, was diagnosed with glioblastoma brain cancer. His presenting symptom was a terrible headache. Following a craniotomy, radiation, and chemotherapy, he died a year later at the age of 27. But on the day he was diagnosed, along with finding the best care, I started wondering what my son's death would be like. Andy didn't want to talk about cancer or death, but when the tumor progressed and then later we found out there were no more treatment options, he broke down. He was furious and sad, but he was also terrified of the explosive headaches coming back. He begged me to help him find a way out. He even talked about finding some heroin and taking an overdose and sadly, we all know how easily that could've happened. In his last week of life at Maine Med and then at Gosnell Hospice House, he was still in pain. Repeat; still in pain. He was on morphine and heavy palliative sedation. For him, that meant still in pain but unable to express it. They said they couldn't give him anymore. There was no comfort until it was all over. If you believe pain can be managed, I'm sorry to tell you that this, as a comfortable belief, is painfully just not true. I will tell you three ways that a prescription for end-of-life drugs would've made my son, Andy's life and death better and these resonate for many people. First, it would have been a simple peace of mind for him just knowing that it was there and not fearing the agony of his head exploding in pain. Many who have the prescription never use it, but it's a precious peace of mind. Second, he would've died at home. We loved him throughout his last breath at Gosnell but he wanted to be at home. Third, it would've allowed him to die in a peaceful act of going to sleep and spent his last week instead of enduring a literally blinding headache, heavily sedated, while he was trying to let go and feel our love all around him. We still want the right treatment as long as we have any hope and we want everyone to have access to palliative and hospice care options. But then we want the right to say it's time when our time comes." I urge you to vote Ought to Pass for LD 1313. Thank you.

The SPEAKER PRO TEM: The Chair recognizes the Representative from Lewiston, Representative Craven.

Representative **CRAVEN**: Thank you, Mr. Speaker. Mr. Speaker, Men and Women of the House, I rise in opposition to this measure.

First, I come from a culture that doesn't sanitize death. Families look after their loved ones at home through their death and dying. In my adult life, I've spent 12 years as a hospice volunteer and the process teaches lessons you can only learn through experience. In my opinion, we need to care for people and let them know they are valued to the very end.

The number one reason that people choose to commit physician-assisted suicide is that they don't want to be a burden to their families, and I think that that robs us of expressing our humanity. Furthermore, this bill as written, well-written as it is, opens the door to elder abuse. People who have had a terminal diagnosis are vulnerable, sometimes despairing, trying to decide what's next and leaving the field wide open for bad actors to manipulate their decisions. Again, the number of reasons people choose assisted suicide is because they do not want to be a burden to their families, making the opportunity for abusers and easy manipulation. I suppose I should be glad about this, but this creates a tiered system and in favor of people of privilege. If the poor wanted to use this method, I can't imagine them being able to secure several doctors' opinions, notarized letters, legal counsel and prescriptions. I'm proud to have invested decades advocating for people who lack the opportunity to speak for themselves and to sit with people who are in the dying process. I've cared for relatives and for people assigned to me on a professional level.

With your permission, Mr. Speaker, I'd like to read a few excerpts from people who have testified in our committee. The first person is a hospice nurse. Her name is Laura Parker from Sidney, Maine, and this is what she says: "I have many issues with the aspects of the language that are contained in LD 1313. Most people seeking to utilize this law are not given one

pill, but rather a hundred pills. They are not assisted to their death by their physician, or it's not required. Once the prescription is written and has been filled, the role of the doctor is not required to be hands on. There have been seizures complicating the process, people have regurgitated the meds or vomited up the medication, and even cases of regained consciousness after ingestion. It's difficult to track how many people have experienced these side effects because in most cases, in Oregon, for example, the healthcare provider was not present at the death. I question if the ingestion of a hundred pills resulting in potential nausea, vomiting, seizures, and side effects is not a tidy or dignified way to die."

The second excerpt is from Kandyce Powell, RN, MSN, Executive Director of the Maine Hospice Council and Center for End of Life: "As an individual with over 40 years' experience in the field of end-of-life care, I hope to share my outrage that not everyone has access to comprehensive resources like hospice and palliative care, which truly offer dignity to those patients and their families. LD 1313 is not the answer to the challenges we are facing. Remember, this is about humanity. I challenge our legislators to look in the mirror and ask, am I properly informed and fully prepared to make a policy decision that will change how our culture looks at the approaches of end of life?" Kandyce Powell.

The second one is: "Do you know that an average of 20 veterans commit suicide every single day? We already have a national crisis without a doctor's help. Our veterans may have returned from the battlefield but their war is far from over. Palliative care and giving help and hope is needed, not physician-assisted suicide."

Another excerpt goes like this: "People are naïve if they don't see the inevitability of insurance companies eventually having the final say in a patient's care. What would be cheaper than government-sanctioned physician-assisted suicide?" Myra Broadway, Board of Nursing Executive. Thank you, Mr. Speaker.

The SPEAKER PRO TEM: The Chair recognizes the Representative from Pittston, Representative Hanley.

Representative **HANLEY**: Thank you, Mr. Speaker. Mr. Speaker, Ladies and Gentlemen of the House, I rise in opposition to this proposal, and I'll start off with that it's a moral issue and it's delicate but nobody has a right to take an innocent life, even your own life. You didn't create yourself, you have no authority to end yourself.

We all have experienced death in our lives. My mother and father, an older brother just a month ago, a mother-in-law, father-in-law, brother-in-law, others, and all of them died long, slow, lingering deaths, sometimes in great pain. But they didn't suffer in pain because they were treated for it. In this day and age, in our society, you can be treated for pain and die a peaceful death mostly, nothing is perfect, but still, they did not die suffering as they might have in some other country. But we are a unique creature. We are like no other creature on earth. We can take care of each other, we can feed each other, comfort each other, clean each other. We can do this from the beginning of our lives to the very end of our lives. No other creature on earth can behave this way. They are not human beings; we are. We are given something extremely special and to turn our back on someone as they die, so to speak, and to offer that fast way out, is no comfort.

The problem with this bill goes on and on. I can hear the arguments now; but, Grammy, you're old, you're sick and you're rich. It's time to go. And, believe me, you think those conversations won't take place? They certainly will. Also, what kind of message does this send to our society as a whole, our children? You know, a few months ago we talked on the issues about childhood suicide, especially with the issue around firearms, and now we're discussing the actual taking of lives. It's like we're schizophrenic, we can't make up our mind here what we want to do. But the problem with all of this is that, you know, when someone says they want to kill themselves today, the police will respond and do everything they can to stop that person. What will happen now with the message being sent when a woman calls up and says my husband wants to kill himself, will the 9-1-1 operator say well, it's okay, you have every right to kill yourself, we're not going to get involved with that.

There's also the issue of the slippery slope. I know that that's argued against, but this is only one Legislature. There are many Legislatures to come and they can add to this in any way they want, and we need to be very careful of these things. In the Netherlands right now, which has had assisted suicide for some years, 25% of all deaths are suicides. Think about that. Fifteen years from now, will that be where we are? What about insurance companies? Will they say oh, you've got quite a disease, you're quite ill, you're quite old, we don't have any solution for you except this $12 prescription for pills. These are all things that can happen. But most of all, we are compassionate creatures created by God and we have no right to end what we had no part in creating. Thank you, Mr. Speaker.

The SPEAKER PRO TEM: The Chair recognizes the Representative from Brewer, Representative Verow.

Representative **VEROW**: Thank you, Mr. Speaker, Ladies and Gentlemen of the House. I rise in opposition to this bill and I have two points of view on that opposition.

One is, Mr. Speaker, we are not Oregon here. We are Maine and our motto, as everybody knows, is "I lead." So, are we thinking about following another state where they had the assisted suicide and for some reason they seem to be promoting this throughout the country? I don't know what end for what purpose that is. Maybe it's financial, I don't know, but you know, our people in Maine are distinct and different and capable of making our own decisions, and it sort of bothered me when they told me this was modeled after another state. And, again, we lead. We are "Dirigo" and if we want to change that name, I hope not.

The other part of this testimony that I'm giving here is we see bills in this Legislature that are the subject of life and death. This bill, death with dignity, is troubling to me. My mother passed away three years ago, 94 years old, Alzheimer's disease. My daughter passed away nine years ago, brain cancer. They left this life when their time came and without any intervention such as this bill would allow and encourage. Both my mother and daughter received excellent care from doctors and nurses in the hospice program and when the time came, they died with dignity. This bill suggests to me that someone who suffered as they did perhaps did not die with dignity.

I looked up the definition of dignity and found this: "Dignity is the state or quality of being worthy of honor or respect." To that end, these great ladies were always worthy of honor and respect.

Mr. Speaker, Ladies and Gentlemen of the House, this is a life and death issue. In the face of this issue, my vote will always be on the side of life and hope. Thank you very much for your attention.

The SPEAKER PRO TEM: The Chair recognizes the Representative from Eliot, Representative Meyer.

Representative **MEYER**: Thank you, Mr. Speaker, Women and Men of the House. I rise in support of the pending motion.

As a registered nurse for 25 years, I've worked with many patients who were delivered the unthinkable; the diagnosis of a terminal illness, and begin a journey through our healthcare system, participating in what may be available for treatment, including palliative care and hospice and, finally, dying. Sometimes their journey is peaceful but often it is horrific in spite of all the services, medication and expert care we have to offer. All of us know for certain that death is the inevitable conclusion to our lives. Thankfully, most of us aren't dwelling on the end but rather on our road through life, reaching goals we set for ourselves, enjoying a rich diversity of choices, how, where, and with whom we might live, work, love and grow as human beings. We chart our course with self-directed freedom and if we're honest when we do allow ourselves to think about our own mortality, we envision that we will draw our final breath peacefully and painlessly sometime far into the future.

Mr. Speaker, some of us will not know the gift of a long and healthy life. Some will face the grim knowledge of precisely how we will die. Some will face the reality of untreatable disease and know the agony of progressive fatal illness. The Maine Death with Dignity Act will offer decisionally capable, mentally capable, terminally ill adult patients within six months of their death an option to avoid prolonged suffering. A choice to reject the notion that they must be passive victims to a frequently brutal disease process that often strips them of their dignity and autonomy. This is not an assisted suicide bill. The terminally ill patients who would be given the option to hasten their death have no interest in committing suicide. They have arrived at a decision having exhausted every available means of prolonging the life that they love. These dying patients are not making the desperate, impulsive choice associated with suicide. Suicide is a repudiation of life. These dying patients love life but recognize with clarity that their death is imminent, and wish to avoid unbearable suffering and loss of autonomy by choosing the option for a serene, dignified death. They seek to shorten the agony of their final hours, not to kill themselves. Cancer is killing them. Lou Gehrig's disease is killing them. The disease ravaging their bodies is killing them.

Death with dignity statutes in other states and the one before this body today contains strict eligibility criteria and multiple safeguards protecting dying patients from abuse and coercion. The combined 40 years of experience with death with dignity laws in Oregon, Washington, Vermont, California, Hawaii, and Washington D.C., has demonstrated that the safeguards built into these laws are effective in protecting patients from any form of undue influence. Concerns for coercion and discrimination simply have not come to pass.

Finally, many in the palliative care and hospice field, and some of us who have lost a loved one to terminal illness are aware that many physicians already dispense life-ending medications at the request of patients or their families. States that don't authorize aid in dying have unclear, unenforceable laws and underground practice has no safeguards. Death with dignity laws stop that sort of back hallway prescribing that happens in the shadows and shines light on the process. This legislation would codify a rigorous process that the dying patient must follow before they, and only they, make a decision to obtain and, if they choose, to self-administer the medication.

Seven in 10 Mainers, our constituents, support death with dignity as an end-of-life option for the terminally ill. The majority of those we represent believe that the terminally ill should have a choice to use aid in dying if their suffering becomes unbearable. I hope none seated here today or anyone we love ever faces the agony that often accompanies untreatable terminal illness. I hope as well that the option for death with dignity is available, and I ask you join me in supporting the pending motion.

The SPEAKER PRO TEM: The Chair recognizes the Representative from Penobscot, Representative Hutchins.

Representative **HUTCHINS**: Thank you, Mr. Speaker, Ladies and Gentlemen of the House. Yesterday we celebrated Memorial Day; a time to remember with dignity those honored soldiers that we've lost. Today we talk about death with dignity on a totally different step. One of them is a lie.

Many years ago, my family lost a family member to suicide. It was just a little bit different; she chose to do the suicide on her own, after being treated with electroshock therapy after a nervous breakdown. That was the in-thing at the time, I guess they still use it some, it didn't work then, probably doesn't work today. But I'm here to tell you that death by suicide has no dignity. Thank you very much.

The SPEAKER PRO TEM: The Chair recognizes the Representative from Kennebunk, Representative Babbidge.

Representative **BABBIDGE**: Thank you, Mr. Speaker. Mr. Speaker, Ladies and Gentlemen of the House, this difficult issue, the extreme suffering of certain people at the end of their lives brings to us a moral decision that we cannot escape. If we choose action with its consequences, that's a choice. But inaction with its consequences is also a choice. I prefer to give that choice to the patient. For a person with painful, debilitating terminal illness who will suffer more and become more helpless with the passage of time, the question before us this day is who shall have the power, the control to determine the circumstances of one's own life and death. In the interest of personal freedom, in the interest of self-determination, end-of-life decisions despite what others may wish, rightfully belong to the patient. If a person suffers at end of life, it is cruel for a person to have to feel it was forced upon him or her because he or she was not permitted this option to make decisions. That person may choose in the end not to use this option but I believe there is solace in knowing that the power, the choice rightfully belongs to the patient. I believe this bill has been carefully crafted with appropriate protections. I urge my colleagues to support the motion. Thank you, Mr. Speaker.

The SPEAKER PRO TEM: A roll call has been ordered. The pending question before the House is Acceptance of the Majority Ought to Pass as Amended Report. All those in favor will vote yes, those opposed will vote no.

ROLL CALL NO. 142

YEA - Ackley, Babbidge, Babine, Bailey, Beebe-Center, Berry, Blume, Brennan, Bryant, Caiazzo, Cardone, Carney, Cloutier, Cooper, Crockett, Cuddy, Daughtry, Denk, Dodge, Doudera, Dunphy, Evangelos, Farnsworth, Fay, Foley, Gattine, Gramlich, Grohoski, Handy, Harnett, Hepler, Hobbs, Hubbell, Hymanson, Ingwersen, Johansen, Jorgensen, Keschl, Kessler, Kornfield, Landry, Mastraccio, Matlack, Maxmin, McCrea, McCreight, McDonald, McLean, Meyer, Moonen, Morales, O'Neil, Pebworth, Peoples, Pierce T, Prescott, Reckitt, Riley, Riseman, Roberts-Lovell, Rykerson, Schneck, Sharpe, Stover, Sylvester, Tepler, Terry, Tipping, Tucker, Warren, Zeigler, Madam Speaker.

NAY - Arata, Austin B, Austin S, Bickford, Blier, Bradstreet, Campbell, Cebra, Collings, Corey, Costain, Craven, Curtis, DeVeau, Dillingham, Doore, Drinkwater, Faulkingham, Fecteau J, Fecteau R, Foster, Griffin, Haggan, Hall, Hanington, Hanley, Harrington, Head, Higgins, Hutchins,

Javner, Kinney, Kryzak, Lockman, Lyford, Madigan C, Marean, Martin J, Mason, Melaragno, Millett, Morris, Nadeau, O'Connor, Ordway, Perkins, Perry A, Perry J, Pickett, Pluecker, Reed, Rudnicki, Sampson, Sheats, Skolfield, Stanley, Stearns, Stetkis, Stewart, Strom, Swallow, Talbot Ross, Theriault, Tuell, Verow, Wadsworth, White B, White D.

ABSENT - Alley, Andrews, Dolloff, Grignon, Hickman, Martin R, Martin T, Paulhus.

Yes, 72; No, 68; Absent, 8; Excused, 2.

72 having voted in the affirmative and 68 voted in the negative, with 8 being absent and 2 excused, and accordingly the Majority **Ought to Pass as Amended** Report was **ACCEPTED**.

The Bill was **READ ONCE**. **Committee Amendment "A" (H-305)** was **READ** by the Clerk and **ADOPTED**.

Under suspension of the rules, the Bill was given its **SECOND READING WITHOUT REFERENCE** to the Committee on **Bills in the Second Reading**.

Under further suspension of the rules, the Bill was **PASSED TO BE ENGROSSED as Amended by Committee Amendment "A" (H-305)** and sent for concurrence.

By unanimous consent, all matters having been acted upon were **ORDERED SENT FORTHWITH**.

COMMUNICATIONS

The Following Communication: (H.C. 187)

STATE OF MAINE
HOUSE OF REPRESENTATIVES
SPEAKER'S OFFICE
AUGUSTA, MAINE 04333-0002

May 28, 2019
Honorable Robert B. Hunt
Clerk of the House
2 State House Station
Augusta, Maine 04333
Dear Clerk Hunt:
Pursuant to my authority under House Rule 201.1 (H), I appoint Representative Matthew W. Moonen of Portland to serve as Speaker Pro Tem to convene the House on May 28, 2019.
Sincerely,
S/Sara Gideon
Speaker of the House

READ and **ORDERED PLACED ON FILE**.

SENATE PAPERS

Bill "An Act To Eliminate Online Burn Permit Fees for All Areas of the State"

(S.P. 604) (L.D. 1788)

Came from the Senate, **REFERRED** to the Committee on **AGRICULTURE, CONSERVATION AND FORESTRY** and ordered printed.

REFERRED to the Committee on **AGRICULTURE, CONSERVATION AND FORESTRY** in concurrence.

Bill "An Act To Clarify and Enhance Fish and Wildlife Enforcement Laws"

(S.P. 603) (L.D. 1787)

Came from the Senate, **REFERRED** to the Committee on **INLAND FISHERIES AND WILDLIFE** and ordered printed.

REFERRED to the Committee on **INLAND FISHERIES AND WILDLIFE** in concurrence.

The SPEAKER PRO TEM: The Chair recognizes the Representative from Portland, Representative Talbot Ross.

Representative **TALBOT ROSS**: Thank you, Mr. Speaker. I request unanimous consent to address the House on the record.

The SPEAKER PRO TEM: The Representative has requested unanimous consent to address the House on the record. Hearing no objection, the Representative may proceed on the record.

Representative **TALBOT ROSS**: Thank you, Mr. Speaker. Mr. Speaker, Men and Women of the House, in reference to Roll Call No. 129 on LD 1566; had I been present, I would’ve voted yea. Thank you.

By unanimous consent, all matters having been acted upon were **ORDERED SENT FORTHWITH**.

On motion of Representative DILLINGHAM of Oxford, the House adjourned at 2:09 p.m., until 10:00 a.m., Wednesday, May 29, in honor and lasting tribute to Eric T. Wight, of Bethel and Earlene “Kitty” Ahlquist Chadbourne, of Cumberland.