TESTIMONY AGAINST HB54, April 5, 2017

My name is Jeanne E Anderson, MD. I am medical oncologist in private practice in Anchorage at Katmai Oncology Group, LLC.

Specialists in Medical Oncology diagnosis patients with cancer; counsel them regarding prognosis and treatment options; prescribe medical (i.e., drug) treatment; and provide supportive, palliative and end-of-life care.

I received my medical degree from Stanford University in 1988. I completed internal medicine specialty training in 1991, and medical oncology fellowship training in 1994, both at the University of Washington. I have been taking are of patients with advanced cancer since 1987 when I was a medical student.

Over the 30 years that I have been caring for patients with cancer, I have seen dramatic improvements in the science of cancer biology and in prognosis, treatment and palliation of patients.

I am strongly against HB54 for many reasons, including 1) the uncertainty in determining an individual patient's prognosis, 2) improvements in palliative care, and 3) hastening death is not the role of the physician or the medical system.

<u>Uncertainty in Prognosis</u>

A critical feature of SSHB54 is that the patient has a "terminal" disease. There is no definitive way to determine that a patient has less than 6 months to live. Estimates of survival are based on published data and a physician's clinical judgment. Survival data come from studies performed years earlier, often using treatment that is not the most up-to-date, and is based on narrowly defined patient populations. Physicians then use their clinical judgment to determine if they think the patient in question fits the published data. Even well informed and well-meaning oncologists make drastic mistakes in their estimates of prognosis.

I would like to describe several of my current patients:

1. David has stage IV bladder cancer and his disease had progressed through several lines of aggressive treatment by 2014. At that time I would have confidently said that he had less than 6 months to live. Now, in 2017, he is in remission living a full, active life after receiving a new form of treatment, known as immunotherapy.

2. Donald has stage IV lymphoma and his disease was refractory to several lines of chemotherapy. He was denied a bone marrow transplant in Seattle, due to the lack of benefit. He declined participation in experimental therapies. I recommended hospice treatment in June of 2016 due to expected survival of less than 6 months. Currently, he is in remission, and just returned from a cruise with his family in January 2017. He knows that when his lymphoma recurs in the bone, we can offer radiation, pain medications and other palliative care therapy to control symptoms of progression.

3. Karen has stage IV breast cancer, in a particularly lethal form, known as "triple negative". Her cancer had spread to her brain in 2015. Chemotherapy made her very sick and I decline to administer her any more treatment. Based on her functional status, spread of her cancer, and the known biology of triple negative breast cancer, I also predicted less than 6 months survival in 2015. She has had an unusually slow course of disease progression and remains alive today without any further chemotherapy.

Patients often live longer than expected due to unexpected diminishment in the aggressiveness of their cancer; due to unexpected response to treatment; due to response to new treatments; due to inaccuracy in assessment of stage or status of their disease; due to the normal statistical variation when individual people are characterized by data; and due to factors outside of our assessment or control, such as a patient's inherent will to live or their strong immune system or vital organ function.

With my experience and credentials, I would be an appropriate attending physician and/or consulting physician for the type of patient that SSHB is designed to serve. However, these cases described above show my inability to determine prognosis as precisely as is required by this bill. In addition, note that a medical oncologist just completing training in his or her early 30s would be considered qualified to make such decisions.

<u>Improvements in Palliative Care</u>

Many patients or their loved ones are fearful of symptoms related to advanced cancer, such as pain and shortness of breath. These are very valid concerns. A core function of a medical oncologist is alleviation of suffering. There are a vast number of approaches that can be taken to alleviate suffering without resorting to active ending of life. These options include numerous medications, localized radiation to painful sites of active cancer, nerve blocks, pain pumps, and oxygen to mention just a few. In addition, there is the growing specialty of Palliative Care. Palliative Care specialists address supportive care for patients in all stages of illnesses, including cancer. They address the many aspects of the "terminally" ill patient including the social, psychological, physical, and medical aspects of these patients.

I recently heard about someone in favor of this bill because of his wife's experience. When she was dying of cancer, her lungs were filling up with fluid. She was not given timely care for her symptoms, resulting in a difficult death. I would like to speak to such a scenario. When a patient is dying of cancer, family and medical providers generally have a sense that the end is imminent in hours, days, or perhaps weeks. At this point, aggressive management of symptoms is the primary focus even if a side effect of management is a sooner death. There are resources for such care, without resorting to a lengthy, complex, and legally defined system that is provided for in SSHB54. Such care in the setting of cancer patients is provided for by medical oncologists, palliative care specialists, nurses, and hospice programs. Fear of poor palliative care and abandonment is not a reason to hasten death.

A physician's job is to alleviate suffering, provide compassionate care, and prevent foreseeable adverse outcomes. Our job is not to hasten death. I request that our resources be placed in improving care for our patients with advanced diseases, including communication with all health care providers and expanding palliative care services. Please vote against SSHB54.