Date: March 16, 2024

To: March 18, 2024 meeting of the Minnesota House Commerce Finance and Policy Committee hearing on the End-of-Life Option Act

I write to request your support of HF 1930, the End-of-Life-Option Act. I am 75 years of age. My GREATEST FEAR IN LIFE IS: NOT having control over my end-of-life experience. Please pass this bill which will grant me autonomy over my dying, just as I have had autonomy over my long life.

Please know that I am not dying and that I continue to be in very good health and enjoy a high quality of life. I ride my bicycle outdoors when the weather permits and ride my exercise bike indoors when the weather is inclement. I continue to play my trumpet (which takes physical stamina) every day, which I have done since I was 8 years old! I do 100 sit-ups, 6 out of 7 days every week. I do a 4 minute plank every other day. In addition, I walk at least 6599 steps every day, as well as do other daily exercises. Plus, I read, write, study, and pray every day. Do I have quality of life? Absolutely! Yes, indeed!

When my mother was living I was her primary caregiver. She died at age 89 and 10 months. She had scoliosis with a curvature of the spine that greatly compromised her respiratory system, as well as had other challenges. Her cause of death was a subdural hematoma suffered from a fall at the nursing home. It was her decision not to have brain surgery which would have either led to a vegetative state or death.

Personally, I hope and pray that I have as peaceful a death as Mom did. Her written wishes were to receive a legal amount of morphine if she became so-incapacitated. As a result she died peacefully in my arms. I truly continue to miss her every day, but I am very thankful that her time of pain and suffering was somewhat limited due to the morphine.

Please support medical aid in dying for me! Without it, I doubt that I'll have such a peaceful death as Mom experienced because I have no child (such as Mom had me) to advocate for a peaceful death for me. No doubt my end time will be one of long-suffering pain and agony, as I've observed in many persons during my professional working life. I will be connected to all manner of life supports because the medical staff will be afraid of litigation if they don't connect me to it. In my health care directive, I direct the medical staff to disconnect me from it if they have already done the opposite. Will this happen? Of course not! They probably won't even read my health care directive let alone follow it.

Please grant me autonomy over my end time, just as I have autonomy over my life now. I value quality of life. I work hard to stay healthy and independent. Please allow me to have medical aid in dying so that I can transition peacefully in joining Gabriel in playing beautiful trumpet music in heaven.

By the way, I’m sure you know by now, that HF 1930 is purely an “option” for Minnesotans. No one is forced or coerced to use it. Death is a natural part of life. This specific bill brings peace and calm to adults over age 18 who face death with a terminal prognosis of 6 months or less to live, as diagnosed by 2 separate health care providers. Indeed, it is optional!

Sincerely,
Lois D. Knutson
300 1st Ave. NE, apt. 203
Austin, MN 55912

Date: March 16, 2024

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300 1st Ave. NE, apt. 203
Austin, MN 55912

James Otremba

3042 Fulton Circle, Clearwater.

To Whom It May Concern:

My name is Jim Otremba and my wife and I have two children with disabilities: one with Down Syndrome and one with autism. I believe that physician-assisted suicide is wrong for many reasons.

One such reason is that it will amplify healthcare inequities. Minnesotans with disabilities, people of color, the elderly, and people with limited income currently face significant barriers to consistent quality health care.

They also experience higher rates of disease due to systemic inequities that impact health, such as education, housing, and income.

Legalizing assisted suicide would deepen these existing barriers. People experiencing inequities would likely qualify for assisted suicide at higher rates and feel added pressure to select it over more costly care options.

Please oppose the Minnesota End-of-Life Option Act (HF 1930/SF 1813).

Thank you for your consideration of this urgent matter.

Sincerely,

James C. Otremba

3/17/2024

Re: HF 1930/SF 1813 – Minnesota End-Of-Life Option Act

We are in strong opposition to the Minnesota End-Of-Life Option Act (HF 1930/SF 1813) for the following reasons:

- It exacerbates financial disparities
- It amplifies health care inequities
- It blurs the line between life-enhancing and life-ending care
- It erodes doctor-patient relationships

We believe that no one should be compelled to accept assisted suicide as their only or best option. Your actions taken today will impact Minnesotans for decades to come and these bills, if enacted, would harm thousands of Minnesotans.

Kenneth E. Cobian Susan M Cobian

Kenneth and Susan Cobian
3300 Townview Ave NE
St. Anthony Village, MN 55418

3/17/2024

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Rebecca S. Sharkey

Todd and Rebecca Sharkey
3515 Skycroft Dr.
St. Anthony Village, MN 55418

NOT DEAD YET
The Resistance

Testimony Opposing “End-of-Life Option Act” HF 1930

Public Safety, Finance and Policy Committee

Anita Cameron, Director of Minority Outreach

March 7, 2024

I'm Anita Cameron, Director of Minority Outreach for Not Dead Yet, a national, grassroots disability organization opposed to medical discrimination, healthcare rationing, euthanasia and assisted suicide.

I am testifying in opposition to HF1930 - End-of-life option established for terminally ill adults. Bills like this are dangerous to communities of color

How do racial disparities in healthcare relate to assisted suicide?

Research has documented Black, Asian, and Hispanic persons regularly experience barriers to palliative/hospice care utilization. A 2016 JAMA Internal Medicine study found that hospice patients were less likely to be visited by staff in their last two days of life if they were Black. Even more alarming, California nursing facilities with higher numbers of Black and Latino residents have "had higher rates of death."

Although Black people and other people of color request assisted suicide less than white people at this point, as the practice is normalized, they are more at risk of pressure to do so. First, racial disparities in healthcare lead to limited health choices and poorer health outcomes including death. Economic disparities make it less likely that patients can afford life-saving treatment and more likely that doctors will "write off" patients as terminal and thus eligible for assisted suicide.

Research also shows that Black patients are less likely to receive adequate pain treatment due to false beliefs about biological differences between blacks and whites, which adds further pressure to seek assisted suicide.

Legislation like HF1930 has no place in Minnesota. Please vote no on all forms of this bill.

March 15, 2024

MN House Of Representatives Commerce Committee
Representative Zack Stephenson, Chair
449 State Office Building
St. Paul, MN 55155

re.: HF 1930

Dear Rep. Stepenson & Committee Members:

I am writing to you to express my opposition to this bill and the practice of assisted suicide in general. The last several years have seen an increase in suicide in our state and nation. While this is tragic, it has also helped bring attention to the topic, which has in turn lead to an increase in resources available to help those who are struggling and hurting and increased awareness of those resources.

I believe this bill, by making suicide a more available and easier option, flies the face of all of those efforts to help hurting individuals. It will only hurt them further, by adding official weight to the narrative that “your life is worth less, there’s no hope for you, you’d be better off dead.” That is the last thing that people in these situations need to hear.

My own father suffers from advanced dementia and is in a skilled nursing facility. He recently developed a urinary tract infection (UTI). While discussing treatment options, one option that was presented to us was that if left untreated, the UTI would develop into sepsis, he would be given medication to make him comfortable, and eventually he would “just go to sleep.” I think this option was presented as a way to “end his suffering” and make us feel like it was okay to do so. I felt like we were even being encouraged to see this as the “best” way to care for him. The alternative was to treat the infection with a common, inexpensive, easily-available antibiotic. We chose the latter option. As the UTI cleared, my father showed dramatic improvement, becoming more lively and talkative. He was clearly happy, comfortable, and able to find joy in his life.

I appreciate the thought that was given toward making my father comfortable and easing his suffering. I believe that there should be strong emphasis on palliative care options and those options should be available to all people, especially those suffering with terminal illnesses. This experience, however, made it clear to me how easy it is for the distinction between supportive care and direct action to end a life to become blurred. If passed, I believe this bill would significantly increase the pressure placed on those suffering with terminal illness, as well as their caregivers, to end their lives, rather than seek palliative care. Such action devalues the individual and contributes to a utilitarian approach to healthcare, rather than one based on caring for health.

My father’s condition is terminal. He will never recover and in fact, he will continue to decline. Thanks to receiving assisted care, however, he has had more time to be alert and interacting with others—staff, visitors, and family members. Does he always remember who those people are, including family members? No, but he still enjoys talking with and spending time with them. That is precious and worthy life time that could very easily never have taken place if a decision had been made that it would be better to end his life.

Minnesota has a strong reputation as a destination for quality healthcare and medical innovation. I feel we should focus our attention on continuing to develop those resources to help care for and support those in difficult life and medical situations. Assisted suicide is not that kind of care. It is a short cut strategy that preys upon the weak and vulnerable, rather than supporting them. Please do not create a legal justification for that kind of mistreatment by passing this bill.

Thank you for your time and consideration.

Sincerely,

Reed Heidelberger

Reed Heidelberger
17000 Co Rd 28
Villard, MN 56385

March 15, 2024

Dear Rep. Stephenson and members of the Commerce Finance and Policy committee,

My name is Amy Smith and I live in Minneapolis, District 63B. I am opposed to HF1930 for a long list of reasons, with the first being that I am a medical provider. I have been working as a Physician Assistant (PA) in the Emergency Department (ED) for over 20 years. I have been taught how to care for patients and how to save their lives. I have been taught to “do no harm” to my patients. The greatest harm I can imagine is being responsible for ending my patient’s life, even at their own request. This proposed legislation goes against the fact that a healthcare providers' obligation is to care for their patients, not to assist in killing them, no matter the circumstance.

The second reason I oppose assisted suicide is personal. My dad ended his own life when I was 12 years old and my mom died at age 62 of Amyotrophic Lateral Sclerosis (ALS). Most people would probably say that my dad ending his own life at age 35 was a tragedy and we should try our best to prevent this kind of tragedy, and I agree. However, this legislation tells us that it would not have been a tragedy for my mom, with the assistance of her medical provider, to end her own life prematurely. This legislation is saying that it would be the caring thing to do. I would argue that both of these situations are absolute tragedies and that we should protect both of them from prematurely ending their own life, whether it be at their own hands or the hands of their medical provider. Both of their lives are worthy to be cared for until the time of their natural death.

My district representative and probably most, if not all, of those writing this legislation argue that autonomy is the reason we need this legislation passed. They would argue that those with a terminal illness should be able to be assisted with an early death to prevent their suffering and that evaluation will be done to determine their mental capacity to make this decision. I would argue that anyone going through a terminal illness has some level of depression and/or anxiety, and are incapable of making such a serious decision. Why even give them this option? Minnesota has some of the best healthcare in the world. We have wonderful hospice and palliative care available in our State to care for these patients until their natural death. It has been shown that in places where assisted suicide is legal- hospice care has fallen below national standards and progress in palliative care has stagnated.

It is also evident that in places where limits on assisted suicide are legislated, in time they are eroded away. The law begins for those with terminal illness and a 6 month life expectancy; however, in countries like Belgium, Netherlands, and Canada, people with depression, poverty, disability and chronic pain are assisted with suicide. This is a slippery slope where the government makes decisions on who lives and who dies. Those that are a burden on our healthcare system due to their chronic illness, cancer diagnosis, mental illness will be encouraged to end their lives prematurely, or worse yet, forced to do so. Allison Ducluzeau is from Canada. She was diagnosed with cancer and Canada refused care for her cancer. She was given only the option of their “euthanasia program”. She had to go out of the country for care, where the provider never considered her to be a poor candidate and she received life saving treatment. I promise you that if you allow for this legislation to pass, we will be doing the same to the people of Minnesota. We will be refusing them care because killing them is much cheaper than caring for them. Is that how we want to care for patients in Minnesota? As a PA, my answer is a resounding ‘No’.

I appreciate you taking the time to read what I have to say on a topic that is extremely important to me as a healthcare provider, a Catholic, a wife and mother, as well as an orphan daughter. Thank you.

From: Faith Oremland <faitho711@aol.com>
Sent: Friday, March 15, 2024 9:18 AM
To: Simon Brown <simon.brown@house.mn.gov>
Subject: Minnesota End-Of-Life Options legislation

Dear Mr. Brown,

I am writing to you regarding ”Medical-Aid-in-Dying”, the Minnesota’s proposed End-of-Life-Options legislation.

If this legislation was in effect, my mother would have been able to die in peace instead of going through day after day of intractable pain knowing she would eventually die after much agony. She could have had her family around her, holding her hands, calm and loving. Instead, we cried as we watched her suffer.

This legislation, if enacted, will offer a small segment of terminally ill adults the opportunity to end their suffering. It is NOT “suicide”. It is NOT “euthanasia”. There are strict controls over who is eligible. No one is encouraged to participate.

Being able to choose when to end your suffering when you have a terminal illness brings peace of mind and comfort even if you choose not to exercise that choice. 73% of Minnesotans, polled at the 2023 State Fair, support this legislation.

People with terminal illnesses deserve to have the choice and the comfort it brings to know they can end their suffering.

Please, in the name of compassion, support Minnesota’s End-of-Life-Options Act. It is NOT “physician-assisted suicide”.

It is the right to choose to die in peace rather than suffer intractable pain.

Thank you for your consideration.

Faith Oremland
360 Spring St.
Apt 134
St Paul, MN 55102

Professor Camosy Testimony Against in Opposition to H.F. 1930
END OF LIFE OPTION ACT
Commerce Finance and Policy Committee– Public Hearing March 18, 2024

Dear Chairman Stephenson and Members of the Committee:

My name is Charlie Camosy, a bioethics professor at the Creighton University School of Medicine in Omaha, Nebraska. Over my 16 years as a bioethicist, I've made a career building bridges of dialogue across polarized differences: religious and secular, life and choice, science and religion—and, significantly, red and blue. I've tried to show that once you study issues of bioethics in depth, these kinds of distinctions—so prominent in our toxic public discourse today—don't really hold at all. Indeed, I am the founding editor of a new book series we are calling "The Magenta Project" (magenta being the color between red and blue on the color wheel) which will demonstrate a brilliant, beautiful moral and legal vision which goes so far beyond red and blue.

The issue of physician-assisted suicide (PAS) is one of the most "magenta" issues in all of bioethics. Notice how it doesn't fit at all into traditional red and blue categories. You have progressives testifying before this committee sounding like libertarians, arguing on the basis of individual freedom, autonomy, and government staying away from the choices of the individual. Meanwhile, you have conservatives sounding like left-wing activists: talking about nonviolence, showing true care and concern for the most vulnerable, and doing analysis of the unintended structural evils that are created when physician-assisted suicide is legalized.

Most bizarrely of all, you have the party of business and wealth doing an implicit critique of capitalism—by insisting that one's value does not come from autonomy, productivity, or how much you "contribute to society." But rather simply because of the fundamental equality of all.

But these are only bizarre places to be if we have a red/blue mindset rather than a magenta mindset.
It no longer becomes bizarre to see right wing pro-life activists taking the same view as left-wing disability rights activists. The magenta commitment to human dignity is the same.

Both are deeply concerned about pain and suffering, of course, but both also know that PAS is not about that. In Oregon, which has had PAS since the 1990s, physical pain and suffering don't even make the top five reasons people request it. Many are sympathetic to end-of-life cases where someone is wracked with terrible pain, but data on the reasons why people ask for PAS from Oregon's public health department shows that physical pain doesn't even make the top five:i

1. loss of autonomy (91.4%)
2. decreased ability to engage in enjoyable activities (86.7%)
3. loss of dignity (71.4%)
4. loss of control of bodily functions (49.5%)
5. becoming a burden on others (40%)

Physical pain and suffering doesn’t make the top-5 because in the overwhelming majority of cases we can control pain through palliative care. And with all due respect to those pushing this bill, that’s where I believe your focus should be—improving access to and trust in palliative care.

Indeed, based on reasons related to the terrible history of explicit and structural racial injustice in medicine, African American communities and other communities of color disproportionately distrust hospice and end of life practices in general. Considered a throwaway population for so long, they are also deeply skeptical of physician assisted suicide and euthanasia. Indeed, when Pew asked whether “there are circumstances in which a patient should be allowed to die” or “medical staff should do everything possible to save a patient’s life in all circumstances,” a striking racial gap revealed itself.ii For whites, only twenty percent say everything possible should be done but for Blacks, that number is fifty-two percent. For Hispanics it is fifty-nine percent. Distrust of the medical system which serves them at the end of life is so profound among Blacks that it even leads to skepticism of hospice—something that, for most white families, is close to an unquestioned good.iii

An authentic focus on racial justice would instead direct us to the structural inequities in health care and especially palliative care. Those who have been told throughout history that they had lives that were not worth living are understandably loath to accept laws which open the door to that disastrous state of affairs once again. In true magenta fashion, you will find that many of the groups and individuals opposing you on this bill will be partners in restructuring our health care system with these concerns in mind.

The recent COVID-19 pandemic has given us terrible insight into the ageist and ableist country we are—one which treats the old and disabled like throwaway populations, discarded into warehouses of death. We’ve also seen how terribly we treat those with dementia in particular, and the thousands and thousands of “excess deaths” of this population during the pandemic is too awful to contemplate. For example, I read about the story of a family who had their loved one with dementia die outside, frozen to death, when she slipped outside and somehow her absence went unnoticed over three different shifts.

In my recent book—titled Losing Our Dignity—I argue that we could very well be headed toward opening the door to PAS for people with dementia. This population will triple over the next generation and we already don’t put enough cultural resources into their care. What will happen as the population grows older and fewer people have fewer and fewer children? The writing, in some sense, is on the wall.

Indeed, a study of Canadian practices found that people who requested PAS “tended to be white and relatively affluent and indicated that loss of autonomy was the primary reason for their request. Other common reasons included the wish to avoid burdening others or losing dignity and the intolerability of not being able to enjoy one’s life. Few patients cited inadequate control of pain or other symptoms.”iv

In my book, I argue that if we don't fundamentally change our eldercare and dementia-care structures and systems, we will slouch toward robot-care and, yes, physician-assisted suicide and euthanasia.

Think that's too dramatic? Think it couldn't happen?
It is already happening. Consider that the Netherlands—a country which has a longstanding practice of euthanasia and assisted suicide—recently found not guilty of murder a doctor who euthanized a patient with dementia against her will.v The patient had previously requested physician-assisted suicide, but later (after she developed dementia) said at three different times that she had changed her mind and no longer wanted to die. The doctor and the woman's husband dismissed the views of this patient, conspired to have a sedative drug put in her coffee, and stealthily killed her via lethal injection. After acquitting the doctor, the Netherlands formally moved to legalize sedating patients with dementia before killing them—in part because, the new code claims, "it is not necessary for the doctor to agree with the patient the time and manner in which euthanasia will be given."vi

If you think similar things cannot happen here, think again. The State of California is already feeling serious pressure to euthanize patients with Alzheimer's disease.vii Once on the slope of legalized medical killing, it is very difficult to stop the slide. And though we aren't quite there with the Dutch when it comes to direct killing, nursing homes are already overmedicating people with dementia (often with antipsychotic drugs) simply to keep them "docile" and generally in need of less care.viii

In addition, take a look at how legalizing PAS has played out in Canada, your "neighbor to the north." In 2016, Canada enacted a bill legalizing PAS for the terminally ill. Then, in 2021, Canada expanded the availability of PAS to those living with physical disabilities as well as those with "chronic, incurable conditions." Now, in 2027, Canada is poised to again expand the availability of PAS to include those suffering from mental illness.

Furthermore, there has been pressure on Oregon and other states to move from six months to twelve months. If, after all, the right is one of autonomy and not coming between a patient and his doctor, then, well, it isn't clear what the principled limitation might be.

And the smartest people defending the law in Oregon know this. Including when they faced pressure to extend their law from six months to twelve months.ix

"We think it's a very bad idea," said Steve Telfer, president of the board of the Portland- based Death with Dignity National Center. Telfer said the six-month limit was "a very appropriate time frame" for the law and that extending it to a year would send the wrong message to lawmakers considering similar laws in other states. "You just run the risk of the slippery-slope argument big time," Telfer said.

Indeed.

Again, there is no principled reason why it should stay at six months. Or even be withheld from people who are dying at all. The fastest growing group in the Netherlands to request PAS are people over 80 in nursing homes who are simply "tired of life." And who could blame them, given what they are told about what their lives are worth—or, more precisely, what their lives are not worth. Who is to tell them what they can and can't do with their bodies? Who is going to get between them and their doctor?

Let me finish with perhaps the most important point of all. If you pass this bill, you totally change the very nature of what medicine is in the State of Minnesota, home of the Mayo Clinic, widely recognized as one of the finest hospitals in the world. A medical system that kills is no longer recognizable as healing and caring. It becomes what I and others have called "The Burger King" model of medicine. Burger King is, of course, where you "have it your way." The consumer is in charge. If you want a Whopper without meat, great. Without bread? Great too. There's nothing that is "a Whopper" that is independent of what the consumer says it is. This is capitalism at work.

We must not allow medicine to be deformed like this. Medicine is something objective. Healing and caring are objective concepts that mean something apart from whatever the market says it is. This is what it means to have a profession.

We should be focused on how best to leverage the healing and caring of medicine to make these populations feel valued. And we should absolutely not be telling them, "Hey, your life is so bad—and such a burden on others—that we can kind of understand why you'd want to kill yourself."

i "Oregon's Death with Dignity Act—2014," Oregon Public Health Division, February 2015, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Docu ments/year17.pdf.
ii Pew Research Center, "Views on End-of-Life Medical Treatments: Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive," Pew Forum, last updated November 21, 2013, https://www.pewforum.org/2013/11/21/views-on-end-of-life-medical-treatments/.
iii Sarah Varney, "Toward Hospice Care," New York Times, August 21, 2015, https://www.nytimes.com/2015/08/ 25/health/a-racial-gap-in-attitudes-toward-hospice-care.html.
iv Madeline Li et al., "Medical Assistance in Dying — Implementing a Hospital-Based Program in Canada," New England Journal of Medicine Vol. 376, No. 21 (May 25, 2017), https://www.nejm.org/doi/full/10.1056/NEJMms1700606.
v "Doctor Cleared of Murder in Euthanasia Case Says She Would Do it Again," Dutch News. June 15, 2020. https://www.dutchnews.nl/news/2020/06/doctor-cleared-of-murder-in-euthanasia-case-says-she-would- do-it-again/
vi Daniel Boffey, "Dutch Euthanasia Rules Changed After Acquittal in Sedative Case," The Guardian, November 20, 2020.

https://www.theguardian.com/world/2020/nov/20/dutch-euthanasia-rules-changed-after-acquittal-in-sedative-case

vii Nicholas Goldberg, “Column: California’s Aid-in-Dying Law is Working. Let’s Expand it to Alzheimer’s Patients.” Los Angeles Times. July, 15, 2020.

viiiHuman Rights Watch, “Using Medicine In a Wrong Way,“ February 5, 2018.
https://www.hrw.org/report/2018/02/05/they-want-docile/how-nursing-homes-united-states-overmedicate-people-dementia?fbclid=IwAR3UVMBBDBKT81uCbgYp8CbF9Ed4iD8DXFV2uYX8x52_KeRUtmqDEyG-05Q#

ix Vijosa Isai, “Death by Doctor May Soon Be Available for the Mentally Ill in Canada,” New York Times, December 27, 2023
https://www.nytimes.com/2023/12/27/world/canada/medical-assisted-death-mental-illness.html

x https://www.oregonlive.com/mapes/2015/03/bill_to_expand_oregons_death_w.html

From: Lorraine Hassing <hassing@bevcomm.net>
Sent: Saturday, March 16, 2024 9:26 AM
To: Simon Brown <simon.brown@house.mn.gov>
Subject: End of Life Option Act

Please, please do not have this on the minds of patients, doctors and others that they would okay something to help people end their own lives. It is the most hideous thing that I have ever imagined that could happen in our state of MN. This is something that should be in the hands of God as to when a person passes away. It is just deplorable even to think that it might happen. Let it never, never happen.
Lorraine Hasssing

I am writing IN SUPPORT of the End Of Life Options Act, HF 1930.

My dear friend, Janet, died alone 10 years ago after many many years living with chronic pain. The medical community had nothing to help, though she had tried going this route to relieve her suffering, repeatedly. Finally, she chose to end her own life. Afraid of implicating her husband, she waited until he left for his weekly visit with neighbors, at which time she put her well-researched method to work, and that was that.

Every major event in our lives is attended by those we love - birth, birthdays, weddings, anniversaries, illnesses, etc - but our final choice, if it does not reckon with the laws as they now stand in Minnesota, must be suffered alone. It is time to change this.

Please support the End of Life Options Act now.

Sincerely,
Sandy Lucas
Saint Paul, MN

I am writing in support of the EOLO Act.

My wife, Peggy, a chemistry professor at the U of MN was diagnosed with metastatic kidney cancer in 1991 (age 47). She died 14 months after the diagnosis in 1992.
I can't know for sure, but as sure as I can be, my wife would have wanted to have the option provided by this bill.

And now I, at age 84, and health wise so-far so-good, would be comforted to know that this option would be available to me when such a time comes.

Thank you for your consideration on this important matter especially to those of us of a certain age.

Respectfully,
William (Bill) Etter
101 Promenade Ave #218
Wayzata, MN 55391

Wednesday, March 6, 2024

To the Members of the Committee:

I write as a public health professional, a voter, constituent, and a 69-year old human being.

My beloved 79-year old sister, a resident of Oregon, has severe Parkinson’s disease. She has secured the medication that will end her life at a time of her choosing. She has no desire to die.

She is not suicidal. Rather, she plans to end her life before the progression of Parkinson’s leads to paralysis, choking, dementia and lingering death. Would you choose otherwise? I would not, and do not want to have to travel to Oregon to exercise that choice, when my time comes.

Please support House File 1930, in this committee, and when it reaches the floor for a full vote.

Thank you,

Patricia Ohmans

Patricia Ohmans, MPH
Health Advocates
843 Van Buren Avenue
Saint Paul MN 55104
651-757-5970

Testimony in support of HF1930, A bill establishing an end-of-life option for terminally ill adults.

Leslie Everett
1794 Tatum Street
Falcon Heights, MN 55113
March 15, 2024

Members of the Minnesota House Commerce Finance and Policy Committee,

I support HF1930, establishing an end-of-life option for terminally ill adults. For the record, I am a 75 year old male in relatively good health, retired from the University of Minnesota, not in the medical profession. I want to have the option of deciding my own fate, if and when I receive a terminal diagnosis with less than six months to live. Some of the following testimony was in my letter to the editor of the StarTribune published January 3 of this year.

I urge the Committee to consider comments for and against this legislation strictly in light of what is actually in the bill, and in consideration of results from similar laws in states where they have been adopted. Most of the bill consists of procedures and standards to ensure that the applicant is within a six month terminal period, is of sound mind, is fully aware of other options, and is free from pressure from outside influences, social or medical. Persons with disabilities apart from those with a six month terminal prognosis, are explicitly excluded from this end of life option. Medical providers and facilities are not obligated to provide this end of life service if requested. Two licensed clinicians, one of which must be a licensed M.D. or O.D., are required to certify eligibility of the requesting patient.

Oregon initiated the Death With Dignity Act (DWDA) in 1997, and ten states have adopted similar legislation. The Oregon law specifies that: a patient must be 1) 18 years of age or older, 2) capable of making and communicating health care decisions to health care practitioners, and 3) diagnosed with a terminal illness that will lead to death within six months. The online 2022 annual report from the Oregon Health Authority states: "Demographic characteristics of DWDA patients were similar to those of previous years: most patients were age 65 years or older (85%) and white (96%). The most common diagnosis was cancer (64%), followed by heart disease (12%) and neurological disease (10%)." (https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.pdf) Note that the diagnoses are not chronic disabilities nor are minority communities over-represented, as opponents of the bill have suggested, and 91% were already in hospice. Consideration of this bill should be based in fact, not fear, and the 25 years of Oregon experience with this legislation provides an excellent factual grounding.

People of Minnesota would be well served by this carefully written legislation, which ensures that applicants are fully qualified, and counseled on all end of life options.

In support of End of Life Option Act:
My husband of 44 years had ALS & ended his own life. Knowing what he did about this horrible neurological disease, he was determined to end his life before he lost all of his functioning & became dependent on others.
Unfortunately his first attempt was unsuccessful & so the nightmare of finding another method only made this journey more painful for
me & our 3 children. Had there been an End of Life Option Act in place, our family would have had the opportunity to spend his final hours supporting him with our love. Unfortunately he died alone.
No family should have to experience what my family did.
I strongly urge the MN legislature to support this important legislation.

Good Afternoon,

It is easy for some to sit back and say that a suffering human being should stay on the Earth until God says they can go. I believe some who support this position have never sat by the bedside of a person to whom every breath brings agony. And that does not even account for those who find themselves alone at this time, perhaps under the care of employees at a care center, even though they may be dedicated. The idyllic image of loving family members gathered around the dying person often does not exist in our world.

Some find it handy to preach about what people should do when faced with an end of life that only offers pain and loneliness. If they find their lives meaningful until the end, they have that option. They should not be able to impose their theological beliefs on the rest of us. If medicine has the means at their disposal to ease agony so that other souls can have the option to transition to a better world with peace and dignity, it should be employed.

Respectfully,

Lee Hendrix

To the House Commerce Finance and Policy Committee:

I am a practicing physician and mental health advocate writing in support of HF1930, the End-of-Life Option Act.

During my short time in practice, I have already encountered numerous patients interested in learning about Medical Aid In Dying (MAID). Based on data from states with similar laws, most eligible patients will not request the medications and even fewer will ultimately take them. Why, then, do so many people ask about it?

One of the most difficult aspects of facing a terminal illness is the eventual loss of control over one's body and future. The existential suffering that comes with those changes can't be treated with medication the way more conventional types of pain can. We could provide infinite assistance, compassion, and support, but without a sense of personal empowerment these efforts will fall short for many people.

The term "death with dignity" is often used in discussions about MAID. For some people this may mean avoiding certain physical symptoms. For others, it is an escape hatch, a backup plan in case their suffering becomes unbearable. For everyone, MAID is a form of agency. Regardless of whether someone decides to use it, there can be peace and dignity simply from having a choice.

This bill provides protections to prevent abuse or exploitation of vulnerable people. No patient or provider can be coerced into participation under this bill. It serves a narrow but critically important role in preserving the dignity of Minnesotans at the end of life. MAID is not about despair or hopelessness, it is about acceptance and empowerment. We must acknowledge the fact of death, but we need not feel helpless in the face of it.

Thank you for your time, and I hope you will consider moving forward with HF1930.

Kaci McCleary, MD

simon.brown@house.mn.gov

HF 1930 Written Testimony

I am opposed to HF 1930. It is wrong to mandate physicians to offer Assisted Suicide to patients and violate the oath they take to uphold life.

We have good options to alleviate pain and provide emotional support through Palliative Care and Hospice Care at the end of life. These options need to be available to all who could benefit from those services.

Assisted Suicide is not compassionate care. It can too easily be used to blur the lines between whose life is worthwhile…not a decision for us to make.

We need to be able to trust that doctors will uphold life from conception to natural death. I have accompanied dying people and know that fear can be alleviated by presence and support as well as pain meds, massage, music, and prayer.

Marva Jorgensen RN retired.

St. Cloud, MN

HF 1930 Physician- Assisted Suicide = A Medical Profession without Heart

Imagine *It's A Wonderful Life* re-written so that Clarence stands by and offers his services as a supportive witness to George's jump. That is the gist of the Minnesota's H.F. 1930 bill legalizing physician—assisted suicide. When a patient learns that he or she has a terminal illness and are told devastating news, words fall short but good physicians and nurses certainly don't shout to George, "Jump!"

As a nurse for over four decades, I have cared for patients at the end of their lives in coronary care, intensive care, medicine, surgery, radiology and radiation oncology. The most rewarding moments of my professional care have come when the patient realizes that time with loved ones was nearing the end. Understanding that "there but for the grace of God go I," true compassion—suffering with—became my duty. It meant that I needed to listen closely and be totally present. It meant I was called to care for them holistically, my soul to theirs. It meant accompanying them with availability, attention, dialogue, understanding, sharing, benevolence, and patience. Professional expertise and science during those times are not enough. But the encounter is not one-sided. Each patient deeply changed my life for the better. What is essential and required for a nurse is a heart-to-heart empathy for the patient. The art of caring shows that the nurse will never abandon the patient.

So, I am deeply disappointed in, and utterly reject, the MN H.F 1930 bill to legalize physician -assisted suicide because it does just that. It abandons the patient. It essentially abandons the very heart of caring in both medicine and nursing. Nursing is an exalted, rewarding and meaningful precisely because it is the integration of profession, vocation and mission. Through advanced education coupled with service we practice the art of caring. Nursing has a demanding missionary dimension. Our entire person comes into play when caring for a patient; it requires a complete commitment. Only then are we able to serve our neighbor in need. We proclaim high moral and professional standards to "do no harm" and to deliver the best nursing care possible. I give the best care when I truly walk with the patients in their suffering and do not abandon them, *even if they suggest otherwise*.

This H.F. 1930 bill proposal negates all of the qualities of mission, vocation and profession in nursing. First, it insinuates the false claim that the nurse must be supportive with patients who wish to end their lives. Ending one's own life is suicide, and as a medical professional, expressing my support for that decision—or even being non-committal about it—is neither aid, nor care, nor compassion. Its only assistance is doing the ultimate harm. It is abandoning a patient who is vulnerable, who needs more than anything else the presence of someone who has the patient's true best interest in mind. It is incongruent with the inherent interpersonal relationship of nursing.

Second, this way of thinking would succumb to giving patients what they *want* instead of what they *need*, which violates a foundational principle of nursing. Patients are not merely consumers who can demand anything they want from healthcare workers. They are, first and foremost, vulnerable and deserving of care. If vulnerable patients ask for something that is not good for their health, it is the healthcare worker's responsibility not to give it to them. How many good nurses encourage, educate and offer pain control to post-op patients, letting them know that getting up and moving is exactly what is needed for good recovery—even when it is not wanted. When people enter the ER wanting opioids for their addiction, every good ER nurse would recommend treatment and recovery, not what they want.

I find this MN H.F 1930 bill unworthy of our professional high calling to care for our patients when they are the most vulnerable and the most distressed. If this policy is adopted the heart and purpose of medicine and, ultimately nursing, would be lost. T. S. Eliot's line from *Four Quartets, Little Gidding* would be fulfilled: *"And what you thought you came for is only a shell, a husk of meaning…"*

Submitted by,

Dianne M. Johnson, RN, MA (with emphasis in Biomedical Ethics) University of St. Thomas
BA in Philosophy and Catholic Studies UST
RN, OCN Nursing for 44 years
Founder and Mission Director, Curatio (Catholic Apostolate for Healthcare Professionals)
7758 Knollwood Drive , Mounds View, MN 55112

I am a Catholic Religious Brother. I am also a caregiver and serve on the Board of Directors for the Terri Schiavo Life & Hope Network, advocating for those who are deemed, "un-useful," or perhaps now, "without dignity." Whether they are living with a serious disability such as a traumatic brain injury as Terri Schiavo had, not needing extraordinary means of life support, or for those who are awaiting their appointed time to pass on from this life by way of a natural, un-hastened death instead of being euthanized or becoming a victim of the inevitable and ever decreasing safeguards of physician assisted suicide. Even with added safeguards, Physician Assisted Suicide is still wrong and unnatural.

Life has meaning and life without suffering is impossible, period! In the words of the great, Dr. Viktor Frankl, "If there is meaning in life at all, then there must be meaning in suffering." "Today's society is characterized by achievement orientation, and consequently it adores people who are successful and happy and, in particular, it adores the young. It virtually ignores the value of all those who are otherwise, and in so doing blurs the decisive difference between being valuable in the sense of dignity and being valuable in the sense of usefulness. If one is not cognizant of this difference and holds that an individual's value stems only from his present usefulness, then, believe me, one owes it only to personal inconsistency not to plead for euthanasia along the lines of Hitler's program, that is to say, 'mercy' killing of all those who have lost their social usefulness, be it because of old age, incurable illness, mental deterioration, or whatever handicap they may suffer. Confounding the dignity of man with mere usefulness arises from conceptual confusion that in turn may be traced back to the contemporary nihilism transmitted on many an academic campus and many an analytical couch."–Man's Search for Meaning by Dr. Viktor E. Frankl. (After earning his M.D. in 1930, Frankl gained extensive experience while treating suicidal women in a psychiatric hospital. In 1937, he began a private practice, but the Nazi annexation of Austria in 1938 limited his opportunity to treat patients. Prior to his deportation to the concentration camps, he helped numerous patients avoid the Nazi euthanasia program that targeted the mentally disabled.)

If we had been given full awareness and reasoning before our birth, who of us would have decided to leave the quiet, warm, soft nurturing atmosphere that is the womb, versus being suddenly contorted and ejected into a cold, blinding, noisy environment, being manhandled, poked and prodded? Probably none of us, because at the time, we would not have been aware of the goodness and love that is to be experienced outside of the womb. But as a mother well knows, and the baby will soon know as well, goodness and love exist after the temporary hardship and pain that comes with childbirth. Why should it be any different with how we die? Life is full of physical, emotional and psychological discomfort, pain and suffering. Why? Because there is meaning in suffering, and like childbirth along with the myriad of life's challenges and sufferings, it does pass.

Br. Conrad Brent Richardson, fbp
1289 Lafond Avenue
Saint Paul, MN 55104
conrad@brothersofpeace.org
651-315-3570

Dear esteemed committee members,
Please do not pass this destructive legislation. We should be legislating to help people, not to harm people. This legislation is not needed. Those who want to commit suicide will find away without this legislation. It will only cause people to wonder if they are burdening their families. I think it’s also telling that this is a commerce committee issue. It seems like you want to save money for insurance companies instead of helping people. This is not healthcare. This is the explicit encouragement of ending life.

From: Mary Davis davism4077@gmail.com
Subject: HF 1930 Written Testimony
Date: Mar 17, 2024 at 12:56:55 PM
To: simon.brown@house.mn.gov
Bcc: mweimholt@yahoo.com

HF 1930 Written Testimony

Fear is a liar. It is out of fear that we make decisions we regret, or we don’t tell people what we truly believe. It’s out of fear that we lie to ourselves when facing something difficult and it obstructs our ability to make solid choices.

You are in a position of authority, and the checks and balances which are to guide critical decisions are being tossed out and targeted. There seems to be something else at play here.

This Bill is based on fear. I know I’m speaking in general, but most people are afraid to die or at least how they’re going to die. As difficult as that reality is, it is unnatural to want to end a life.

It IS NOT natural! Yet-we still need laws to protect us from ourselves.

Bill HF 1930 is nonchalant about ending a life and it is attempting to persuade us into an acceptance of an unnatural decision. By extension, voting for this bill is saying that you are helping someone end their life. Are you really okay with that?

I ask you to step out of fear. Please represent and protect Minnesota by opposing HF 1930.

Thank you,

Mary Davis
Mound Minnesota

Written Testimony of Bobby Schindler
Opposing H.F. 1930
Submitted to the Commerce Committee

Dear Committee Members:

My name is Bobby Schindler, and I serve as President of the Terri Schiavo Life & Hope Network. My work as a disability rights advocate began with fighting for the life of my sister, Terri Schindler Schiavo. Advocating for Terri started in 1993 and lasted 12 years until she was starved and dehydrated to death by a court order at the demand of her husband in 2005. Terri was simply a disabled American woman; she had been neither actively dying nor near death, but death was intentionally caused by the denial of her basic care, food and water. I have spoken extensively throughout the United States and internationally about Terri, her case, and countless thousands of individuals facing the prospect of similar forms of denial of basic care.

For the past decade acting as a patient advocate, it has become disturbingly evident that protections for medically vulnerable persons— the elderly, disabled, chronically ill, and those with forms of depression or other treatable health issues—are slowly being eroded, thereby increasing the risk of patients facing an encouraged or imposed premature death by laws, policies, and healthcare systems.

While Oregon legalized "physician-assisted suicide" in 1997, the experiences of states that have enacted legal suicide underscore the deep concerns opponents of suicide-enabling laws have long expressed – that legal permission for certain forms of suicide will result in the expansion of the so-called "right to suicide." H.F. 1930 will adopt suicide as a right, abandoning the trust of the state to legitimately regulate the practice and thus afford an individual protection from abuse.

Abuses and Coercion of Vulnerable Patients

Any language incorporating vague or over-broad interpretations of the law will lead to abuse that will be impossible to control or to prove. Persons who are made to feel unwanted or a burden, mainly persons with disabilities and the elderly, will be at serious risk by the expanded suicide regime.

The introduction of legalized suicide in Oregon has not stopped the abuse of the elderly and infirm in that state. In 2016 alone, nearly 4,000 Oregonians were victims of elder abuse. [1] Instead of diminishing protections, the state should prioritize protecting all vulnerable individuals. This is why I oppose suicide in all its forms, whether by physician or through other means. The relative or subjective quality of one's daily experiences in life does not determine the objective and fundamental value of one's life. No state should enshrine suicide and death as a legitimate alternative to living with a disability or terminal disease.

American Medical Association Opposes Suicide by Physician

Leaders in the fields of bioethics, law and policy, and medicine share serious and fundamental concerns regarding abuses and failures in states that have embraced forms of suicide as a legitimate social policy. [2] This would include a lack of reporting and accountability, as well as the failure to assure the competency of the requesting individual. [3]

Perhaps most noteworthy is that the American Medical Association (AMA) opposes suicide by physicians, even in "end-of-life" scenarios. This is because the AMA believes that "permitting physicians to engage in assisted suicide would ultimately cause more harm than good." Furthermore, suicide by physician "is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." [4]

In a recent article, a neuroscientist identified three reasons why patients often recover from what might be a seemingly hopeless prognosis: (1) their will to live, (2) support from family, and (3) love. Similar studies conclude that those contemplating forms of suicide almost always suffer emotionally or psychologically and often lose their will to live or lack family support.[5] Expanding assisted suicide unquestionably increases the vulnerability of already vulnerable persons who are not genuinely terminal and who would benefit from authentic care and treatment.

Encouraging new forms of suicide would do nothing to provide the sort of care and treatment that thousands of vulnerable Minnesotans would benefit from each year. What people who allegedly "want to die" need is encouraging life-affirming care, comfort, and compassion.

Because H.F. 1930 encourages vulnerable individuals to embrace despair as an answer to compassionate care, I respectfully ask you to oppose this dangerous bill.

Sincerely,
Bobby Schindler, President
St. Petersburg, Florida
Terri Schiavo Life & Hope Network
bschindler@lifeandhope.com
855-300-HOPE (4673)

[1] Zarkhin, & Terry, (2017) Kept in the Dark: Oregon hides thousands of cases of shoddy senior care, https://www.oregonlive.com/health/2017/04/senior_care_abuse_neglect_poor_care_hidden.html

[2] Washington State Death with Dignity Act Report (2018), https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf

[3] Disability Rights Education & Defense Fund (DREDF), Why Assisted Suicide Must Not Be Legalized, https://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/

[4] AMA Code of Medical Ethics Op. 5.7 (Physician–Assisted Suicide), https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide

[5] Wardle, Lynn D., A Death in the Family: How Assisted Suicide Harms Families and Society, https://www.avemarialaw.edu/wp-content/uploads/2022/02/WARDLE-CORRECT-1.pdf

March 16, 2024

To the House Commerce Committee:

Working as a nurse in hospice and now provider over 15 years, I found the end of life was one of the most raw and beautiful times of life that is so hidden from our society. Our culture values the young and healthy, but not the old or sick. We all want to alleviate suffering but I do not believe physician assisted suicide is the answer. I just wanted to share a few experiences that I hope will propel you to say no to physician assisted suicide here in Minnesota.

Just because someone has a terminal illness does not mean they are going to die in a predetermined amount of time. Often patients are given 6 months but survive significantly longer. I have seen many patients on hospice 2+ years and many patients "graduate" from hospice as they are no longer considered terminally ill. I have seen patients have what I can only describe as miraculous healings- I walked with a patient who had terminal cancer and several months into hospice she started telling me she felt like the tumors were shrinking, a few months later she got another scan and it was determined the cancer was completely gone. This happened more than once. For any of these patients, physician assisted suicide would rob them of the years of life!

As most (if not all) people come to the end of their life, there come points of reflection, sharing, joy, sorrow, reconciliation with others, healing, and deep love. Typically, those who are able to work through their experiences and questions exude a peace and joy that leaves its imprint on those who are privileged to be present with them in the end. Sometimes these wrestlings or needs for reconciling do not happen until the last moments of a person's life. I realize there is an argument that this could happen before the physician assisted suicide occurs, but in my experience these are the experiences that happen in the last weeks, days, and hours of a person's life. The peace and joy that come with resolution of internal or external conflict would be taken from both the person who is ill and those near to them. This would be a great tragedy.

Natural death is an incredible moment of a person's life and, because our culture and society runs away from death, many people do not know this. Please do not allow us to rob these last moments of life from people that can bring healing to them and those around them. Please oppose HF 1930.

Chiara Johnson, APRN, resident of District 53A

HF 1930 Written Testimony

Hello, my brother with downs syndrome passed away in 2021 and I would like to share my experience of the healthcare system in his regard and what I would expect to happen if this legislation is passed.

One of the most memorable events that comes to mind is when Jerry, who was at about a 1st or 2nd grade cognitive level, was in the hospital with aspirational pneumonia. After a couple days we and the hospital staff were able to get him stabilized and the intubation tube removed. He was on the mend and we were relieved, and even better than that, we were able to get one to one staffing for the overnight so we could actually go home and get some rest! Great we thought, but when I came to be with him in the morning he was intubated again and to my surprise they gave him morphine! I asked why and what was noted in the record was that the patient said his leg hurt. Amazing that they wouldn't start with something like ibuprofen! Knowing my brother as I did and the staff did not, his leg probably didn't hurt but he would parrot back whatever the staff would ask and so they would take it and run with it. As we investigated what all happened that night it pretty much boiled down to the staff didn't really want to care for Jerry but just to immobilize him so he wouldn't be a bother to them. I am sure if I asked Jerry when he said his leg hurt to just cut it off to make it better and he would have agreed!

This is the problem with this legislation, it opens the door to wide spread abuse of the mentally/physically disabled and the elderly. My experience shows that even when the level of care is at its best with motivated family members the desire to take the path of least resistance is already endemic to the medical system not to mention the political system. Passing this legislation will only allow politicians, medical staff, and/or family members to intentionally kill people for whose care they are responsible because they see them as a bother or are too expensive to care for. They will opt for the path of least resistance instead of the path to the best available care. This undermines hospitals, nursing homes, and medical staff who truly want to help people. Please do not support any form of legislated euthanasia. It will only be an avenue for abuse of the vulnerable we are tasked to protect and care for.

Sincerely,

Peter Yurek

Peter Yurek

North Saint Paul

Dear Legislators,

Please vote NO to HF 1930. This bill is not just a bad idea. It is evil. Those who are susceptible to the temptation of suicide would be in danger of pressure from the very people who are supposed to be looking out for their wellbeing encouraging them to choose death. Right now, the bill is limited in its scope, but if we look to other places that have implemented this kind of legislation, we can see that it broadens over time. As someone with a disability, this is a cause for concern. This is a foot in the door for suggesting suicide to people rather than providing them with the loving care they need and deserve. Imagine a person with a physical or mental disability being given the option to end their life rather than getting some help alleviating their pain. If we start down this road by passing this bill, it could easily lead to a situation where people are even denied treatment or care due to the push for suicide. It seems like that would never happen, but history is full of examples where things that began with good intentions spiraled out of control soon after. This is the very thing that led to the Holocaust. Many people don't know that this horrendous event actually began with the legalization and acceptance of euthanasia. It was deemed more humane to just euthanize all the people with disabilities rather than force them to suffer their miserable lives. As someone with a disability, that is incredibly insulting. I love my life. Yes, I deal with chronic pain, but I would never want someone to suggest that the solution is to end my life. Imagine going to your family members, telling them you are in pain, and hearing them suggest for you to kill yourself. Would you feel loved by that suggestion? People are not disposable objects. Life is not something that is ours to give and take. That belongs to God alone. Please do not fall for this wicked temptation. Please vote against HF 1930.

William Scheremet
Northfield, MN

From: Mary E. McClure <mmcclure1387@outlook.com>
Sent: Saturday, March 16, 2024 12:18 PM
To: Simon Brown <simon.brown@house.mn.gov>
Subject: HF 1930/SF1813

Know of our strong opposition to the Assisted Suicide bill pending in the MN legislature. It is beyond the scope of a government to be making such moral decisions particularly when the only rationale is financial.

Compassion does cost and sacrifice may hurt us but that is what teaches us about relationships and love.

Do not create a state where money rules .

Please encourage all legislators to take a moment to think of who they admire in this world; their elders, the challenged individual who lives his/her life, one who faces adversity and continues…

We create only more suffering when we ignore the call to serve and place money, efficiency and an easier life " for me" ahead of care for others.

Please choose the good.

Thank you,
Randall & Mary McClure
1169 Edgcumbe Rd.
St. Paul, MN 55105

March 18, 2024 Minnesota House Commerce Finance and Policy Committee

HF1930: End-of-life option established for terminally ill adults

The MN End of Life Options Act uses language very similar to the language used in all other authorized states of which there are ten plus the District of Columbia. In regard to the Articles of the act being considered today, never in nearly 30 years of history has there been one case of coersion, complaints filed, deniability of insurance proceeds or penalties administered. This law has absolutely nothing to do with suicide and the language in the bill enforces that. People that are dying simply want a degree of control over their dying process. Medical aid in dying laws work as advertised and the language in this bill is entirely appropriate.

Here is why I support the Minnesota End of Life Options Act:

My end of life journey, my end of life process, is ***MINE***. If I am of sound mind, no one should have any say in this except ***me***. That is what autonomy is: An ability to make one's own end of life decisions. These decisions may not be what others choose and I fully respect that. Medical Aid In Dying is the option I want for myself. I have no idea whether I would ever use it, but I want this option available.

Allow me to tell the story of two starkly contrasting deaths. First was my father who passed in 2013. He was clearly at the end of his very robust life. 98 years old, bedridden, covered in squamous cell cancer lesions, unable to stand, bedsores, medications, morphine, on and on. What he did have was his mind. Two days before he passed, he offered the following to one of his caregivers whom he cherished for her kindness: "I will write you a letter of recommendation." He never got to do it, but his caregiver told me about this offer and I did it. My dad would beg me – "Take me to Oregon". He knew all about Oregon's Death With Dignity law and would have loved to take advantage of it. Instead he died choking on fluid filling his lungs, a Hospice nurse at his side trying desperately with morphine to quiet his choking and obvious pain.

Exactly the death my dad didn't want.

Then, in Dec. 2022 there was a similar situation with a close friend. My friend Tom (85), in Hospice care, was dying of severe heart disease, also at the end of life. He lived in a rest home in California and was also nearly bedbound, in pain much of the time, short of breath and heavily medicated. He learned of California's End of Life Options Act and decided he wanted that option if his suffering became unbearable. It did. Going through California's strict protocols, he was given a prescription for the life ending medication. He picked a day, told his friends and family who were all supportive of his decision. I was there and it was probably one of the most impactful moments of my life. His passing was incredibly peaceful. He said his goodbyes and expressed his love for us, drank the medication, told one last anecdote, went to sleep, and in 20 minutes had passed with family and friends at his side. It was highly emotional as you might expect, incredibly peaceful and this is what he wanted. This was his option.

None of us are getting out here alive. When my time comes, do I want my dad's experience or my friend Tom's experience? I'll tell you what I want and what this legislation will do. I want the option that the Minnesota End of Life Options Act will provide.

Thank you.

Dave Sturgeon

Tonka Bay, MN

As a full-time family medicine physician, I stand strongly in opposition to the Physician Assisted Suicide legislation (HF1930). This bill is inherently coercive, because it financially incentivizes patients to end their lives prematurely through assisted suicide.

In locations where PAS is legal, patients do not primary opt for it to avoid pain. **Many opt for it due the fear of becoming a physical or *financial burden* on their families**. Physician assisted suicide is **a cheaper option for care than treating the underline disease**. In our low-income patients, it is easy to see how the financial burden would pressure them to end their life prematurely. Rather than the state of Minnesota working towards optimizing our palliative and hospice care systems, it would be a clear sign where we prioritize our resources. Even more abominable is that those who elect for physician assisted suicide are able to claim life insurance benefits after their passing. It is obvious how coercive this seems that the state of MN would support a 'healthcare' where not only can your doctor help you die faster, but you can also make money for your family when you do it. **These patients would be worth more dead than alive.**

When patients receive the worst news of their lives—that they have a potentially terminal illness—the last thing they need is for their trusted physician to prescribe a facilitated overdose. It seems obvious that introducing this as an option in medical practice in Minnesota will do irreparable harm to patient-physician trust. How could a patient be sure that their doctor has their best interests at heart? **How could they know if the doctor, God forbid, wants to "move things along" to ease hospital bed capacity or financial burdens?** In the last few years I have seen a serious degradation of trust between patients and providers. **I have a hard enough time talking to my patients about getting their vaccines!** Introducing the idea of physicians purposely overdosing their patients will further erode trust in our medical institutions and is completely counterintuitive to the Hippocratic that I took. **The American Medical Association similarly recognizes the damage proposals like these do to the physician/patient relationship and stands staunchly in opposition to physician assisted suicide.**

When people are experiencing what could be terminal illness, there are so many pressures that weigh on their hearts and minds – pain, cost, burden on others, etc. They are extremely vulnerable and in these situations, the last thing that physicians should be offering is an opportunity for an overdose and a big payout from the life insurance company.

Protect the most vulnerable Minnesotans and the future of our state's medical care.

I ask you to oppose HF1930.

Christine Broszko, MD, Blaine, Minnesota - District 32/32B

Greetings Committee Members,

My name is Jennifer Williams, I live in St Paul in district 67B. I oppose the HF1930 bill for numerous reasons.

I am a nurse of 27 years with 25 of those in inpatient and outpatient care of medical and oncology patients, and I have witnessed many deaths. The “Request for Medication to End My Life in a Peaceful Manner” is misleading and assumes that death will be peaceful. Death is not always peaceful. Even with the proposed method of terminating one’s own life, unanticipated things can occur as death draws close. A person approaching death is going to the unknown and oftentimes this brings many unexpected physiological and psychological changes, including but not limited to some level of anxiety, and most distressing very high anxiety and agitation. The person who is ending their life intentionally will be left without the care and support of health care providers who can assist with the unexpected that often happens as death approaches.

The bill refers to the importance of having another person present when the individual self-administers the medical aid in dying medication. This other person will very likely suffer trauma, initially and long term from witnessing this kind of death, which is in all truth and honesty, a suicide. Please note the definition of suicide is according to Merriam Webster “the act or an instance of taking one’s own life voluntarily and intentionally”.

It is also a hypocritical bill in our current times of “opioid overdose crisis”. Thousands of family & friends in MN have suffered loss & trauma from death of loved ones to opiod overdose and this bill is legalizing overdose causing death and perpetuating the crisi & suffering.

It is an unnecessary bill as people with terminal diagnosis have a plethora of options for care to manage & alleviate suffering caused by the disease, such as traditional pain medications, palliative care and hospice.

It is unfortunate to have a person end their life prematurely when their last days could be full of meaning. I have witnessed many times personally and as a nurse, friends & families reflecting and sharing, laughing and crying and loving deeply in the last months & days of life.

It must be noted that prognosis is not a certainty, it is an educated guess. I have known many people I cared for as a nurse die much quicker than their prognosis and I have had the joy of many more months to years with people I love who were given a prognosis of less than 6 months.

Death is always a tragedy and intentionally ending life increases the trauma, tragedy, suffering, anguish and pain.

Please do not pass this bill for the good and well-being of the people of the state of MN.

Thank you for your time and serious consideration.

March 16, 2024

Simon Brown, Committee Administrator-DFL Caucus
House Commerce Committee
Room 10, State Office Building, 100 Rev Dr Martin Luther King Jr Blvd
St.Paul, MN 55155

Re: HF 1930 Written Testimony

Dear Mr. Simon,

My name is Kimberly Howard. I reside in Stillwater, MN zip code 55082. My legislative district is MN House-33B and MN Senate-33. Please accept this email as my written testimony for the opposition of the HF1930 end-of-life option bill. I vehemently oppose HF1930.

HF1930 is not the solution for end-of-life medical treatment for terminally ill patients. Physician assisted suicide/medical aid in dying is ethically and morally repugnant. This proposed legislation isn't a one size fits all approach for terminally ill patients. This isn't healthcare! A patient should be able to die naturally, and not die from a drug induced coma.

If a patient expresses a desire for only "palliative care/comfort measures." This leads to a cruel duplicity of implementation of terminal sedation of that patient. It's horrific and gut wrenching watching your loved one die in this manner. This is not, to quote the pro-PAS/euthanasia advocates, a "good death.”

Please know that my opposition to PAS/medical aid in dying is based upon witnessing my beloved mother die from terminal sedation in 2020. My 88-year-old mother was euthanized in 2020 at a hospice facility in St. Paul, MN. My mother was a newly diagnosed lung cancer patient. When she was admitted to the hospice facility, she was **not in an active state**

of dying. She didn't complain of pain. All of her routine medications were stopped. Both she and I were in a state of shock, grief stricken and fearful of what we would face together in the near future.

The day after my mother's hospice admission. The hospice medical director threatened my mother with discharge if she didn't revoke her healthcare directive. The medical director made a disparaging remark about my role as her HCA/POA(healthcare agent, power of attorney). My mother was alert, able to speak for herself, but medicated during that conversation. I was her HCA/POA as of 2015. The facility ignored my HCA/POA status.
The medical director refused a request to have my mother's primary MD consult with him about my mother's hospice plan of care. I was illegally banned from the facility for seven days from visiting my terminally ill mother.
The hospice medical director accused me of "interfering" in my mother's plan of care. Whenever I attempted to advocate for the safety of my mother, the hospice nursing and medical team exhibited unjustifiable hostility towards me.

At the time,given my mother's history of allergies to narcotics and sedatives. I was greatly concerned about the hospice's immediate implementation of terminal sedation.
My mother was in and out of consciousness due to the 24/7 drugs administered by the hospice nursing staff. I watched in horror as my beloved mother died slowly (20 days) from a toxic cocktail of narcotics, benzodiazepines, antipsychotics and sedatives. Her death was caused by

overmedication, dehydration, malnutrition. Palliative sedation should be an option utilized as a **last resort** for patients whose symptoms cannot be controlled by any other means. My mother didn’t exhibit uncontrollable symptoms. Tragically, her premature death was caused by physician assisted suicide.

After my mother died, I obtained her hospice medical records. I was angry and heartbroken to discover she had endured a fall, was dropped to the floor from a bath chair and given three doses of Ativan, a drug she was allergic to. The hospice facility never informed me my mother had a fall or was given medication she was allergic to. I firmly believe my mother's hospice patient bill of rights was violated by this hospice facility.

Ativan caused my mother to experience a code blue (medical emergency) at Regions Hospital, St .Paul, MN on January 3, 2020. The code team administered/treated my mother for a Lorazepam(Ativan) overdose with Flumazenil, a benzodiazepine antidote medication. This drug overdose occurred a few days prior to her admission to the hospice facility. I was at my mother’s hospital bedside when this incident occurred. I'm certain anyone can imagine the trauma of witnessing your loved one suffering a medical emergency that clearly should have never happened.

My point is my mother was in a vulnerable emotional and physical state. She should have been offered treatment options with her best interest in mind. Instead, she was fast tracked by the hospital palliative care team into a hospice facility. She requested on several occasions to have homecare in her own apartment. She also expressed her fear of

substandard care in a skilled nursing facility. Her comments are documented in her Regions Hospital medical records.
Under duress, my mother revoked her full code status and signed a DNR and POLST. I witnessed coercion by the hospital and hospice healthcare team under the false guise of comfort care. My mother in her angst-ridden state naively trusted these healthcare professionals.

In closing, I do not want another family and their loved one to endure what my mother and I experienced at the hospice facility. Please, I implore our legislators to consider my mother's experience. It's not an anomaly. When care is expensive and killing is cheap, which do we think will prevail?

HF 1930 end of life option is modeled after Canada's MAiD. There is well-documented research data that addresses MAiD and the horrific dangers of physician assisted suicide/medical aid in dying. Patients are being euthanized by overt and covert euthanasia in Canada. Please don't legalize PAS/euthanasia in Minnesota. Thank you for the opportunity to voice my strong opposition against HF1930.

Respectfully,
Kimberly Howard
2400 Orleans St W, Apt 215
Stillwater, MN 55082-7542

I strongly support HF1930, the End of Life Options Act that allows mentally capable adults suffering with a terminal illness with six months or less prognosis to request medication they could choose to use to end their suffering if they decide it is intolerable and they want to die with their personality and sense of identity intact.

Susan Eckfeldt
880 Wheeler Street N
Saint Paul, MN 55103
651 210-8353

Written Testimony of Rebecca Thoman,
Doctors for Dignity Program Director, Compassion & Choices Action Network
Regarding MN HF 1930, In Support of the Minnesota End-of-Life Option Act
Minnesota House Commerce and Finance and Policy Committee
March 18, 2024

Chair and Members of the Committee:

My name is Rebecca Thoman and I reside in Minneapolis. I am the Doctors for Dignity Program Director at Compassion & Choices and the Compassion & Choices Action Network. We are the nation's oldest and largest consumer-based nonprofit organization, working to improve care and expand options at life's end. We advocate for legislation to improve the quality of care for terminally ill patients and affirm their right to determine their own medical treatment options as they near the end of life.

On behalf of hundreds of thousands of Minnesota residents and supporters nationwide, the Compassion & Choices Action Network supports HF 1930, the Minnesota End-of-Life Option Act. which authorizes the practice of medical aid in dying. It is modeled after similar statutes found in 10 jurisdictions in which the practice is narrowly defined and has multiple safeguards. The End-of-Life Option Act (HF1930) is subject to all state and federal laws, rules, and regulations.

Section 11 of HF 1930 prohibits insurers from denying or altering health care benefits based on the availability of medical aid in dying.

There is no connection between the denial of expensive or experimental treatments and the coverage of medical aid in dying as an end-of-life option. Insurance providers cover treatments that are deemed effective and proven, and they deny coverage for those considered unnecessary, experimental or below the standard of care. Not infrequently, insurance companies wrongly deny coverage for life-saving treatment and patients and their advocates spend an extraordinary amount of effort convincing them to reverse those decisions. This is true in every state, those that authorize medical aid in dying and those that do not.

Additionally, no federal funds can be used for care associated with medical aid in dying. The 1997 Assisted Suicide Funding Restriction Act (ASFRA), an antiquated, 25-year-old federal law, bars the use of federal funds "to provide any health care item or service for the purpose of causing, or for the purpose of assisting in causing, the death of any individual." 42 USC 14402. If a patient wishes to access medical aid in dying and is unable to use federal benefits or receive care in a federally-funded facility, the patient must find a supportive provider outside of the federal healthcare network as well as an alternative payment method for all medical aid-in-dying-related services and medication.

Medical aid in dying, like other end-of-life medical care options, is different from suicide as indicated in Section 14 and should, therefore, have no impact on life insurance or annuity policies.

Please support passage of HF 1930.

Respectfully submitted,
Rebecca Thoman, M.D.
Compassion & Choices Action Network

To voting members who REPRESENT the people's voices of this state,

Please vote **NO** to proposed assisted sucide bill **HF 1930/SF1813**. Enacting this bill will **further erode the hope and significance of the people of this state**. It has began with a few people in despair, who feel hopeless or trapped wanting to end their own life. It will not take long before **this "option" will become a suggestion** to those who are looking at end of life. Ask the people of Canada who have testified that there are doctors who offer this "solution" as a first option as opposed to a last. You are not freeing people from their suffering by "giving" them this as a "solution." You are telling them they are a burden, they are worthless, they are without hope. Why **would you EVER want to take the humanity away from a human being. This will put pressure on people who have financial struggle, (the poor and under served). And will be killing people who may still have a chance at life.** A close family friend was **told 20 years ago they had cancer and treatment options were limited**. **At that time they weren't going to even try to treat**, but was encouraged to do so by family. **That person is living a full, cancer free life 20 years later.** Had this been the "option" at that time **they would have missed years with their loved ones.** Dying is sad and painful for everyone who is near to you. **Having experienced someone committing suicide, it did not provide resolve for the people this person loved. It did not provide an answer for this human being who was loved. It doesn't matter the manner in which this happens. It is all the same.** And **this bill puts a burden on suffering people, their families, and erodes the quality of healthcare in this state! Emphatically vote NO!**

Sincerely,
Jennifer Hensley
Cannon Falls

March 15, 2024

TO: House Commerce Committee Members
FROM: Christina Ogata, resident of House District 33A

RE: HF 1930, End-of-Life Options bill

Honorable Committee Members:

Minnesota's 2023 legislative session included a renewed focus on a bill that gives terminally ill patients the option to seek a prescription from their doctor for medication to end their life peacefully. Ten other states already allow medical aid in dying - from Oregon, the first state to approve the measure (1994), to New Mexico, the most recent state to adopt the law (2021). A divided legislature in Minnesota has considered the bill since 2015, but has yet to adopt it. This year, 2024, is the year lawmakers join hands and vote the bill into law.

Polling shows support for the measure is strong and is nonpartisan. A 2020 Gallup poll not only showed 74% support for medical aid in dying option, but also showed robust approval percentages across all demographic groups surveyed. Similarly, those who completed the Minnesota state legislature's questionnaire at the 2016 state fair also supported the measure (67% in the House poll; 68% in the Senate poll). In the 2023 legislative poll, support increased to 73.2% in the House poll (the Senate poll didn't ask the question). Many organizations, including the Minnesota Nurses Association and the Minnesota Medical Association, are in support, as long as the current proposed safeguards remain in place.

With this broad-based approval level from voters, why hasn't the Minnesota legislature enacted the law? Two well-known benchmarks: First, political party loyalty to interest groups. Second, personal beliefs. The political party loyalty explanation is well-known. Despite a significant split in its membership on "right-to-life" issues such as abortion, Minnesota's Republican party platform adheres to positions asserted by "pro-life" groups, led by the Minnesota Citizens Concerned for Life (MCCL). MCCL opposes the medical aid in dying option and frames it as assisted suicide. Republican legislators who vote contrary to MCCL's views risk losing funding, support for the bills they author, and endorsement of their party in the next election. Republican legislators who support the medical aid in dying option are loudly quiet about the question by avoiding meetings to discuss it, deferring requests to be quoted on it, and referring questions back to the authoring legislators.

The personal belief explanation is more nuanced. A few legislators, both DFL and Republican, have either a current or past experience that convinced them that medical aid in dying is a poison rather than a protection.

To both of these arguments, I remind you that people who die by suicide either don't want to live or have lost the mental capacity to cherish life. In contrast, people who use the end-of-life option actually want to live, but they are dying. They want the option of a peaceful, quiet death instead of a painful, wretched death, one that causes suffering not only for themselves for the family and friends who love them.

Each of us can only speak to how we found our place on the issue. In my case, my older brother Doug's experience showed me that giving the option to the dying is the best avenue to peace, acceptance, and relief to both the dying individual and their family.

In 2014, Doug received a diagnosis of Multiple System Atrophy, a neurodegenerative disease for which there is no effective treatment. Over time, Doug's muscles slowly lost their strength until he could barely stand or walk, and his voice was reduced to a whisper. He was so hunched over he could only see the ground. He lived in a tremendous amount of remitting pain. He suffered contractures, severe tremors, and bladder and blood pressure dysfunction. He wrote that he felt "hemmed in at every turn. Life should be more than enduring various therapies in a futile attempt to keep death at bay."

Fortunately for Doug, New Mexico passed its End of Life Options Act in 2021. Doug's relief was palpable: "I've lost control of my life; this law allows me to take control of my death." Multiple doctors agreed that Doug qualified: he was terminally ill with a prognosis of six months or less to live; he was mentally capable of making his own healthcare decisions; and he was able to self-ingest the medication. He was one of the very few ailing individuals who meet all the qualifications.

As he neared his 73rd birthday, Doug chose a date to ingest the medicine. He and his caregiving spouse Shelley invited us to celebrate Doug's life with them during the days preceding. We played music, told stories, and looked at old photographs. When the day arrived, we all sat in a semicircle around Doug's bed while the doctor carefully reviewed the process in detail. Doug ingested the medication. He quickly said he felt dizzy, then hot, then tired. He closed his eyes. It was quiet; he didn't seem anxious; everything just slowed down. His tremors went away. Eventually he let out a long, slow exhale, which the doctor declared was his last. From ingestion to death was less than 20 minutes.

Witnessing Doug's peaceful death compelled me to actively advocate for bringing medical aid in dying to Minnesotans. My personal reasons are shared by so many people who have experienced this in their own lives, their own family. If you are hesitant to support the MN End-of-Life Option Act because of your party's expectations, please bring your advocacy to party leadership. Speak to their hearts rather than their party loyalties or demands. Remind them that this bill could help their own siblings, parents, or even themselves. Thank you.

I am strongly opposed to Assisted Suicide HF 1930 for I fear my own life could be shortened without my consent! Many states which have legalized Assisted Suicide have since added additional options to the law. I feel strongly that my death is in God's control; not humans.
Dorothy Vandendriessche, Marshall, MN

I have been a Family Physician and taking care of the elderly for over 30 years in Minnesota.
Many of my patients I help through hospice care and death and dying.

I OPPOSE PHYSICIAN ASSISTED SUICIDE!
Physician assisted suicide is wrong in principle, and violates the duty of a physician, which is to preserve life and care for the patient.
Minnesota House file 1930 (HF1930), authored by Mr. Mike Freiberg and others, provides legal protection to doctors who prescribe deadly doses of drugs to hasten the death of patients. This legislation is a project of individuals, and of “Compassion and Choices”, whose goal is to legalize assisted suicide.

Our patients are not asking us for this!

We need to:
1.) support the Hospice movement in helping patients in their last stages of death and dying, which include Comfort cares Not actively giving them something to end their life!
2.) continue to pursue only treatments that help the patient, but do not end their lives.
3.) of course in a terminal situation, we should withdraw any treatments that are unnecessary and only prolong life.

So often as a family doctor in primary care, I don't know the exact prognosis of each illness. It is my duty to guide the patient through the process, and not predict their death, and certainly not give them anything to end their lives!
The AMA does not support physician assisted suicide.
While states such as Oregon collect information on the practice, some questions cannot be adequately answered by available data. In the case of a patient who receives a prescription for deadly drugs but changes their mind and does not use them, it is not possible to know if someone else uses the drugs.
Patients will feel coerced, especially when some potential treatments are more expensive than poisons to end their lives.
We know that in many past societies and countries, physicians have become the tools for a society that looks upon the dying and the disabled as unwanted and offers them tools to end their lives.
This is not the duty of doctors!
We as Physicians, are a profession esteemed for healing, but can be corrupted into hastening death. Conscience obligates us to oppose laws which are contrary to the common good. I oppose this legislation.

Mark Druffner MD

3/15/24

Dear Judiciary Committee,

I respectfully ask that you oppose HF 1930/SF 1813, that would legalize physician-assisted suicide in Minnesota.

It distresses me greatly that this bill is continuing to advance. It is horribly immoral and unacceptable. Only God is in charge of when a person dies and while some people think they know better than God, those people do NOT know better than God.

In many countries and states where physician-assisted suicide has been legalized, regulations have gradually expanded to include longer-term prognoses, non-terminal illnesses, and mental health conditions. I find this rather scary as I grow older because I don't want someone telling me it is my responsibility to die before God actually calls me home to him.

Canada legalized assisted death in 2016 for people with terminal illness. Since then, the law has gradually been expanded. In 2021, the country expanded it to people with incurable, but not terminal conditions. Now, in March of 2024, Canada will offer assisted suicide to those whose sole underlying condition is mental illness. This slippery slope was made possible by the initial passage of the law in 2016, and Minnesota should not set this precedent. People with mental illness need to be given the appropriate treatment to deal with the underlying causes of their mental illnesses.

This puts individuals with disabilities and those living with chronic illness at risk and makes it harder for them to access care. Vulnerable patients – especially people concerned about being a burden – will be at risk of feeling compelled to select assisted suicide as a cheaper option compared to genuine, patient-centered treatments. I have already read stories of people in other states who are denied life saving treatment but offered the cheap death treatment - this is horribly appalling and ought never to come to MN.

We cannot let this happen in our state. Please oppose HF 1930/ SF 1813.

May God bless and lead you to work for Godly values in everything which would include opposing this bill.

Sincerely,
Marie Winker
Burnsville

March 5, 2024

John B. Kelly
Communications Director
Not Dead Yet
Boston, MA

Public Safety Finance and Policy Committee
Bill HF 1930

Chair Moller, Vice Chair Feist, Members of the Committee:

My name is John B. Kelly. I am Communications Director for Not Dead Yet, the leading national disability rights group opposing assisted suicide, futility judgments, and "better dead than disabled" policies. We organized in 1996 to help stop Kevorkian, whose client victims were presented in the media as terminally ill. Two thirds of them were later found by the New England Journal of Medicine to be NOT terminally ill but chronically ill and disabled.

Assisted suicide exists in the context of a broken down, discriminatory healthcare system that puts everyone at risk. Under assisted suicide laws, the main witness to abuse is the deceased person. Behind closed doors, family and caregivers can do almost anything under these laws and be immunized against accountability.

From the first Oregon report in 1998 regarding its "Death with Dignity Act," it's been clear that use of assisted suicide has been most associated with perceptions of individual control and autonomy, not the experience or fear of physical pain. The reported "end of life concerns" in Oregon largely reflect people's "existential distress," as one study termed it, in reaction to the disabling features of their illness: "losing autonomy" (over all years, 90%), "less able to engage in activities" (90%), "loss of dignity" (72%), "burden on others" (48%) and "losing control of bodily functions" (44%). These are all disability-related concerns.

No less an authority than Lonny Shavelson, now the Chair of the American Clinicians Academy on Medical Aid In Dying, has said, "It's almost never about pain, it's about dignity and control."

We disability rights advocates view the assisted suicide movement as a reaction to disability, especially dependence on other people. In September 2020, I debated Mitchell Hamline School of Law bioethicist Thaddeus Pope, who conceded that "Everybody who's using medical aid in dying is disabled. And probably you could go to the next step and say the reason they want medical aid in dying is because of their disability."

In a February 2021 online Q and A, Pope answered affirmatively to my question whether he predicted extension of medical aid in dying (MAID) eligibility to non-terminal disabled people, and remarked that the US is alone among countries with legalized MAID in limiting eligibility to people diagnosed as terminally ill. Last October, Pope published “Top 10 New and Needed Expansions of US Medical Aid In Dying Laws,” in which he called for the elimination of any time frame for predicted death. He wrote that “many seriously and irreversibly ill [i.e., disabled] individuals not within six months of dying may still suffer greatly every day from their disease.”

I personally feel threatened by legalized assisted suicide because my disability – commonly described as “paralyzed from the neck down” – has been the subject of a number of movies, from “Me Before You” to “Million Dollar Baby” and “Whose Life Is It Anyway?,” depicting the disabled character demanding their own death because their life has lost all meaning. In Canada, a law that started off with requiring that the person be officially diagnosed terminally ill morphed within a few years to extending eligibility to anyone with a “serious illness, disease or disability.”

As medicine has focused increasingly on patient “quality-of-life” as a barometer of life-worthiness, death has been recharacterized as a benefit to an ill or disabled individual. Most physicians (82%, a 2020 Harvard study found) view our “quality-of-life” as worse than nondisabled people.

Disability advocates have raised concerns about the fate of disabled people like nonverbal Oregonian Sarah McSweeney and Black Texan quadriplegic Michael Hickson. Both wanted to live, both were loved by family and caregivers, but they died after hospital personnel denied them treatment based on their supposed low quality-of-life.

The 2012 Massachusetts ballot results and the patient demographics in states like California show there is a social class, race, and ethnicity component in the use of and support for assisted suicide. A 2013 Pew Research Center study showed that Black people oppose assisted suicide by 65%-29%, and Latinos by 65%-32%. Majority Latino Lawrence, Massachusetts, voted 69% against the 2012 ballot question, while white working-class towns like Taunton and Gardner also opposed. Wealthier Massachusetts towns voted heavily in favor. In California, 88% of reported assisted suicides have been by non-Hispanic whites, more than twice the group’s share of the state population. Virtually no Black people have used the program.

Black patients under legalized assisted suicide will be more likely to be "written off' as better off dead, just as has happened with medical responses to COVID-19.

Meanwhile, terminal diagnoses are often wrong. Jeanette Hall wrote the Boston Globe in 2011 that she voted for Oregon’s Death with Dignity bill, and when she received a terminal diagnosis, sought assisted suicide from her doctor. He persuaded her to try more treatment, and she is still alive more than 20 years later! The late actor Valerie Harper reported in 2013 that she had been given three months to live. She lived *six years*, and in that time appeared in a movie and starred in a play.

A few years ago, Oregon revealed that 4% of people who entered the assisted suicide program were still alive after six months. But NPR reported in 2017 that nearly 20% of people who enter hospice outlive their six month prognosis. The difference between 4% and nearly 20% is the percentage of people and their families who may have lost months, years, and in some cases decades of meaningful life.

That 4% survival rate in Oregon happens to match the percentage of people sentenced to death row who are estimated to be innocent. Many people, especially progressives, base their opposition to capital punishment at least in part on this unavoidable fact. We believe that people with serious illnesses and disabilities deserve the same level of concern.

In this and other ways, we are making social justice arguments against systemic discrimination against vulnerable communities. Indeed, Not Dead Yet joined a federal lawsuit against the state of California, arguing that its assisted suicide program violates the Americans with Disabilities Act and the Constitution by discriminating against disabled people. While younger, more able people receive suicide prevention services, old, ill, and disabled people all too often experience support for our deaths over support for our lives.

Minnesota must not become a sponsor of people's suicides because other people consider them a burden, because they believe they are dying when they are not, and because they have been denied the treatment and support services that would keep them alive.

Please protect vulnerable people. Reject this bill and the discrimination it promotes.

Dear Committee Members,

From the moment my mom was diagnosed with Ovarian cancer at age 57, **she chose life**. And she continued to choose life by enduring excruciating surgery, chemo, radiation, and other treatments for years with the goal of beating the cancer and enjoying much more time with her loving husband of 40 years, daughters, and granddaughters.

But there came a definitive point when life was no longer a choice for her. Her doctors let her know there was nothing else they could do. There was no more hope. **She regretfully acknowledged death was inevitable, but it was not her *choice* to die**. The cancer decided that. Without the option to live, the only choice she could've hoped for was a peaceful death. She entered hospice with this hope in mind. But unfortunately it wasn't enough. After an agonizing 5-year battle with cancer she endured an even more agonizing last week and an agonizing death.

Until shortly before her death my mom was fully mentally competent. **Had she been able to exercise End of Life options, she would not have been choosing death, she would have been choosing to ease the pain of a death that was already decided for her.** That would not have been suicide, that would have been a brave act of self-care. And of care for her family. My last memories of her could've been from the beautiful weekend that our whole family spent together a month before she died. But instead my last memories are of the week of her death when she was barely recognizable to me (and I to her) and in unending, excruciating pain.

When this bill is passed I want those who are uncomfortable with it to know that they never have to choose it for themselves if they don't want to.

But **I want this option for me**. I, like my mom, will choose life as long as possible. But I want this option so that if I find myself in a similar situation to hers, I have the option of a peaceful end for my sake and the sake of my family.

Please give me that choice. Please support HF1930.

Thank you for your consideration.

Kim Horton
Minneapolis, MN

Testimony from the Standpoint of Philosophy on Assisted Suicide

Matthew Kent, Ph.D.

As a Ph.D. in philosophy living here in Minnesota, I would like to point out to you that assisted suicide violates in a fundamental and serious way the crucial notions of virtue and Natural Law.

Socrates, for example, actually looked forward to death, since he provided philosophical arguments for the immortality of the human soul. But when his friends asked him why he did not simply commit suicide, he replied by defending the thesis **"that a man should wait, and not take his own life until God summons him."**

Thus, in philosophy at least, the idea that human life is sacred, and must be treated as something that we are mere stewards of, goes back to the ancient Greeks – along with medical ethics, specifically as found in the great physician **Hippocrates**, whose oath is of course taken to this day in the medical profession.

The famous philosophical notion of **Natural Law** points out that a thing is good when it fulfills its purpose. A good pen is one that writes. A good ear is one that hears. Likewise, then a good human is one who fulfills the human purpose. What, then, is the human purpose? Well, as Aristotle and myriad others have pointed out, we are not mere plants or animals; we humans have reason. Thus, we are called upon to live according to reason, **not as if mere bodily pleasures and pains were the ultimate goals of our nature.**

So what does it mean to be reasonable? It includes respecting the fact that human life is a gift that all of us have **received** and none of us has **made**.

Thus, virtue (a word that means "excellence" – that is, excellence at fulfilling our human function of living toward ideals and thus as more than animals) requires that we should indeed strive to alleviate suffering for the dying. This is in accord with important ideals – apprehended by reason – like mercy, compassion, generosity, and courage. But virtue also requires that we must alleviate suffering in a way that respects **another fact that reason can apprehend**: the nature of human life as not a **piece of self-made property** but rather a **gift** (since this is what reason rather easily proves it to be – *did you make yourself?!?*). This is why the most fundamental job of a doctor is to *heal* – to support life, not to take it.

The end does not justify the means. If I have the end goal of donating money to the poor, that is a laudable goal, but I may not do it by means of beating up my next-door neighbor and stealing her purse. The choice of end goal is praiseworthy but the choice of means is morally wrong. Likewise, the end goal of alleviating suffering must be accomplished by means of an ethical method – namely, a choice that respects the value of every human life, including the life of one who is terminally ill. Otherwise, I have made one ethical choice but one unethical choice, and indeed in a very major way.

We should not play God. Our human condition requires us to admit that human life contains mysterious elements, and our job is to face them with virtues such as love and compassion and respect for life – not to violate any one of these ideals. **The state should exist to serve human life, not to encourage the taking of it.** Assisted suicide is not merely "letting nature take its course," which can be justified in some circumstances – it means actively trying to attack human life!

One final remark: Assisted suicide sends **an extremely negative message to others, especially the handicapped.** It is a slippery slope by which a society irrationally declares for the philosophy of Hedonism – as if (contrary to the evidence presented by Socrates and others) this life before death is all we have, and as if this life before death lacks rational purpose for ourselves and others once it can no longer be enjoyed. (And if any members of the House would like to debate me about whether we should adopt Hedonism as the official State Philosophy of Minnesota, which in effect this law implicitly does, then I accept the challenge. It is easy to show that human nature, whether one likes it or not, is made for virtue, not mere pleasure, and thus that all human lives have dignity and meaning, and must be respected by both themselves and others!)

We can do better than this. Let's heed the message of Socrates, Hippocrates, Aristotle, and others who have championed the cause of virtue and the Natural Law. All lives have meaning, and thus medical service to all lives (including the reduction of suffering by means that respect human life) has meaning.

Let's respect the inviolable dignity of every life, all the way to natural death.

Let's respect the fact that **the elderly and the handicapped and the mentally ill have lives worth living**, and that those who care for them, even up to their final moments, are not wasting their time!

Respectfully,

Matthew Kent, Ph.D.

Letter regarding PAS bill HF 1930/SF 1813

As your constituent and a family physician, I respectfully ask that you oppose HF 1930/SF 1813, that would legalize physician-assisted suicide in Minnesota. Regardless of all the "safeguards" in place, the bottom line is that a physician writes a prescription intended to end the life of his or her patient. This is against everything we were trained to do as physicians. We are taught to preserve life and "do no harm". In the Hippocratic oath it says "Nor shall any man's entreaty prevail upon me to administer poison to anyone; neither will I counsel any man to do so." Even if we are not personally administering the medication, we share moral responsibility for providing counsel and permitting access to the overdose of medication. There will be physicians who will participate in this practice, but that does not negate the fact that it harms (kills) the patient. It is NOT the role of the physician to end a patient's life.

Minnesota has a long, proud history of being a leader in healthcare with some of the best medical capabilities in the world. We must continue this by investing in real, holistic solutions, including increased access to palliative care, and addressing the shortage of personal support for individuals.

Palliative and personal care are long-term solutions to address the primary reasons patients request assisted suicide: fear of becoming a physical and/or financial burden to loved ones, loss of independence, long hospital stays and unmet service needs. If this is allowed, as in other countries and states, it will become the DUTY of a patient to die to save on resources for others. The elderly, disabled and mentally ill will be the victims, as their lives are judged not worth living.

I have never had anyone ask me to end their life. My sister, when dying of stomach cancer at age 45, never asked for death, amid much suffering. We as a family, were at her side caring for her in hospice at home. We were happy to be there and serve her in those precious last days. She would have qualified for assisted suicide according to this bill, and her doctor would be required to offer it as an option. I am grateful that there was no such law at the time.

All Minnesotans should have access to affordable and quality care. Please oppose legalizing assisted suicide and instead, support real care throughout life's journey.

Terese Shearer, MD

Burnsville, MN

To whom it may concern,

I am opposed to the proposed legislation to legalize physician-assisted suicide in Minnesota and here is why:

Physician-assisted suicide may sound like a compassionate option to relieve suffering for seriously ill people, but I’m concerned it will actually exacerbate financial disparities and amplify health care inequities.

Seriously ill people fear being a financial burden on their loved ones. This is a top reason they may seek assisted suicide. Mounting healthcare costs are why they fear being a burden. We should be working to reduce healthcare costs rather than providing an inexpensive way to end their lives!

Minnesotans with disabilities, people of color, the elderly, and people with limited income currently face significant barriers to consistent quality health care. They also experience higher rates of disease due to systemic inequities that impact health such as education, housing, and income. Legalizing assisted suicide would only deepen these existing barriers. People experiencing inequities would likely qualify for assisted suicide at higher rates and feel added pressure to select it over more costly options.

I’m also concerned that providers would be required to offer assisted suicide as a standard treatment option even if the patient has never considered or requested it. Suicide should not be presented as an equal option to treatment. Treatments should ease pain and maintain or improve quality of life, not end it. Doctors pledge to uphold the utmost respect for human life. They should be working to save peoples lives, not end them.

Also, have you considered the number of people who may ultimately decide not to use their prescribed lethal medication? Data has shown where assisted suicide is legal, up to 40% of the prescribed lethal drugs are never used. What happens to those drugs? This would increase the risk of lethal drugs landing in the hands of children or other unintended recipients.

For all of the reasons listed above, I oppose the proposed legislation to legalize physician-assisted suicide and I ask you to please oppose it, too.

Sincerely,

Erin Hage
Fridley, MN

March 16, 2024

Representative Simon Brown
Mn House of Representatives
St. Paul, MN

RE: HF 1930 Written Testimony

Dear Mr. Brown:

We are writing to let you know that we strongly oppose House File 1930, which would legalize physician assisted suicide in the state of Minnesota! There is no reason to pass this bill, as there are many ways to assist people when they are truly ill, experiencing a lot of pain and facing imminent death. Doctors know how to deal with patient's pain levels and can prescribe the pain relief that may be needed. By passing this legislation, you are telling the elderly, disabled, and severely ill patients that there is no reason to keep on living, that they are a burden to their families and society, and should just kill themselves! it is God's decision when to call that person home, not a doctor, or a person who is depressed and thinks they can't go on living. Patients need help with pain and counseling (spiritual counseling would be a great help!), not encouragement for them to end their lives.

Thank you for listening to our concerns!

Sincerely,

Bernadette and James Berger
31824 633rd Ave
Gibbon, MN 55335 507-834-6321

Mar. 11, 2024

To Whom it May Concern:

Please reconsider any support for the physician assisted suicide bill of MN.

I am 69 years old and as a senior citizen am deeply concerned about this bill which not only allows physician assisted suicide but also contains no limitations.

Many senior citizens have numerous health issues and could be assessed as a burden to their families and to society. How sad to think that we as a society cannot care better for those who have given so much to their families and communities in their lives. It is distressing to me to be thought of as disposable or useless or forgotten. Or to be reduced to a financial commodity.

Can we not do better, with all our wonderful medical advances, to help people at the end of life instead of giving them the tool to end it? Can we not do better with providing for our mothers and fathers and siblings? Can we not do better with those who are poor and helpless and without medical care? Where is our compassion? Can we not do better in MN?

Sincerely,

Christina Smith
11849 Knolls Path, Lakeville

I would like to voice my support for the MAID bill, which I understand will be heard in the Commerce Committee on Monday. My father died a slow death at home in home hospice with ALS. He eventually started refusing food and drink to hasten his death. I don't wish that on anyone and I would like to know I might have some additional choice as to how I die when the time comes.

Dolores Voorhees, SD64B

March 17, 2024

Commerce Committee Written Testimony on HF 1930

I address you as a Family Physician from New Ulm, MN. I have been a physician at our Medical Center for almost 30 years. I love my small community and rural MN. This bill has the potential to kill rural community clinics and hospitals like ours.

Today, I spoke with several physicians who are in the last ten years of their medical career. All of them said they would be willing to lose their license rather than prescribe this medication or refer to someone who does. I spoke with three hospice nurses from a neighboring small community who would all quit their jobs if this becomes law. I spoke with some experienced ICU nurses who would quit if their jobs involved "helping" people die instead of helping them to live. WE CANNOT AFFORD TO LOSE THESE PEOPLE IN RURAL COMMUNITIES!

Just 24 years ago, Dr. Jack Kevorkian was sentenced to prison for 10-25 years for euthanizing patients. He had lost his medical license eight years prior to that for euthanizing patients. His name was well known, and I suspect all of you have heard of him. Here we are 24 years later, voting on a bill to not only authorize physician assisted suicide, but to penalize doctors if they do not refer a patient for someone else to write a lethal prescription.

When the AMA surveyed doctors about Kevorkian at that time, almost all of them said he deserved to go to jail. That has not changed! Very few doctors want to play God and be the one responsible for determining the premature time of death. This is going to prevent some young people from working in health care facilities or going into the medical field. It is going to divide the medical community in MN.

According to bill HF 1930, Section 5, Subd 5, if a physician is not willing to prescribe medication to end the life of a patient, before they die a natural death, they must transfer the care to another physician who will do so OR, they will be charged with a gross misdemeanor and may be subject to disciplinary action by the provider's licensing board. There is no immunity or conscience clause for doctors to opt out of this referral/transfer process.

I would like to suggest that we rename this bill the Kevorkian Bill as that is what anyone who votes to pass this bill is signing on to. Ultimately, YOU will be culpable for every prescription that is written and every person who was told that they only had 6 months to live but had an incorrect diagnosis or prognosis. We know that is not uncommon. Every one of these deaths comes back to the Kevorkians who pass this bill. And, when small hospitals close because doctors have refused to partake in killing patients instead of walking with them from life to death, that is also on you.

I times of virtual medical visits, more physicians are signing on to be virtual doctors with out of state companies. We will lose physicians who work in ERs, clinics, oncology, psychiatry, and nursing homes. This will have devastating effects on our farmers and small-town factories and businesses who need local doctors in their hospitals and clinics.

One of your colleagues on another committee suggested that this is not a concern and there is not a shortage of providers. I would recommend that you check the facts on this. The projections of the future physician shortages will soon be at a critical level. The AMA and other organizations have been speaking about this for quite a few years.

In honor of all medical providers, medical facilities, nursing homes and assisted living facilities in your districts, I urge you to vote “no” on HF 1930.

Sincerely,

Francille Knowles, MD

New Ulm, MN

My name is Mary Carlsen, and I am a health care social worker with 10 + years of experience in hospice, emergency department, long term care and an HIV/AIDS clinic. I have recently retired as a professor of social work and family studies and provide education in my community for end of life planning and medical aid in dying. And I have sat at the bedside of too many people who suffering at end of life could be alleviated by medical aid in dying. Hospice and palliative care are central to our end of life options in Minnesota, but sometimes they are not enough. The continuum of empathy and care from our health care providers needs to include the carefully considered, ethical option of medical aid in dying.

It's time to pass this legislation in response to the wishes of the majority of Minnesotans. People in our state, regardless of age, political persuasion, or religious beliefs, believe that adults who are terminally ill, have decision-making capacity and are able to self-ingest medication to hasten their inevitable and imminent deaths should have this right. The End of Life Option Act includes the safeguards needed to assure a safe process, as attested to by the Minnesota Medical Association. Please pass this legislation out of the Commerce Committee.

Mary S. Carlsen
1008 Juniper Avenue W
Northfield, MN 55057

Maria K. Poirier, M.D. Testimony on H.F. 1930 End-of-Life Option Act

March 18, 2024

Chair Stephenson and members of the Commerce Finance and Policy Committee,

Thank you for allowing me to submit written testimony in **opposition** to the End-of-Life Option Act. My name is Maria Poirier and I am an internal medicine physician from Rochester with 33 years of clinical experience treating patients with complex medical diagnoses.

As this committee considers the moral question of whether to allow persons with a terminal illness the option of assisted suicide, please note that HF 1930 is ethically and legally challenged in several ways. I note two examples below:

Example: *Sec. 5 Concerning responsibilities of attending provider*

Subd. 5. No duty to provide medical aid in dying. (a) ***A provider must provide sufficient information to an individual with a terminal disease regarding available options, the alternatives, and the foreseeable risks and benefits of each so that the individual is able to make informed decisions regarding the individual's end-of-life health care****.*

I frequently see seriously ill patients who tell me they would be better off dying. Requiring a provider to counsel a despairing terminally ill patient about the option of medical aid in dying could be emotionally devastating for patients and may trigger them to have suicidal thoughts. Our duty as licensed healthcare professionals must be to give patients hope, comfort and compassion, not to offer deadly medication.

Healthcare is defined as a restorative or palliative effort. Because the intent and purpose of prescribing a lethal drug is to assist the patient with suicide, not to receive healthcare, the state of Minnesota should not compel providers to counsel patients about medical aid in dying as an end-of-life option.

I take care of many patients who live outside of Minnesota where assisted suicide is illegal. If I diagnose an out-of-state patient with a terminal illness, would this bill require me to provide information about the option of medical aid in dying?

H.F. 1930 does not allocate mental health resources for healthcare providers who may be traumatized by losing a patient to assisted suicide if this bill passes. Experiencing the loss of a patient by suicide, even one resulting from an informed autonomous decision, will cause some providers to experience moral and emotional distress.

Example: *Sec. 8. [145E.30] IMMUNITIES FOR ACTIONS IN GOOD FAITH; PROHIBITION*

AGAINST REPRISALS.

(b) No provider or health care facility shall subject a provider, pharmacist, or licensed mental health consultant to discharge, demotion, censure, discipline, suspension, loss of license, loss of privileges, discrimination, or any other penalty for:

(3) ***choosing not to practice or participate*** *in medical aid in dying.*

How is "choosing not to practice or participate" being defined? Does this clause provide immunity for providers who refuse to counsel terminally ill patients about medical aid in dying as an option? Will H.F. 1930 provide free speech and conscience protections to healthcare providers?

I urge committee members to vote NO. Thank you.

Maria K. Poirier, M.D., F.A.C.P.

Rochester, MN

MINNESOTA FAMILY COUNCIL

TRUE NORTH LEGAL

March 18, 2024

Commerce Finance and Policy
Minnesota State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

Chair Stephenson and Members of the Committee,

Minnesota Family Council represents tens of thousands of families across the state, and together with True North Legal, we **urge you to oppose H.F. 1930,** the so-called "End-of-Life Option Act."

Renowned nationally for excellence in healthcare, Minnesota innovates in providing patients with the highest quality of care. Our access to top providers and practices ought to make us champions of care for our most vulnerable communities rather than promoting death in policy. Rather than prioritizing policies of proper treatment and management of pain or death through varied merciful options listed below, H.F. 1930 legalizes assisted suicide with few safeguards.

Policy Analysis

As written, H.F. 1930 does not require a physician to prescribe the lethal drugs.[1] Neither a physician nor a witness is required to be present when the individual seeking assisted suicide self-administers the lethal drugs; moreover, the individual requesting the drugs does not need to be a Minnesota resident. States that have previously legalized healthcare provider assisted suicide typically require requesting patients to be residents of the state.[2] H.F. 1930's failure to include such a requirement opens Minnesota to suicide tourism. These aspects of the policy expose how there could be close to no relationship between the prescribing provider and the individual requesting the lethal drugs.

Although a mental health professional's evaluation of the patient's mental state may be procured, it is not a requirement according to the proposed policy. Additionally, there is no requirement for notification to family or friends that an individual is seeking assisted suicide.

As proposed, the policy requires no waiting period and allows nurse practitioners to prescribe lethal drugs, although Medicare prohibits them from qualifying patients for hospice, which is similarly based on a six-month prognosis.[3] Further, under current law, Minnesotans already have the right to a legally binding end-of-life directive, such as power of attorney and other medical decision-making directives, and the right to access hospice and palliative care. These opportunities for self-directed care already exist in Minnesota under current law. Again, with our wealth of resources, we should be prioritizing innovative policy solutions of care.

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[1] HF 1930 1st Engrossment.

[2] *See, e.g.*, WASH. REV. CODE §70.245.020 ("An adult patient who is competent, ***is a resident of Washington state***, and has been determined by the attending qualified medical provider to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication that the patient may self-administer to end the patient's life in a humane and dignified manner in accordance with this chapter) (emphasis added).

[3] CMS Manual System. (2018, September 14). Pub 100-02 Medicare Benefit Policy. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R246BP.pdf.

Cultural Impacts

Recklessly ignoring common-sense safeguards, the proposed policy abandons the very reason healthcare exists—to do no harm in the assistance of individuals seeking care or the relief of pain. The impacts on suicidality in Canada since assisted suicide's legalization are well-recorded. The *BBC* reports that since its legalization in 2016 until 2021, assisted suicide grew exponentially, from just over 1000 people seeking assisted suicide in the first year to 10,064 people seeking it in 2021.[4] A physician who has "overseen" assisted suicide for "hundreds" of people in Canada since its legalization expressed her concern to the *BBC*: "'Making death too ready a solution disadvantages the most vulnerable people, and actually lets society off the hook,' Dr Li said. 'I don't think death should be society's solution for its own failures.'" Dr. Li makes a point worth noting–policy proposals such as H.F. 1930 shape cultural thinking on which patients are suited to live versus which patients are better off eliminated from society. Healthcare is costly, and when healthcare professionals must make the judgment call on prescription of assisted suicide, economic considerations will play a role.

As evidenced in research from neighboring Canada, where assisted suicide is legal, the cultural impacts of assisted suicide legalization are realized rapidly. In May 2023, *National Post* reported the results of a poll conducted by Research Co. in which 28% of survey respondents stated their approval that people should be able to seek assisted suicide simply because they are homeless.[5] According to the survey, an "irremediable medical condition" would not be a variable in that scenario. In addition, 27% of survey respondents stated their approval that poverty is sufficient reason to seek assisted suicide. Again, no medical condition would be a variable in that scenario. There is significant reason to be concerned that legalization of assisted suicide is linked directly to devaluation of vulnerable communities.

Minnesota's public policy should explore ways to create better resources for vulnerable populations rather than simply sending people home with lethal drugs to die alone. Because every human life is created in the image of God, life is sacred and has the right to be protected at all stages. Every human life is worthy of dignity and respect. We are particularly responsible for protecting the life and dignity of the most vulnerable in our society, including people with disabilities, elderly people, and folks from historically marginalized communities.

Surely, Minnesota can do better than H.F. 1930. We urge you to oppose this bill.

Sincerely,

Rebecca Delahunt
Acting Director of Public Policy
Minnesota Family Council

Renee K. Carlson
General Counsel
True North Legal

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[4] Honderich, H. (2023, January 14). *Who can die? Canada wrestles with euthanasia for the mentally ill*. BBC News. https://www.bbc.com/news/world-us-canada-64004329.

[5] Hopper, T. (2023, May 16). *One third of Canadians fine with assisted suicide for homelessness ...* National Post. https://nationalpost.com/news/canada/canada-maid-assisted-suicide-homeless.

MINNESOTA
APRN
COALITION
We Care for You

March 15, 2024

Representative Mike Freiberg
381 State Office Building
St Paul, MN 55155

Dear Representative Freiberg,

We are writing this letter regarding HF1930, the End-of-Life Option for Terminally Ill Adults Bill. The Minnesota APRN Coalition is an organization that represents over 10,000 Minnesota Advanced Practice Registered Nurses (APRNs), including Certified Nurse Midwives, Certified Nurse Practitioners, Certified Registered Nurse Anesthetists, and Clinical Nurse Specialists. Our organization works to ensure that Minnesotans have access to quality healthcare with fewer barriers to access that care, and fewer barriers to practice for APRNs. The MN APRN Coalition has a diverse membership which holds varying personal beliefs on end-of-life options.

The APRN Coalition appreciates the guardrails of HF1930 that:

- Does not compel providers or patients from participating in end-of-life options,
- Requires patient self-administration,
- Requires determination of mental capability of individuals with a terminal disease by a qualified provider, and
- Provides legal protection for providers who choose to participate in this practice.

The American Nurses Association Code of Ethics, provides (ANA, 2015) guidance to nurses practicing quality nursing care and ethical obligations of the profession. Two statements that relate directly to the end-of-life option is an individual's right to self-determination and the duty of the nurse to preserve wholeness of his/her character and integrity. The guardrails in HF1930 align with the ANA Code of Ethics and specifically to the two statements mentioned above.

We want to thank you for the inclusion of Advanced Practice Registered Nurses in the definition of "provider" on line 2.23 of the delete-all amendment. We request that psychiatric Certified Nurse Practitioner and psychiatric Clinical Nurse Specialist be added to the definition of "licensed mental health professional" under the Sec. 2 definitions (starting on line 2.5 of the DE). This addition is consistent with the Mental Health Uniform Service Standards Act: Provider Qualifications and Scope of Practice (MS 245I.04 Subd. 2(1)) definition of a mental health professional. As of March 14, 2024, the Minnesota Board of Nursing reports 97 mental health focused CNSs, and 1,444 psychiatric CNPs.

The Minnesota APRN Coalition shares the goal of ensuring that Minnesotans have access to all providers who are educated and licensed to provide the type of care described in this bill, the ability to choose the type of provider based on their personal needs, and that an individual's decision on end of life should be between a provider and the individual.

Thank you for your tireless work on this challenging issue. Please don't hesitate to contact us if you have any questions.

Respectfully,

Julie Sabo

Julie Sabo, PhD, APRN, CNS, FCNS
President, Minnesota APRN Coalition

cc. R. Thoman, MD

American Nurses Association. (2015). *Code of ethics for nurses*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

The proposed assisted suicide bill (HF1930 & SF1813) would **legalize physician-assisted suicide** in Minnesota.

I have been a Family Nurse Practitioner since 1991 working with all ages and stages of life, from premi-babies to geriatrics. During any stage of life, healthcare cannot offer pills to end your life as an option for specific diagnosis, even only in very specific circumstances. Patients of sound mind already have the right to refuse life prolonging treatments in the MN (POLST) Provider Orders for Life Sustaining Treatment and can thoughtfully excersize control over the treatment they do & do not want to receive at the end of life. My body, My Life is theirs to believe and choose, but healthcare teams can NOT be actively involved in the taking of another's life. THIS bill offers those with "sound" mind an easy way to kill themselves, and in doing so we are clearing assisting in the suicide of a person in fear. They are in a spiritual and psychological dark place that leads them to desire death while they are still alive and talking and this cannot be humanely ignored. Putting a lethal prescription in the hands of a person in fear gives them the message that things ARE hopeless and they are not worth the trouble… Even the thought, "I am not worth all this trouble" can be more devastating to the human spirit than the illness. Yet so many others can deal with the same diagnosis and suffer well, even see hope and meaning in their suffering and bring hope to others. Yes, many can do good in the world, even from the sick bed, with their words, prayers, their example to others. In their work to overcome the darkness they are in, they are praiseworthy! Life is a struggle and we all have different times and weights of our struggles. We are not animals to be put down! We have human souls and we help one another. This plan to give out pills so they can kill themelves when they are down, the more it is used, the more it will become casual, easy to offer for this or that diagnosis. This will not only kill your patient who deserves love and pain relief all the way to the end, but also kills the soul of healthcare worker along with them. These death pills are a failure to truly care, a failure to love, a failure to bring hope and light to the darkness, a failure to accompany those in despair, a failure to sacrifice for others, a failure of humanity!

Sincerely, Christin W Morey Family Nurse Practitioner.
Formerly resident of Plymouth for 29 yrs, now in Mound, MN

Michael Blissenbach Testimony Against H.F. 1930
Commerce Finance and Policy Committee– Public Hearing March 18, 2024

Dear Chairman Stephenson and Members of the Committee:

My name is Michael Blissenbach, and I am a 37-year-old man from Apple Valley, MN in House District 56B. I live with a mental health disability called Unspecified Trauma and Stressor Disorder, which is similar to Post Traumatic Stress Disorder (PTSD). I take two different medications each day to manage my condition and I require accommodations at work under the Americans with Disabilities Act (ADA) in order to be able to do my job.

I strongly oppose both physician-assisted suicide (PAS) and HF 1930 because, as we've seen play out in Canada, Belgium, the Netherlands, and other countries that have legalized PAS, whether intentional or not, PAS establishes a legal regime where the life of anyone not able-bodied is considered a life not worth living, a form of discrimination called ableism.
As an amicus curiae brief filed on behalf of a coalition of disability rights groups in the New York case *Myers v. Schneiderman* states: "By asserting that it is irrational for a non-disabled person to end his or her life, but rational for a disabled person to do so, appellants argue that the non-disabled person's life is intrinsically more valuable and worthwhile than a disabled person's life."
This should give us all pause.

Moreover, in Canada, our neighbor to the north, PAS and euthanasia eligibility criteria will expand in 2027 to include mental health conditions like my own. Just as PAS proponents are seek to do here in Minnesota, Canada initially authorized PAS solely for those with terminal illnesses, but, once it was legalized for the terminally ill, PAS eligibility has been incrementally expanded to include more and more groups who don't fit our society's definition of perfection.

To make matters worse, we also know from places where PAS is legal, for people who fit the eligibility criteria and don't want to take their lives, economic and social pressure is applied to attempt to convince them to do so. This is done either through health insurance covering assisted suicide drugs instead of lifesaving or life-extending treatment, or doctors attempting to convince patients that they are better off dead than alive.

Therefore, although HF 1930 doesn't directly threaten my life or access to quality healthcare as written, I have no doubt that, if this bill passes, it will, in a few years' time, through court decisions or subsequent legislative enactments, threaten both of those.

I am indeed an economic net burden on society, but I'm a lot more than that. I am a human being with inalienable dignity, who both loves and is loved by his friends and family, is active in his community, and who brings joy to the lives of many, and the same is true of every human being that HF 1930 directly or indirectly would regard as "life unworthy of life."

Disabled people like me don’t want assisted suicide, and we don’t want pity. We want to love and be loved and to be seen as the valuable members of society that we are. HF 1930, in contrast, devalues and degrades the lives of people with disabilities. Please stand up for the dignity and rights of people like me and oppose HF 1930. Thank you for your consideration.

Sincerely,
Michael

Michael P. Blissenbach, JD
MN House District 56B
Apple Valley, MN

My name is Carol Mueller from Hastings, Mn. and I have lived in Minnesota my whole life. I love Minnesota but I know of many people opposed to this suicide bill including myself. Minnesota is becoming the state of death with our abortion policy and this suicide policy. This policy starts out as death for less than 6 months to live but it can snowballs into something so much worse. Please take a look at what is happening in Canada and Oregon. Please look at there records. And also, the insurance then doesn't want to cover treatment but will cover suicide. I know Minnesota does not want to be known as the state of death.

You have been specially chosen to represent your people. You are not alone. God loves each one of you. And He is with you.

Isaiah 41:13

13
For I am the Lord your God
  who takes hold of your right hand
and says to you, Do not fear;
  I will help you.

2 Chronicles 7:14

If my people who are called by my name humble themselves, and pray and seek my face and turn from their wicked ways, then I will hear from heaven and will forgive their sin and heal their land.

Deuteronomy 30:19

19 "I call heaven and earth to witness against you today, that I have set before you life and death, blessing and curse. Therefore choose life, that you and your offspring may live."

The fifth commandment forbids suicide and the mercy killing of those who are dying, even to eliminate suffering.

Human life is that most precious and sacred gift of God. It is a direct expression of His love for us.

Exodus 20.13 God said:

13 “Thou shalt not kill.”

Matthew 5.21-22

21. Ye have heard that it was said by them of old time, Thou shalt not kill; and whosoever shall kill shall be in danger of the judgment.

Jeremiah 1:5

"Before I formed you in the womb I knew you, and before you were born I consecrated you; I appointed you a prophet to the nations.”

Jeremiah 29:11

11 For I know the plans I have for you,” declares the Lord, “plans to prosper you and not to harm you, plans to give you hope and a future.

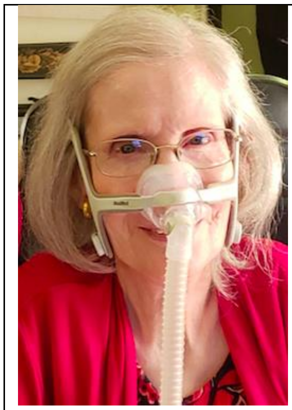
That’s how much God loves you. 😊💕These are his words not mine. Thank you for reading my testimony. God bless all of you.

Testimony Opposing "End-of-Life Option Act" HF 1930

House Commerce Finance and Policy Committee

Diane Coleman, JD, President & CEO, Not Dead Yet

March 18, 2024



This testimony is filed on behalf of Not Dead Yet, a national disability organization headquartered in New York with members in Minnesota. Not Dead Yet is among 17 major national disability organizations that oppose assisted suicide laws. Not Dead Yet is also a plaintiff in a major lawsuit filed under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act and the U.S. Constitution to challenge the California assisted suicide law as discriminatory based on disability.

I depend on a full-time noninvasive ventilator. The Minnesota assisted suicide bill is a clone of the Oregon law. Under the Oregon law, I could qualify as terminal if I lost my ventilator because I couldn't afford co-pays or refused it because I became depressed. Oregon reports that the types of non-cancer conditions found eligible for assisted suicide have grown over the years, to include neurological disease, infectious disease, gastrointestinal disease, "endocrine/ metabolic disease (e.g. diabetes)", arthritis, kidney failure, musculoskeletal systems disorders and, most recently, anorexia.

One of the most frequently repeated claims by proponents of assisted suicide laws is that there has not been "a single documented case of abuse or misuse." To the contrary, I refer you to two resources describing problem cases. The first is from the Disability Rights Education and Defense Fund, Oregon and Washington State Abuses and Complications. The second is a journal article by two New York medical doctors, Drs. Herbert Hendin and Kathleen Foley, Physician-Assisted Suicide in Oregon: A Medical Perspective (2008).

Data from states where assisted suicide is legal show that all people who request assisted suicide have disabilities, even if some don't think of their impairments that way, and that unmet disability related needs are their reasons for wanting to die. The top five reasons Oregon doctors give for their patients' assisted suicide requests over all reported years are not pain or fear of future pain, but psycho-social issues that pertain to disability. Three of these (losing autonomy, losing dignity, burden on family) could be addressed by consumer-directed in-home personal care services, but the law operates as though the person's reasons don't matter, and nothing need be done to address them.

We are deeply concerned that the proposed bill requires providers to offer physician assisted suicide along with other treatment and palliative care options when a patient receives a terminal diagnosis. Doctors and other providers are in a position that carries status and authority.

Bringing up assisted suicide to a patient who has not raised the issue themselves conveys a dangerous and demoralizing message by its very nature and could even be taken as an implicit endorsement. This should never be permitted.

There's not supposed to be coercion to request lethal drugs, but what counts as coercion? How about lack of insurance coverage for treatment? How about limits on pain relief due to provider fears about opioid oversight? How about limits on home care?

What about family coercion such as, "Grandpa, this will just give you more options," or "Mom, this is getting to be more than we can handle." Or even "It's this or a nursing home." Coercion is too hard to detect, too hard to prevent.

Doctors are also supposed to detect coercion, but how could they do so when, for example, Oregon's state reports say that the median duration of the prescribing physician patient relationship was only 5 weeks in 2021 and 2022. Over all the years, a supposed lack of coercion is not usually determined by a physician with a longstanding relationship with the patient. This is significant in light of well-documented elder abuse-identification and reporting problems among professionals in a society where an estimated one in ten elders is abused, mostly by family and caregivers. (Lachs, et al., New England Journal of Medicine, Elder Abuse (2015).)

In about half the reported Oregon cases, there is also no independent witness to consent or self-administration at the time of ingestion of the lethal drugs. If the drugs were, in some cases, administered by others without consent, no one would know.

Research on healthcare disparities has also shown that medical providers are not immune to prevailing social biases. Making assisted suicide part of "end-of-life care" and designating doctors as its gatekeepers and administrators could only further undermine patient safety, particularly for older adults, disabled people, Black, indigenous, communities of color and other multiply marginalized people who already experience life threatening healthcare discrimination.

And legislators should readily see the problem with the "good faith" standard of culpability for violations of the bill's provisions. A claim of "good faith" renders any so-called safeguards unenforceable, empty and meaningless.

Legislators should also be concerned about the pressures toward expansion in the broader euthanasia movement. Minnesota's bill already incorporates expansions adopted by a few states, allowing non-physician prescribers of lethal drugs and eliminating waiting periods and residency requirements. It would be appropriate to look north. Only five years after Canada passed its national law for people with terminal illnesses, Bill C-7 was passed making assisted suicide and euthanasia available to healthy people with disabilities. Canadian press has since reported on disabled individuals getting euthanasia by lethal injection when they want to die because they can't get housing or otherwise can't afford to live on government payments. Next year, Canadians whose sole illness is psychiatric are scheduled to become eligible for euthanasia. See Coelho R, Maher J, Gaind KS, Lemmens T (2023). The realities of Medical Assistance in Dying in Canada. *Palliative and Supportive Care*.

Equal rights include equal suicide prevention, not suicide agreement and assistance for people who are too often devalued. Minnesota should firmly reject the dangerous discrimination of assisted suicide.

Diane Coleman, JD, President/CEO, Not Dead Yet, 708-420-0539

Members of the MN House Commerce Finance & Policy Committee:

As a Minnesotan with a severely disabled sister for whom I serve as co-guardian, I urge you to oppose HF 1930, which would legalize physician-assisted suicide in our state. As PAS is less expensive than medical care for someone with disabilities or older people with more complex health needs, passage of PAS legislation sets up a perverse incentive to eliminate people with severe disabilities and needs rather than acknowledge their membership in the human family and the positive qualities they foster in those around them.

Happily, my sister is currently served by wonderful doctors who treat her as a person worthy of the best care to make her life as positive and comfortable as possible. I don't think my sister's doctors would relish the prospect of having to offer PAS to patients for whom they've previously served in more constructive ways. As doctors, they've pledged to uphold the utmost respect for human life, and I expect them to help my sister, not suggest actively killing her if a time comes when she is severely ill or expected to die. In moments of medical need, patients with disabilities like my sister need care and compassion, not coercion, manipulation and the suggestion that their families and communities would be better off without the "burden" of their existence.

The legislation proposed for Minnesota would require doctors to offer PAS as a standard treatment option in qualifying situations or refer patients to providers who will, even if a patient has never considered or requested it. *Think about the message Minnesota sends with that to people given a diagnosis of terminal illness, especially those with disabilities and the elderly*. If you support this legislation, you are making judgment calls about the value of people's lives, however much time they have left. My sister can't walk or talk; what gives you legislators the right to allow another person to determine or insinuate whether she has value or not? She is a human being, an unrepeatable person, and is my sister--the only one I have.

Over my sister's lifetime, my family members and I have sat by her bedside during previous hospital stays. While I have immense empathy for those facing difficult prognoses and the loved ones who care for them, I don't regard physician-assisted suicide as a positive option. We need only to look at Canada and European countries that have allowed assisted suicide to see that what begins as a narrowly defined option for the terminally ill eventually expands and is now offered to even those under 18 years of age and to people who do not have incurable illnesses but conditions such as mental illness.

Let's opt to use modern medications, treatments and compassionate care to alleviate pain for those who need them rather than pass legislation that puts many people at risk of death. PAS gives an instrument of elimination to those who look at people of limited abilities as a drag on society and its resources. PAS conveys to people in their last moments that they are an inconvenience. It would be far better and more humane to put our state's resources toward palliative care and creating a positive environment that honors the humanity of all and allows for those moments of grace often experienced during people's final days and hours.

In a state that prides itself on exceptional healthcare, let’s advance real care that supports a physician’s oath to do no harm and maintains patient-doctor trust. Oppose efforts to legalize physician assisted suicide.

Thank you for your time,

Theresa Lauber
St. Paul, MN

House Commerce Committee,

Please oppose this bill!

Assisted suicide would amplify healthcare inequities for Minnesotans with disabilities, people of color, the elderly, people with limited income and the homeless. These groups of people already struggle to obtain consistent quality healthcare and, they currently face higher rates of disease and sickness due to systematic injustices such as education, income and housing. Providing assisted suicide as an option would likely widen this divide, and it will put added pressure on these groups and individuals to choose assisted suicide instead of more costly healthcare options.

Doctors pledge to provide healthcare in the best interest of their patients and to save life. We trust that doctors are people that care and want to help, heal and guide. Providing assisted suicide as an option will make it harder to trust, that a doctor is truly acting in the best interest of their patient.

All Minnesotans need quality healthcare with options that value the inherent dignity of the human person. Healthcare that provides ethical options for managing pain, options for hospice, counseling or spiritual guidance. Options that say your life matters and you're not alone.

Assisted suicide robs an individual of dying with dignity by providing an option that says your life no longer matters.

Minnesota law makers please oppose this bill.

Sincerely,

Joe Brownrigg
Lakeville Minnesota

Dear House Commerce Committee Members,

Based on my personal and professional experience, I am respectfully asking you to oppose the H.F. 1930 bill as and a mother who recently loss her daughter to cancer and as a RN for over 40 years. I believe that the bill is flawed terribly.

Our daughter who was diagnosed at age 27 and died at age 35 of ovarian cancer this past fall. She opposed this type of legislation also. At home, she had a PCA medication pump to keep her comfortable while in hospice. What was thought was going to be 2 days in hospice, turned into 8. What a gift each day was with her and she was comfortable. Family and friends got to say good bye.

I also was privileged to accompany my father over a long illness with several setbacks. While the medical community may have been baffled at our decision to continue care, the healing I saw in my parent's marriage was beautiful.

I believe that we as a state can do better. Let's expand palliative, hospice and mental health care, provide support for caregivers and uphold the dignity of all people, in all stages of their life.

While dying and accompanying those who are is heart wrenching, we can keep people comfortable. I don't believe that assisted suicide should be a standard of care even if you change the wording of it.

In addition, I believe that this bill doesn't honor doctors and other health care providers who worked hard to get their degrees and who can't refer patients to other providers as it violates their moral ethics of practice.

I also am concerned of the lack of mental health assessment and support. Being sick is hard but also there are many blessings that occur, e.g. healing of relationships, etc.

I also am concerned for the other vulnerable people who may be affected by this bill down the road, the aged and disabled.

Please stop this bill. If it's worthy to be law in MN, then give the voters a chance to weigh in on it in a state wide vote.

Thank you.

Sincerely,

Nancy Shatek-Suek
1680 Scheffer Ave
St. Paul, MN 55116

I write as a physician who practiced family medicine in Shoreview for over 34 years. The idea of physician-assisted suicide is utterly abhorrent to me and (as surveys indicate) to the majority of practicing physicians. That physicians should be REQUIRED, under penalty of prosecution, to present “assisted death” as an option at end of life, even if the individual has not specifically requested it, is simply anathema to the very practice of medicine itself. Our solemn, sworn duty as physicians is to PROMOTE and encourage the health and well-being of every one of our patients, throughout their lives, from birth through natural death. And at the END of life, this means promotion of life-affirming hospice and comfort care - focusing on alleviation of pain, and ministering to the psychosocial and spiritual needs of both the patient and family during this difficult time. Hospice care IS real medical CARE - the prescribing of pills to actively end life is not CARE at all.

The bedrock principle of Hippocratic medicine, as you may know, is the principle of “non-maleficence” - referred to most commonly as “first of all, do no harm”. Here are the words from Hippocrates’ Oath regarding the idea of assisting in a patient’s death: “Neither will I administer a poison to anybody when asked to do so, NOR WILL I SUGGEST SUCH A COURSE” (capitals mine).

Do not ask me to do this. I will not. I CANNOT. We as a society MUST NOT. The moral integrity of medical care is at stake.

-Richard Glasow, Blaine.

To Whom It May Concern,

I am Brian Hoyland, a practicing psychotherapist residing in Rosemount, MN. I am writing to express my strong opposition to the proposed bill legalizing physician-assisted suicide.

As someone dedicated to healing patients over many years, I implore our elected representatives not to enact what would be a seismic cultural and ethical transformation in modern medical practice—the act of taking life instead of preserving it.

Additionally, I speak from personal experience that further underscores the dangers of legalizing physician-assisted suicide. I have faced extreme suffering due to end-stage heart failure, enduring multiple cardiac events and even dying for over 10 minutes. Despite these challenges, I firmly believe in the sanctity of life and the importance of preserving human dignity.

My journey has taught me that suffering, though difficult, can lead to profound growth and spiritual transformation. By embracing our suffering and seeking support from compassionate healthcare providers, we can find meaning and purpose even in the midst of pain.

Legalizing physician-assisted suicide would undermine the dignity of disabled persons like me, sending a message that some lives are not worth living. This devaluation of human life is not only morally wrong but also harmful to individuals and society as a whole.

Currently, there are ten states and Washington, D.C., where physician-assisted suicide is legalized, along with several countries worldwide. This trend, coupled with discussions of pediatric euthanasia, raises profound concerns about the direction of medical ethics and the sanctity of life.

Allow me to articulate three key arguments against this concerning practice:

1. Physician-assisted suicide fundamentally alters the nature of the psychotherapist-patient relationship, undermining the core principle of healing and care. Once therapy condones killing, we abandon the sacred oath to prioritize the well-being and dignity of our patients.

2. Physician-assisted suicide is unnecessary, given the availability and effectiveness of Palliative Care and Hospice services. These compassionate approaches prioritize dignity, autonomy, and symptom management, offering profound comfort and support to terminally ill patients.

3. The legalization of physician-assisted suicide opens the door to a slippery slope of unintended consequences and abuses. Despite assurances of safeguards, history shows that such laws can lead to the erosion of protections for vulnerable populations and the normalization of euthanasia.

In conclusion, I firmly oppose physician-assisted suicide as it contradicts the fundamental principles of psychotherapy and threatens the dignity and sanctity of human life. I urge you to consider the psychological and spiritual implications of legalizing physician-assisted suicide and to prioritize the well-being and dignity of all individuals, especially those facing serious illness or disability.

Sincerely,

Brian Hoyland

presbyterian
homes & services

March 15, 2024

VIA EMAIL

Minnesota House of Representatives,
Commerce Finance and Policy Committee
c/o Simon Brown, Committee Administrator
simon.brown@house.mn.gov

RE: H.F. 1930 – "End-of-Life Option Act"

Dear Chair Stephenson and Committee Members:

Please accept this written submission summarizing several concerns regarding H.F. 1930 (the "End-of-Life Option Act").

I am an attorney who has represented health care providers, and I presently serve as in-house counsel to Presbyterian Homes and Services ("PHS"), one of the largest nonprofit aging services providers in the country. The comments in this letter are solely my own and should not be construed as the official position of PHS.

Provider Conscience

One of the most serious legal and public policy concerns the Committee should consider is protecting providers whose consciences do not permit them to participate in or promote medical aid in dying ("MAID"). For some providers this is a religious commitment; for many others this conviction is rooted in the ancient Hippocractic oath of physicians to "do no harm."

H.F. 1930 would violate the conscience of many providers by requiring that all providers affirmatively present MAID to patients who are terminally ill. Section 5 provides:

> A provider must provide sufficient information to an individual with a terminal disease regarding available options, the alternatives, and the foreseeable risks and benefits of each so that the individual is able to make informed decisions regarding the individual's end-of-life health care.

(*Id.* at 10.4-10.7) (emphasis added). While this language seems innocuous, H.F. 1930 purports to establish that MAID is part of the standard of care (Sec. 3 at 3.11-3.13) that should be presented to patients amongst other traditional options for end-of-life care (Sec. 5 at 6.26-6.30, 7.1-7.4, 7.18-7.20).

Health Facility Compulsion

Many institutional healthcare providers (referred to as "facility[ies]" in H.F. 1930) have missional commitments that are not compatible with MAID, but H.F. 1930 would compel institutional providers to participate in MAID in many cases.

Most health care facilities have "providers" on their premises (i.e., physicians or advance practice registered nurses) who see patients in the facilities but may not be employed by the facility. Section 7 prohibits a health care facility from restricting providers from recommending MAID to residents or patients in the facility's care. (*Id.* at 11.8-11.9.) The purported carveout at Subdivision 1 allowing facility restrictions on its own employees' direct participation in MAID "performing duties for the facility" ignores the practical reality of how health facilities operate. Facility employees who "perform[] duties for the facility" are part of a care team who must work in concert with outside providers to care for patients and residents and cannot simply withdraw from care, as suggested in the bill. The practical implication of Section 7 is that it would force facilities to participate in MAID.

Moreover, Section 7 leaves entirely to the discretion of the patient or resident whether to transfer to another facility. (*Id.* at 11.18-11.20) State and federal law severely restrict the grounds for facility-initiated involuntary transfers and discharges, which may not apply. Transfers and discharges also are subject to appeals that may take many months and remain unresolved up to when a terminally ill patient or resident dies. *See, e.g.*, 42 C.F.R. § 483.14(c) (establishing grounds for transfer or discharge, process for appeals, and stays of transfers or discharges during pending appeal); Minn. Stat. §§ 144G.52, 144G.54 (same). This will create direct conflict between patient wishes and provider restrictions on MAID and likely increase litigation.

Amending the bill to unambiguously recognizie facilities' right to restrict MAID will promote the interests of both residents and facilities. Facilities will be able to clearly communicate in advance to providers, patients and residents any restrictions they place on MAID. And patients and residents who may be interested in MAID will be able to make an informed choice.

Sincerely,

Peter Gregory
Co-General Counsel

WRITTEN TESTIMONY IN SUPPORT OF H.F. 1930 BEFORE THE MINNESOTA HOUSE OF REPRESENTATIVES COMMERCE FINANCE AND POLICY COMMITTEE

MARCH 18, 2024

Thaddeus Mason Pope, JD, PhD
www.thaddeuspope.com

1. Introduction

I am a law professor at Mitchell Hamline School of Law in Saint Paul, Minnesota. I have published over 300 articles and two books on end-of-life decision making. I write in favor of the H.F. 1930 in my personal capacity.

I submit this testimony for three purposes. First, I address Article 1 Sec. 11 and Article 2 Sec. 1 which both address the bill's impact on insurance. Second, I address a misplaced and ungrounded concern that Minnesota's enactment of this bill could lead to a "slippery slope" such that Minnesota would soon (inadvertently or involuntarily) permit medical aid in dying (MAID) far more broadly like Canada. Third, I address the overall bill.

2. Sections on Insurance

H.F. 1930 Article I Section 11, and Article II Section 1 provide that insurance policies cannot be conditioned upon or affected by the use or non-use of medical aid in dying. These are standard provisions not only in MAID laws and bills but also in decades-old healthcare decision making laws in almost every state, including Minnesota.

First, the sections on insurance in H.F. 1930 are common in the MAID statutes of other states (California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington, and Washington, DC). Second, these sections are also common in the more than 20 bills now being considered by other state legislatures in early 2024.

Third, these sections parallel those in the 31-year-old Minn. Stat. 145C. That statute addresses healthcare decisions and advance directives. Like H.F. 1930, 145C addresses actions taken by healthcare professionals that end patients' lives at their request. Therefore, it makes good sense to have parallel provisions in both statutes.

Like H.F. 1930, Minn. Stat. 145C prohibits insurance policies from being affected by individual's healthcare treatment choices. Specifically, section 145C.12 provides:

> A health care provider, health care service plan, insurer, self-insured employee welfare benefit plan, or nonprofit hospital plan may not condition admission to a facility, or the providing of treatment or insurance, on the requirement that an individual execute a health care directive.
>
> A policy of life insurance is not legally impaired or invalidated in any manner by the withholding or withdrawing of health care pursuant to the direction of a health care agent appointed pursuant to this chapter, or pursuant to the implementation of health care instructions under this chapter.

Minnesota patients use section 145C every day. When terminally or seriously ill, they exercise their constitutional, statutory, and common law rights to withhold or withdraw life-sustaining treatment such as mechanical ventilation, dialysis, antibiotics, CPR, and artificial nutrition and hydration. When patients make such decisions, the discontinuation of treatment typically causes their death. Yet, 145C prohibits health and life insurers from considering such choices in whether or how they write insurance policies.

H.F. 1930 similarly prohibits health and life insurers from considering patients' choices for MAID in whether or how they write insurance policies. Like instructions that a patient makes in their advance directives, a patient's choice for MAID must be free and voluntary. It must not be influenced or coerced by their insurance company.

3. The Minnesota Legislature Has Total Control to Regulate MAID.

The terms and conditions under which MAID is authorized in Minnesota are wholly under the control of the Minnesota Legislature. In contrast, that is not true in Canada. In 2015, the Supreme Court of Canada declared a constitutional right to MAID.[1] That ruling required Parliament to enact legislation implementing that fundamental and constitutionally protected right.[2] Moreover, when Parliament subsequently enacted statutes specifying individual rights that were narrower than the previously declared constitutional rights, those laws were successfully challenged in court.[3] So, Parliament was "forced" to amend the original statute.[4]

There is no such danger that constitutional litigation that would force amendment or expansion of the Minnesota End of Life Option Act. First, in 1997, the U.S. Supreme Court ruled that there are no constitutional rights to MAID.[5] Second, while more than a dozen other lawsuits sought to

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[1] Carter v Canada (AG), 2015 SCC 5.

[2] Bill C-14, An Act to amend the Criminal Code (medical assistance in dying) (2016).

[3] Truchon v Canada (AG), 2019 QCCS 3792.

[4] Bill C-7, An Act to amend the Criminal Code (medical assistance in dying) (2021).

[5] Vacco v. Quill, 521 U.S. 793 (1997); Washington v. Glucksberg, 521 U.S. 702 (1997).

find rights to MAID in state constitutions, they too were unsuccessful.[6] In short, MAID has only ever been authorized by state statute.[7] Because MAID is solely a creature of state statute, the Minnesota Legislature has the last word on whether MAID is authorized at all. It also has the last word on how to regulate MAID. The Minnesota Legislature has the last word on specifying eligibility conditions and safeguards for MAID in Minnesota.

4. MAID in the United States is Materially Different from MAID in Canada.

The eligibility conditions in H.F. 1930 are the same as in every other U.S. jurisdiction with MAID. And those conditions have never changed. The individual must be:

(1) an adult
(2) who is terminally ill with a six-month or less prognosis
(3) with decision-making capacity
(4) who makes an informed decision

Furthermore, if eligible, the healthcare service at issue is narrowly and concretely defined. First, the patient gets only a prescription for lethal medications. The patient may or may not fill that prescription. The patient may or may not ingest the medications (nearly 40% do not). Second even if the patient obtains the medications and wants to ingest them, she must do that herself. H.F. 1930, like every other U.S. MAID law, requires patient self-administration.

In contrast, Canadian law differs on both the eligibility criteria and the nature of the healthcare service. First, Canada does not require that the patient be terminally ill. Rather, it is sufficient that the patient has a "grievous and irremediable condition. That is constitutionally required, and Parliament cannot narrow those conditions. Second, Canada does not require self-ingestion. It permits clinician administration. And it permits intravenous administration. Neither is authorized in any U.S. jurisdiction. These are all material differences between the healthcare service authorized in H.F. 1930 and how MAID is authorized in Canada.

Summary of Material Distinctions between U.S. and Canadian MAID

	Canada	United States
Constitutionally protected	Y	N
Terminal Illness required	N	Y
Self-administration required	N	Y
IV administration permitted	Y	N

In Minnesota, unlike Canada, there is no risk that state or federal courts could hold that the right to MAID is constitutionally too narrow. Once the Minnesota legislature authorizes MAID, only

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[6] Thaddeus M. Pope, Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures, 48(2) *New Mexico Law Review* 267-301 (2018).

[7] MAID is permitted in Montana because, unlike every other state, it lacks a preexisting applicable prohibition like Minn. Stat. 609.215.

the legislature itself can amend the eligibility conditions and safeguards it specifies. Notably, no U.S. legislature has ever even considered removing the terminal illness requirement. No U.S. legislature has ever even considered removing the self-ingestion requirement.

5. Testimony on the Rest of the Bill

My testimony above is narrowly and specifically directed to one asserted concern regarding H.F. 1930. But in case it might be useful to the Committee, I address the rest of the bill below.

Minnesota Law and Practice Supports End-of -Life Liberty. Over 50,000 Minnesotans will die this year. Many of them want to control the timing and the manner of their death. And many already do that: (1) through withholding life-sustaining treatment, (2) through withdrawing life-sustaining treatment, (3) through palliative sedation, and (4) through VSED - voluntarily stopping eating & drinking. Medical aid in dying is just one more option.

Medical Aid in Dying Is Not New. Medical aid in dying is a tested and proven option with a long track record, with a solid track record. The bill (H.F. 1930) introduced by Representative Freiberg is closely modeled on the Oregon Death with Dignity Act passed by a ballot initiative in 1994 - 30 years ago. Over the past 3 decades, 10 more states have authorized medical aid in dying based on that same model. 73 million Americans live in those 11 jurisdictions about one-fourth of the entire country.

Medical Aid in Dying Is Safe. Today, we have over 104 years of combined experience with more than 15,000 patients using medical aid in dying in the United States. And that experience shows a solid patient safety track record.

First, each state's department of health publishes an annual report that describes who, where, when, and why patients use medical aid in dying. Second, many health services researchers have conducted their own studies published in peer reviewed medical literature. All that data shows: these laws are working as intended and there is no evidence of abuse.

Indeed, while medical aid in dying has always been safe, it is even safer today. From 2020, we have a professional medical society that offers training, CME, and resources for clinicians. The practice is robust and has a standard of care for everything from patient counseling to pharmacology.

We do not need to speculate or hypothesize about the effects of passing this bill. It includes the same core elements as medical aid in dying laws already in effect in 11 other states. It includes the same core elements as medical aid in dying laws in California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington, and Washington DC.

Medical Aid in Dying Has Not Changed. We hear about laws in other countries like those in Europe. Those laws have changed in fundamental ways concerning the eligibility criteria. That has not happened in the United States. In all 11 U.S. states, all core elements have remained the same. They have not changed. The patient must:

- Be terminally ill (with a 6 month or less prognosis).
- Have decision making capacity.
- Ingest the medications herself.

Over the past 30 years, only two things have changed. One is the types of licensed clinician. Three states now permit not only physicians but also - APRNs to participate. This follows a broader trend in expanding the scope of practice. The second change is the waiting period. The original model required the patient to make 2 requests separated by 15 days. But substantial evidence showed a large fraction of patients either died - or lost capacity before the end of the 15 days. So, most states have now ether shortened or permit waiver of the waiting period.

Medical Aid in Dying is Optional for Both Patients and Providers. One last point. Medical aid in dying is completely optional for patients, for clinicians, and for healthcare entities. In over 100 years of combined experience in 11 states no patient got MAID who did not want it. No clinician had to participate who did not want to. No entity had to participate that did not want to. Medical aid in dying is opt-in only.

Conclusion. Terminally ill Minnesota patients already control the timing and manner of their deaths. Medical aid in dying is another important option. One with a proven track record.

Dear Senator Wiklund,

I am reaching out to strongly and emphatically support Minnesota's End-Of-Life Options Act. As a trained and certified end-of-life Doula, I believe that individuals with a terminal illness should be allowed the autonomy to die with dignity and respect. If for them this means medical aid in dying, we should honor their choice. **Please schedule a hearing NOW in the Senate's Health and Human Services Committee, to meet the March 22 deadline**.

Testimony given to the House:

My name is Marie Koehler. When I retired in 2021, I started reading all kinds of books on death and dying, and listened to dozens of podcasts on the topic. I then enrolled in training to become an End-of-Life Doula. I now have the great privilege of providing support to people during their end of life journey. You can learn A LOT from dying people, if you just "listen" to them. I firmly believe that for people with a terminal, life-limiting illness, the dying process should be THEIRS to control. Their wishes for how they die should be respected and allowed to unfold as THEY want. If they want extraordinary measures taken to save and extend their life, that should be their choice. On the other hand, if they want a more peaceful and controlled end to their life, THAT should be THEIR choice. As a doula, it is not for me to dissuade patients. My role is to be non-judgmental, supportive, and compassionate.

Individuals with a terminal diagnosis are already dying. We should honor their bodily autonomy to take charge of their dying process, after all, it's their "final act." It is their death; not mine, not yours, not anyone else's. Please allow them the dignity to use medical aid in dying if that is their choice.

I will close with this quote from a doctor specializing in hospice and palliative care:

> "It shouldn't be a privilege to die well. It should be a right."*

Thank you for your time.

*Dr. Chandana Banerjee

Sincerely,

Marie Koehler

Chair Stephenson

March 16, 2024

I am submitting written testimony against HF 1930.

I have practiced family practice in Shoreview, MN as a family physician and attended to hundreds of patients at the end of their lives.

I have been asked to write life-ending prescriptions once, in the mid 1980's, and never since. I conclude from this that the advances of Hospice and Palliative care have made assisted suicide (PAS) unnecessary. The 2022 Oregon statics would support this - 278 people ended their lives in a state with 40,000 deaths that year (0.6%).

Patients who made use of PAS most commonly reported they did so to not be a burden on others, rather pain or pain the fear of pain, which is used as justification for PAS. I agree with 80 % of the AMA delegates who voted in 2023 that PAS was incompatible with the role of a physician as healer.

The current bill offers extensive protections for those clinicians who will provide lethal prescriptions, yet those of us who will not promote this as an option face serious legal repercussion.

The bill threatens MN with a loss of good clinicians, especially in rural MN, and legal jeopardy, which will tie up physicians, attorneys and the courts.

Please do not pass HF 1930.

Steven C Bergeson MD
Shoreview, MN

Members of the House Commerce, Finance and Policy Committee,

I am writing to voice my support for HF 1930 and want to share the story of my mom's end-of-life journey with you in the hopes of bringing a broader understanding to how important the Minnesota End of Life Options Act is, and how passing this law will reduce suffering.

74 million terminally ill patients have access to Medical Aid in Dying in the US, but Minnesotans do not have that option. That must change and it must change now. And according to a recent poll, the majority of Minnesotans agree (73%) and want the MN End-of-Life Options Act to pass.

People with a terminally ill disease often endure unimaginable pain and prolonged suffering. They have lost all control over their body, and their life. Medical Aid in Dying gives them control over their death. Having a voice and choice over your life, your body and your death should be a right afforded to all terminally ill Minnesotans.

I wish it had been an option for my mom.

It is commonly thought that hospice and palliative care sufficiently addresses pain and suffering at the end of life. It is also commonly thought that if you voluntarily stop eating and drinking, you will pass peacefully within a few days.

If only that had been true for my mom. Her’s and many many other heartbreaking stories, tragically, tell a very different tale.

My mom, Tonny Willems, died of cancer in March of 2022. She had asked for Medical Aid in Dying many times prior to her death.

Many of us imagine hospice to be a peaceful time where we say our goodbyes to loved ones, reflect on our life and our memories until we quietly slip away holding the hands of those we cherish. Sadly, this could not have been further from the truth for my mom. For her, and for my sister and me, hospice turned out to be a time of tremendous suffering, pain, trauma, and sadness.

A couple of days into hospice care, my mom could no longer move, talk, eat or drink. Her pain continued to worsen. We were told by the hospice team that they were seeing the signs that she would pass soon and that without water, it would be just a few days at most. We thought, “Thank God, her suffering is nearly over.” Those few days turned into FOUR WEEKS! Four weeks without water or food. Four weeks of watching my mom literally disintegrate and decompose in front of our eyes, her body relentlessly convulsing, while we begged and pleaded with her medical team to address her suffering. Four weeks of a living hell! Her hospice team was extremely compassionate, but was at a loss as to what to do. There is nothing beautiful, sacred or peaceful about watching your mom suffer in this manner, stripped of all choice, autonomy and dignity.

My sister and I were her voice then and, exactly two years later, we are still her voice. And we are speaking on behalf of many Minnesotans who are actively dying and want and need this bill to pass. I don't want any other human or their family to live what we went through and neither would she.

There is nothing humane or compassionate about forcing someone to suffer in their last days and not giving them a voice and a choice over their own body. It is inhumanity at its worst. We were not able to truly grieve, mourn, honor and remember my mom after she passed because the trauma of what we had lived was all consuming. It still continues to haunt us daily and has left lifelong scars.

Some minority groups opposed to the option of medical aid in dying do so in the name of protecting vulnerable populations. According to the dictionary, vulnerability is the quality or state of being exposed to the possibility of being attacked or harmed, either physically or emotionally. I would argue that giving patients no choice, voice, or control over their final days and forcing them to suffer actually makes them immensely vulnerable.

So by not passing this legislation, it will indeed be the most vulnerable who will continue to suffer. Who is protecting them?

I ask myself, why do we as a society not give people bodily autonomy at the end of life, when people are actively dying and suffering. Is it because external interests are pushing to keep people sick but alive? Let's face it, you can't make money off a dead person.

Those of us who support this bill are not trying to force anyone to go against their beliefs or values and choose medical aid in dying upon their death. Every eligible person should have the freedom to make that decision for themselves. But that is the whole point, without the MN End-of-Life Options Act, there is little choice or freedom for the terminally ill.

This should not be a partisan issue. ALL of our terminally ill Minnesotans and their families deserve Choice, Dignity, Humanity, Compassion, and Love. Let's please respect and honor their end-of-life wishes.

What a gift to give our mom a peaceful passing might have been. Please have the fortitude, the courage and the compassion to pass the Minnesota End-of-Life Options Act.

Sincerely,
Françoise Willems-Shirley

Tara Flaherty Guy
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Roseville, MN 55113
651-343-1603
taramguy058@gmail.com

March 15, 2024

TO: MN House Commerce Finance and Policy Committee

RE: HF 1930 – Minnesota End of Life Option Act

Dear Chairman Stephensen and Members of the Committee,

I am writing to express my deep support for the Minnesota End of Life Options Act which you will be considering in pertinent part on Monday 3/18/24. I've been working to have this legislation adopted in Minnesota for nearly ten years.

I came to volunteer for Compassion & Choices after I lost my best friend following a botched suicide attempt. Doris was dying of ovarian cancer and also suffering unendurable pain from injuries she had sustained in a hit and run car accident. One day while her boyfriend was out, she took all of the narcotics, sleeping pills and tranquilizers she had stockpiled for days - imagine her pain as she kept all that medication in reserve – and laid down in her bed to die. She left letters of love and apology for her family, next to her advanced directive which stipulated no extraordinary measures or life support should be used to sustain her life. Her boyfriend, disregarding her wishes, had her air lifted to Regions Hospital, then insisted that she be placed on a ventilator despite her daughter (and health proxy) presenting her advanced directive time and again to the medical staff. He was louder, he was a bully, *he* was listened to, instead of Doris's final wishes as expressed in her legally executed directive. Eventually (after being threatened with legal action) the hospital acquiesced and extubated her after three days on the ventilator. Doris died "naturally" four terrible days later.

Many dying people suffering unbearable, intractable pain (statistically 25% of terminal cancer patients) will try the same route Doris did —the noose in the barn, the running car in the garage, the shotgun in the orchard. My friends and co-volunteers in Compassion & Choices have witnessed many variations on these scenarios undertaken by their dying loved ones. This is why they work to legalize medical-aid-in-dying.

In conclusion, medical aid in dying is not suicide. These people wanted to live. That choice was taken from them the day of their diagnosis. Please restore one final choice to terminally ill Minnesotans: the option of a good death, filled with grace and peace, surrounded by the love and support of family and friends.

Thank you for your time.

Sincerely,

Tara Flaherty Guy

Tara Flaherty Guy

Stephen Mendelsohn
171 Hartford Road, #19
New Britain, CT 06053-1532
smendelsohn5845@att.net

Testimony in strong opposition to HF 1930
End of Life Option Act
March 18, 2024

Rep. Zack Stephenson and members of the House Commerce and Finance Policy Committee:

I am an autistic adult and one of the leaders of Second Thoughts Connecticut, a coalition of disabled people opposed to the legalization of assisted suicide. I also serve on the board of directors of Euthanasia Prevention Coalition-USA.

I submit this testimony in response and opposition to previous testimony from Thaddeus Mason Pope, JD, PhD on March 7, 2024 before the House Public Safety Finance and Policy Committee and again on March 12, 2024 before the House Judiciary Finance and Civil Law Committee.[1] [2] Pope argues that there is no “slippery slope” leading to a radical euthanasia regime like that in Canada. I will demonstrate that this “slippery slope” is actually a paved road, in which proponents have openly boasted about using an incrementalist, bait-and-switch strategy to first pass less ambitious legislation and then later expand the law whether by legislation or through the courts.

Pope erroneously claims that the Minnesota Legislature has total control to regulate the parameters of assisted suicide (which he calls “medical aid in dying” or MAID). Not so: Compassion & Choices has successfully sued the states of Oregon and Vermont to get them to eliminate their residency requirements. They currently have a lawsuit against New Jersey on the same issue. This shows that states that have legalized assisted suicide **do not have full control** over regulating the parameters of the legislation they pass.

It is true that under *Washington v. Glucksberg*, the Supreme Court has ruled there is no constitutional right to assisted suicide, and state courts have consistently rejected attempts to compel enactment of these laws. Nonetheless, challenges to laws legalizing assisted suicide based on equal protection and/or the Americans with Disabilities Act (ADA) from both sides remains largely an untested issue.

While one case (*Shavelson et al. v. Bonta et al.*) seeking to force California to allow for lethal injections for persons who may not be capable or may lose the ability to self-administer was denied, it is easily conceivable that another court in another jurisdiction would rule otherwise. The core “safeguards” of six months terminal illness, mental competence, and self-

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[1] Thaddeus Mason Pope, JD, PhD, Written Testimony in Support of H.F. 1930 , Before the Minnesota House of Representatives Committee on Public Safety Finance and Policy: https://www.house.mn.gov/comm/docs/peqp-qSyH0aRdWY7Tn41Bw.pdf, pp. 95-98

[2] Thaddeus Mason Pope, JD, PhD, Written Testimony in Support of H.F. 1930 , Before the Minnesota House of Representatives Judiciary Finance and Civil Law Committee: https://www.house.mn.gov/comm/docs/8YF2ui3vZkKG02ue19P6Xw.pdf, pp. 100-106

administration all make distinctions on the basis of disability, granting some people suicide prevention and others suicide assistance. I would also note there is currently a disability-rights lawsuit, *United Spinal Association et al. v. State of California et al.*, seeking to overturn the End of Life Option Act on ADA and 14th Amendment equal protection grounds.[3]

Pope claims that "… no U.S. legislature has ever even considered removing the terminal illness requirement. No U.S. legislature has ever even considered removing the self-ingestion requirement." His March 7 testimony to the House Public Safety Finance and Policy Committee was rendered utterly false a mere one day after it was submitted, and his March 12 testimony to the House Judiciary Finance and Civil Law Committee was knowingly false. On March 8, 2024, California State Senator Catherine Blakespear submitted a press release on SB 1196, explaining the provisions of her bill to radically expand that state's End of Life Options Act.[4] This legislation would eliminate the terminal illness requirement, replacing it with "a grievous and irremediable medical condition" similar to what was originally enacted in Canada. It would allow people with early to mid-stage dementia to access the law, and would also allow for lethal injection, moving from assisted suicide to active euthanasia. In addition, it would eliminate the meager 48 hour waiting period, allowing for a same-day death. Pope posted on March 8 about this development approvingly on his Medical Futility Blog, "California Makes Big Move on Medical Aid in Dying."[5] Yet four days later, he submitted testimony denying what he had just blogged about.

Pope is a zealous advocate of expansion in this direction.[6] Even under current law, he has advocated using voluntary stopping of eating and drinking (VSED) as a bridge to enable non-terminal patients to qualify for assisted suicide in states such as Oregon, California, New Mexico, and Hawaiʻi which have either significantly shortened the waiting period or allowed it to be waived. Pope published an article in the *Journal of the American Geriatrics Society* approvingly citing the case of Cody Sontag, an Oregon woman with early-stage dementia who used VSED to qualify for lethal drugs under that state's law.[7] He notes that "if anyone can access VSED, then anyone can qualify for MAID," thereby doing an end-run around the law's terminal illness requirement.

The American Clinicians Academy on Medical Aid in Dying (ACAMAID) has an "Ethics Consultation Service" report on "Voluntary Stopping of Eating and Drinking and Medical Aid in Dying" noting that:

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[3] United Spinal Association et al. v. State of California et al. https://endassistedsuicide.org/wp-content/uploads/2023/04/Complaint_Accessible.pdf; for more detail, see https://endassistedsuicide.org

[4] Senator Catherine Blakespear, Factsheet on SB 1196: https://img1.wsimg.com/blobby/go/cd607dce-3325-492b-b030-b0a22331af65/downloads/SB%201196%20(Blakespear)%20Factsheet.pdf?ver=1709911469736

[5] https://medicalfutility.blogspot.com/2024/03/california-makes-big-move-on-medical.html

[6] Thaddeus Mason Pope (2023) Top Ten New and Needed Expansions of U.S. Medical Aid in Dying Laws, *The American Journal of Bioethics*, 23:11, 89-91, DOI: 10.1080/15265161.2023.2256244 https://www.tandfonline.com/doi/full/10.1080/15265161.2023.2256244

[7] Thaddeus Mason Pope, JD, PhD, Lisa Brodoff, JD, Medical Aid in Dying to Avoid Late-Stage Dementia, *Journal of the American Geriatrics Society*, February 5, 2024: https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/jgs.18785?domain=author&token=VA68TTBJN9VDRCRMRPIP

> Legally, there is nothing in the letter of the law of any of the U.S. states' aid in dying bills that explicitly prohibits accepting voluntary stopping of eating and drinking as a terminal diagnosis to qualify for aid in dying. This remains a legal gray zone.[8]

ACAMAID confirms that allowing VSED to qualify for lethal prescriptions would "essentially eliminate the criteria of terminal illness to qualify."

Most significantly, if passed, HF 1930 would be the most expansive and permissive assisted suicide law in the nation to date. Similar to the extreme euthanasia bill in California, it has **no waiting period at all, thus allowing anyone**—theoretically even otherwise healthy people who may be depressed—**to instantly qualify for the lethal dose and die on the same day**. It would thereby enact two principal elements of Canada's radical death regime—widespread eligibility for non-terminal conditions and same day deaths.

Passage of HF 1930 would also shift the Overton window toward more radical legislation. Over the past two years, while no new states have enacted laws to legalize assisted suicide, several states have moved to expand their laws. It is far easier to pass an expansion bill after a state accepts the principle that it is acceptable for doctors to prescribe lethal drugs to patients than it is to pass legislation to legalize the practice in the first place.

Proponents of assisted suicide bills across the United States have not been shy about their incrementalist bait-and-switch strategy and desire for future expansion. In my home state of Connecticut, Rep. Josh Elliott openly admitted he wanted to get anything on the books even if it was unusable so it could be later expanded. Paul Bass reports in the New Haven Independent:

> Elliott has been sponsoring bills for years to allow terminally ill people to take their lives (aka "aid in dying"). The bill finally passed the legislature's Public Health committee; it got stuck in Judiciary.
>
> The version he plans to resubmit this year has been narrowed to cover terminally ill people with prognoses of less than six months to live, with sign-offs from two doctors and a mental health professional, monthly check-ins, and at least a year of state residence.
>
> "Almost no one" would qualify under that restricted version of the law, Elliott said. But passing it would open the door to evaluation and expansion.[9]

Here is the full on-air quote from Rep. Elliott on Dateline New Haven:

> The bill would be, um, exceptionally narrow in scope, it would be the most narrow in scope bill of this kind were we to pass it. It would be, uh, six months left to live, you have to get sign-offs from multiple doctors—two doctors and one mental health physician—uh, and then you need to go for frequent check ins—I think it's like once a month—and you have, there is a one year residency requirement, so there are so many

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[8] American Clinicians Academy on Medical Aid in Dying, Ethics Consultation Service, "Voluntary Stopping of Eating and Drinking and Medical Aid in Dying, January 3, 2023: https://www.acamaid.org/wp-content/uploads/2023/01/Voluntary-Stopping-Eating-and-Drinking-and-Medical-Aid-in-Dying.pdf Pope is part of ACAMAID's Ethics Consultation Service's team.

[9] Paul Bass, Elliott Readies Next Legislative Steps Toward Freedom, New Haven Independent, January 4, 2004: https://www.newhavenindependent.org/article/elliott_readies_next_legislative_steps_toward_freedom

> ways we limit who could actually use this bill, to the point I believe if we were actually to implement the way that we are talking about it, almost nobody would use it. But the important thing for me is to get this bill on the books, and then see how it's working, and if it's not and people aren't using it, then make those corrections to actually allow people to use it. So that is what we've been discussing.[10]

Similarly, J.M. Sorrell, Executive Director of Massachusetts Death with Dignity, was quoted on a similar bill in his state, saying "Once you get something passed, you can always work on amendments later."[11] And Compassion & Choices past president, Barbara Coombs Lee said almost ten years ago regarding assisted suicide for people with dementia unable to consent, ""It is an issue for another day but is no less compelling."[12]

There are many other problems with this leglsiation. There is an explicit requirement in HF 1930 Section 12 to falsify the death certificate as to the cause and manner of death, thereby covering up foul play. The Connecticut Division of Criminal Justice has repeatedly testified against a similar provision, stating that falsifiying the cause of death as the underlying terminal illness rather than the lethal overdose would prevent prosecution for murder.[13] There is widespread evidence, most recently from ACAMAID, that the laws in other states are not being followed, and with no consequences to the prescribing medical practitioners.[14] Also, the lethal drugs have often caused prolonged and agonizing deaths, sometimes with patients waking up and then dying in greater agony from their terminal illness.[15] The current drug cocktail, DDMA-Ph, includes amitriptyline, which burns the throat.[16] In a case in Colorado, after the intended patient took a swallow and exclaimed, "Man that burns!", a bystander also swallowed the lethal concoction and nearly died before being rescued by EMS personnel.[17] The problems with oral ingestion have been cited by Senator Blakespear in her press release on California SB 1196 as a reason for expanding from assisted suicide to euthanasia via lethal injection. You will hear plenty of testimony on other problems with this legislation, particularly from others in the disability rights community.

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[10] https://www.youtube.com/watch?v=Z0hWOjITspE at clip position 21:30

[11] Alexander MacDougall, Comerford to Reintroduce Medical Aid-in-Dying Bill in Wake of Court Decision, Greenfield Recorder, December 28, 2022: https://www.recorder.com/SJC-Aid-In-Dying-Not-A-Protected-Constitutional-Right-49298186

[12] Luke Foster, Compassion & Choices Draws Full House at Real Art Ways for Panel Discussion, Film, CT News Junkie, October 10, 2014: https://ctnewsjunkie.com/2014/10/10/compassion_choices_draws_full_house_for_panel_discussion_film

[13] Testimony of the Connecticut Division of Criminal Justice, H.B. 6425 (Raised), An Act Concerning Aid in Dying for Terminally Ill Patients, Joint Committee on Public Health, February 26, 2021: https://www.cga.ct.gov/2021/phdata/tmy/2021hb-06425-r000226-the%20division%20of%20criminal%20justice-tmy.pdf

[14] American Clinicians Academy on Medical Aid in Dying, Ethics Consultation Service, "What is the appropriate response when a colleague is not following an aid-in-dying law?, March 2, 2024: https://www.acamaid.org/wp-content/uploads/2024/03/Response-to-Non-Compliance.pdf

[15] Anita Hannig, The Complicated Science of a Medically Assisted Death, Quillette, March 18, 2020: https://quillette.com/2020/03/18/the-complicated-science-of-a-medically-assisted-death

[16] American Clinicians Academy on Medical Aid in Dying, Amitriptyline and Oropharyngeal/Esophageal Burning, October 21, 2020: https://www.acamaid.org/amitriptylineburning

[17] Nikole Baxter, EMT-P, NRP, Sean G. Morgan, MD, FACEP, Thom Dunn, PhD, NRP, JEMS, Death with Dignity: When the Medical Aid in Dying Cocktail Gets into the Wrong Hands, November 29, 2022: https://www.jems.com/patient-care/death-with-dignity-when-the-medical-aid-in-dying-cocktail-gets-into-the-wrong-hands

I conclude by emphasizing that HF 1930 is not merely a “slippery slope,” but a paved road north to Canada’s radical euthanasia regime where disabled people are routinely denied services needed to survive but offered “medical aid in dying” instead. To paraphrase Reverend Dr. Martin Luther King, Jr., assisted suicide anywhere is a threat to disabled people everywhere. Please do not put Minnesota—and the rest of the nation—on this path. Please reject HF 1930. Thank you.

My name is Meghan Schrader and I teach people with intellectual disabilities at the University of Texas at Austin. I have been asked to contact you to provide a disability rights perspective on HF1930, or MN's current "End of Life Options Act." As a disability rights advocate who has published research on our country's deep history of ableism and eugenics, I strongly urge you to vote against this bill. Although some of the proponents' desire for the law is understandable, these laws exacerbate already intense systems of oppression that disabled people deal with on a daily basis. Here are some facts that I would like you to consider in making your decision:

-The American Association of Suicidology made a 2017 statement saying that “MAiD” was not suicide. But in 2023 the AAS had to retract that statement https://suicidology.org/2023/03/08/aas-update-on-previous-statement/ because it was used in the 2019 Truchon decision that expanded assisted suicide to disabled Canadians. https://twitter.com/TrudoLemmens/status/1666067817035190272 , which was opposed by the Canadian Association for Suicide Prevention. https://suicideprevention.ca/media/statement-on-recent-maid-developments/ The consequences of the AAS’s statement are an example of how green lighting assisted suicide for the terminally ill easily results in violence against people with disabilities.

-Well known right to die leader and Minnesota resident Thaddeus Mason Pope tweeted to me that he thinks it’s good for disabled people to die by suicide. https://twitter.com/ThaddeusPope/status/1669450726831976449 The director of Compassion and Choices appeared on Dr. Phil with Thaddeus Mason Pope in January of 2023.

-A disabled Canadian friend of mine with
PTSD was subjected to further wounding trauma when a suicide prevention hotline operator told her that she should consider killing herself with “MAiD.” Today’s bill would lay the scaffolding for the proponents to build that same world.

-In 2021 the United Nation’s Special Rapporteur on the Rights of People with Disabilities asserted that even assisted suicide laws that are limited to the terminally ill violate its Convention on The Rights of People with Disabilities https://www.ohchr.org/en/press-releases/2021/01/disability-not-reason-sanction-medically-assisted-dying-un-experts

-Compassion and Choices has acknowledged that an eating disorder specialist published a case study about helping people with eating disorders kill themselves with “MAiD,” (https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2022.11.9.4 , https://www.compassionandchoices.org/news/colorado-response), but then it’s representatives say that these laws have never been abused. So, has the law been abused or not? As someone with an eating disorder who may have no choice but to seek treatment from people like the opportunist who wrote that case study in the future, I want to know which one it is.

-Harvard Medical School disgustingly invited the director of Canada’s euthanasia program to come talk to them about how much she loves her job killing disabled people; her book is in my University’s library.

https://m.youtube.com/watch?v=LtysjDKxmLg&t=8s&pp=ygUmSGFydmFyZCBNZWRpY2FsIFNjaG9vbCBzdGVwaGFuaWUgZ3JlZW4%3D

-In January of 2023 the New York Hastings Center tweeted out an essay about how great it is that disabled Canadians are killing themselves and giving their internal organs away. https://twitter.com/hastingscenter/status/1618030388542148608 The USA right to die movement has a very cavalier attitude towards traumatizing people in the disabled community.

-Disabled people already experience a higher rate of suicide than the general population and peer-reviewed research indicates that people are more likely to think suicide is acceptable if the victim has a disability. https://pubmed.ncbi.nlm.nih.gov/26402344/ Passing these laws clearly further normalizes the sentiment that disabled people's suicides might be a good thing, and that's a monstrous way for society to bully people in the disabled community.

If you pass this bill, you reward a movement that is hostile to people with disabilities. Vigilantly safeguarding equality and justice for people with disabilities as a group is more important than the proponents' individual autonomy. Do not pass this bill.

Here is a presentation that I made in January about disability rights opposition to assisted suicide and the ways in which assisted suicide undermines the civic equality of persons with disabilities:
https://m.youtube.com/watch?v=dD63swGsGJQ&t=3311s&pp=ygUfRXV0aGFuYXNpYSBwcmVzZW50aW9uIGNvYWxpdGlvbg%3D%3D

My name is R. Paul Post, MD and I am a retired board-certified family physician, having practiced medicine in Minnesota for 37 years. I am currently consulting for several health care organizations. I am testifying in opposition to HF 1930.

Section 13 of the bill indicates that it will be a crime to use coercion, undue influence, harassment, etc. to compel someone to choose this option. However, this bill sets the standard of care as requiring all physicians to offer medical assistance in dying as an option. If practitioners are continually reminding patients that physician assisted suicide is a treatment option, this is incredibly coercive. People view doctors with a tremendous amount of respect and trust them. In my practice, I know I was able to convince my patients to take the course of action that I felt was best for them on many occasions, yet I felt I was not harassing or coercing them.

Making this the standard of care and requiring doctors to offer it as an option will feel like a suggestion, intended or not. And when each new provider a patient encounters offers this, imagine the effect this will have. Many will begin to think they have a duty to die, rather than a right to die. They will feel it is their duty to relieve the burden on their family and society.

Since the bill states the standard of care is to offer this option, there is no opt out or right of conscience protections for those physicians who find this unethical (as the AMA has affirmed repeatedly). Physicians are not required to write the prescription but are required to refer the patient to someone who will. This is not conscience protection as this will result in the act being accomplished ultimately.

The bill provides immunity for those who practice physician assisted suicide, but coercion for those who are opposed to the act.

The bottom line is that making this the standard of care threatens the trust between physicians and patients, puts pressure on patients to feel a duty to die, and threatens the most vulnerable in our society. I urge you to vote no on HF 1930.

R. Paul Post, MD, FAAFP
Minnesota State Director, American Academy of Medical Ethics.

March 4, 2024

I feel compelled to submit a testimonial on why I vehemently oppose HF 1930 regarding assisted suicide. I have been working in senior care/long term care for 15 years, and during that time have witnessed and experienced countless deaths. While death is never easy, and the dying process can take many months and may be painful to witness, I have found it can also be a beautiful and moving experience to be a part of. I have witnessed laughs, tears, smiling, prayers, reconnecting, and countless other emotions from both the dying person and their loved ones and caregivers. I believe that it is an important part of life, to be able to die naturally as your body and God intended! I recently had a resident's family member tell me that although it was difficult to witness their mother in her journey with dementia, they wouldn't have changed a thing, because she was able to tell them she loved them until her dying day, even if it was just through non-verbal actions at times. What an incredible testimony - I would never want to take away that beautiful experience from a person just because the dying process is difficult.

I have also been blessed to work with wonderful hospice agencies, who partner with a person/their families/caregivers to care for a person in their remaining days/months, who listen to and respect their end of life wishes, who assist with pain management, and can educate on and anticipate the upcoming needs of the dying person. Their support, care and services are immensely helpful and may be overlooked by those who wish to take the easy route by choosing assisted suicide.

Simply put, it is immoral and unjust to pass legislation supporting assisted suicide. We need to value human life, from conception to natural death. We cannot allow assisted suicide to become a reality in Minnesota – instead we should utilize our many healthcare options and supports in our state until the final breath is taken.

Sincerely,

Stephanie Capelle

Stephanie Capelle
Resident of Jordan, MN

world without
GENOCIDE
AT MITCHELL HAMLINE SCHOOL OF LAW

March 18, 2024

To Members of the House Finance, Commerce, and Policy Committee,

World Without Genocide, a human rights organization located at Mitchell Hamline School of Law, supports the ***End-of-Life Options Act*** currently under consideration in the Minnesota legislature.

Our organization has Special Consultative Status at the United Nations. In this position, we are honored to uphold the principles that guide United Nations actions around the world. The most essential of those principles is the ***Universal Declaration of Human Rights***, which, with other international human rights agreements, underscores that bodily autonomy is a fundamental right. People must be able to make decisions freely and responsibly about their own bodies.

These decisions are based on each individual having power over decision-making about their bodies throughout the life course, including, when appropriate, at the end of life, through medical assistance in dying.

Medical aid in dying (MAID) is a practice proven by decades of experience in authorized states.
In more than 20 years of experience since the first law was enacted in Oregon, and an additional 40+ years of cumulative longitudinal data from other jurisdictions, there is not a single substantiated case of abuse or coercion nor any civil or criminal charges filed related to the practice. Not one.

The proposed legislation is designed to protect patients and health care professionals, while deterring and punishing those who would abuse, coerce, or harm those involved in this practice. Punishments are severe, with up to 25 years of imprisonment and steep financial penalties for violations. The legislation also clearly specifies that an individual's use of MAID does not invalidate life, health, or accident policies, nor does it preclude issuance of such policies.

The option for MAID is currently available to more than 280 million people around the world and to 74 million people in ten U.S. states and Washington, D.C. **We urge passage of the End-of-Life Options Act in Minnesota.** Thank you,

Ellen J. Kennedy, Ph.D.
Executive Director and Adjunct Professor of Law

TESTIMONY ON MINNESOTA END-OF-LIFE OPTION ACT (HF1930)

JANUARY 25, 2024

C. Eric Bergh, 7385 115th St. East, Northfield, MN 55057

My name is Eric Bergh, and I am a retired Licensed Psychologist.

I originally thought I would testify about the value of this bill from a clinical perspective and talk about the success similar acts have had in other states, as well as the fact that there has not been a consequent increase in death by suicide. But you can find that data elsewhere.

Rather, I will share two brief stories of my family.

My brother, Christopher, died by suicide on May 2nd, 1997 in my parent's home in Vermont. He shot himself in the head. My mother found him when he did not come down for dinner. He'd suffered from untreated depression, he was an active alcoholic, he had a gun collection- a trifecta of vulnerability. This event was tragic in every sense of the word, heart rending to our entire family, and it continues to echo down the decades.

Flashback now to early December 1989. Same lovely country home. I am sitting in my parent's bedroom listening to my father's erratic breathing and groans of pain as he wavers in and out of sleep. He is in the later sages of a melanoma that has metastasized to his liver, his lungs, and his entire body. He is still able to limp to the bathroom; this is when I can see how shriveled his body is on one side and how swollen he is with tumors on the other. He is a shell of the strong father who raised me, of the 7 year Navy veteran from WW2. My father is in palliative care at home. He is in constant pain. When conscious, he talks mainly of wanting this to be over, of wanting to die. I agreed that it was a good day to die- a beautiful sun on glittering snow day in Vermont. I prayed that he might die before I had to return to MN so I could be with him for his passing. Such was not to be.

Little did I know that he and my mother had planned for his demise after his years of battling different cancers. When his condition became terminal and when he was ready. They had a compassionate doctor friend who gave my father what he would need when he felt he was ready to die. He was ready on December 17 and after self-administration died very peacefully in my mother's presence.

But there was still tragedy….For one thing, it was all against the law, and that caused great worry for both of my parents. The dying was a relief as life, such as it was, had become intolerable. But the fact that my mother had to do this alone, that it had to be secretive to protect the rest of us, that we could not be present to say goodbye and usher my father on…this was the tragic part. And this still echoes as well.

Ending one's life by suicide is indeed a tragedy. Dying on your own terms when terminally ill, surrounded by those you love, peacefully, with dignity, is a gift.

That is why I support this bill.

Thank you for your time.

To Simon Brown
Chair, Minnesota House Commerce Finance & Policy

RE: Hearing on Monday, March 18, 2024

This note is my personal plea you to show compassion for people like myself who have had diagnoses of always fatal diseases that will end with months of pain and disability for no reason. It would be so liberating to me NOW as I plan and think about the end of my life, if I could know that I would have a choice to forgo the last months of misery for myself, for my friends, for my family, and for the the financial well being of all.
No one likes to mention that it costs everyone in dollars for that end time: families miss work, caretakers and medical bills need to be paid, there are costs for Medicare and costs for the State. These dollar costs add to the burden and stress of everyone concerned.
I have watched others and been caretaker to others who were dying, so I have some idea what I am facing.
The last days are never happy and always painful.
I know all the slippery-slide arguments against it. And I believe this bill addresses some of the pitfalls and concerns.
But please, give us the freedom over our own lives. Don't force me to either leave the state or to choose VSED.
We consider it a kindness to help a fatally wounded animal to die. Why is it not a kindness to help a person in the same way?

Thank you for your time

Kathryn Peterson

To the Commerce Finance and Policy committee:

My name is Terry Knowles. I am a family physician in New Ulm, Minnesota. I have been practicing family medicine for 30 years now. I know that the practice of medicine has changed now as have many things. At my graduation from medical school, we did take the Hippocratic Oath obligating us to first do no harm. Unfortunately, that oath today is whatever people want it to say. Most of us went into medicine to help heal and comfort. Not to aid and abet in killing. We are not the authors of life, or of death. That is up to God.

I recently testified at the Judiciary Finance and Civil Law committee last week. I want to expand on my thoughts of this bill.

I am vehemently opposed to this bill. I did ask Deacon Dolan who was at that committee hearing if he had anything else to add. He said he was going to say only one thing. It's in the 6th commandment: Thou shall not kill. We used to claim that we were one nation under God. Unfortunately, I know we are a post Christian society. But we will still be held to God's law at the final judgement.

The argument of undo suffering and pain for the terminally ill is founded. Our hospice programs are awesome. My mother and mother-in-law had great relief of pain and a very peaceful death with their help. If someone is enrolled in hospice and still experiencing terrible pain—they are not in the right one. If somehow our hospice programs are not up to speed then this should be the focus of our efforts. Not the effort to play God and help in ending their life.

We all know people who have outlived their prognosis of "one year left to live" or "they've only got 6 months left." As far as we have come in medicine we are often wrong in our prognostication. So, to say someone has only 6 months or less to live and therefore we can help them end their life now is not right on that account.

This bill has several statements in it that states full knowledge of end-of-life care options must be given to the patient. The health care provider should also inform the pt and their loved ones of the potential of irreversible damage and harm that their loved ones in some way participated in this and they will have to carry this with them to their grave and likely undergo counseling for such. A good friend of mine is currently seeing this issue with her sister who help her other sister end her life in Colorado just last year.

In section 10.15 it states:

10.15 (c) If a provider is unable or unwilling to fulfill an individual's request for medical aid 10.16 in dying medication or to provide related information or services requested by the individual, 10.17 the provider must, upon request, transfer the individual's care and medical records to a new 10.18 provider consistent with federal and Minnesota law.

What is implied here is that I must find a health care provider that participates in physician assisted suicide and I cannot do this in good conscience. I do not want to be criminalized for my conscience. This part needs to be removed.

Finally, this bill is also asking me to falsify the death record. It states:

15.24 (b) When a qualified individual dies after self-administering medical aid in dying 15.25 medication: 15.26 (1) the cause of death on the qualified individual's death record shall be attributed to the 15.27 qualified individual's underlying terminal disease; and 15.28 (2) the death shall not be designated on the death record as a suicide or homicide.

I cannot and will not falsify the death record. I am the county coroner for Brown County, and I will continue to complete the death record in truth and honesty.

The language of this bill in one area states that there will be no coercion of the patient to agree to physician assisted suicide or the falsification of any records. Yet at the same time this bill is forcing me to falsify the death record.

This bill should not pass. Please vote “no.”

Sincerely,

Terence J. Knowles MD

Special Article

WHAT ARE THE POTENTIAL COST SAVINGS FROM LEGALIZING PHYSICIAN-ASSISTED SUICIDE?

EZEKIEL J. EMANUEL, M.D., PH.D., AND MARGARET P. BATTIN, PH.D.

IN the *Washington* v. *Glucksberg* and *Vacco* v. *Quill* decisions rejecting a constitutional right to physician-assisted suicide, the Supreme Court allowed each state to decide whether to legalize the intervention.[1] In state legislatures rather than courtrooms, factual claims about the probable extent and implications of permitting physician-assisted suicide assume a preeminent role in the debate about legalization.[2] Particularly sensitive in these discussions will be the issue of the potential cost savings from legalizing physician-assisted suicide, and how the savings might influence decision making by health care institutions, physicians, families, and terminally ill patients.[3-6]

Although we do not agree with each other about the ethics or optimal social policy regarding physician-assisted suicide and euthanasia, we do agree that the claims of cost savings distort the debate. Within the limits of available data, we offer an assessment of the potential cost savings from legalizing physician-assisted suicide, demonstrating that the savings can be predicted to be very small — less than 0.1 percent of both total health care spending in the United States and an individual managed-care plan's budget.

SPECULATING ABOUT COST SAVINGS FROM PHYSICIAN-ASSISTED SUICIDE

There is a widespread perception that the United States spends an excessive amount on high-technology health care for dying patients.[7-20] Many commentators note that 27 to 30 percent of the Medicare budget is spent on the 5 percent of Medicare patients who die each year.[21] They also note that the expenditures increase exponentially as death approaches, so that the last month of life accounts for 30 to 40 percent of the medical care expenditures in the last year of life. To many, savings from reduced use of expensive technological interventions at the end of life are both necessary and desirable.[11,12,18,19]

Many have linked the effort to reduce the high cost of death with the legalization of physician-assisted suicide. One commentator observed: "Managed care and managed death [through physician-assisted suicide] are less expensive than fee-for-service care and extended survival. Less expensive is better."[22] Some of the amicus curiae briefs submitted to the Supreme Court expressed the same logic: "Decreasing availability and increasing expense in health care and the uncertain impact of managed care may intensify pressure to choose physician-assisted suicide"[23] and "the cost effectiveness of hastened death is as undeniable as gravity. The earlier a patient dies, the less costly is his or her care."[24] Indeed, the Supreme Court noted the potential for cost-saving motives to influence the legalization and use of physician-assisted suicide, speculating that "if physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health care costs."[1]

FACTORS DETERMINING SAVINGS FROM PHYSICIAN-ASSISTED SUICIDE

Computing the likely cost savings from legalizing physician-assisted suicide is based on three factors: (1) the number of patients who might commit suicide with the assistance of a physician if it is legalized; (2) the proportion of medical costs that might be saved by the use of physician-assisted suicide, which is related to the amount of time that a patient's life might be shortened; and (3) the total cost of medical care for patients who die.

Each of these factors is uncertain. Although available data indicate that physicians in the United States currently provide euthanasia and assistance with suicide to some patients,[25,26] it is impossible to determine how many additional Americans would die as a result of physician-assisted suicide if it were legalized. The savings from legalization would depend on the additional number of physician-assisted suicides beyond the current number. Since predictions about any patient's precise date of death are inherently uncertain, it is impossible to determine how much life would be forgone. Finally, only limited data are available on the costs of care near the end of life in

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the United States.[15,16,21] However, by combining data on physician-assisted suicide and euthanasia in the Netherlands, where these interventions are openly performed[27,28] and have been studied,[29-31] and available U.S. data on costs at the end of life, we can estimate the cost savings that would be realized in the United States if physician-assisted suicide were legalized. Although such an estimate is very crude, sensitivity analysis can minimize the effect of the uncertainty by providing the range of savings under reasonable conditions.

THE NUMBER OF PATIENTS WHO MIGHT CHOOSE PHYSICIAN-ASSISTED SUICIDE

In the Netherlands, approximately 3100 cases of euthanasia and 550 cases of physician-assisted suicide occur annually, representing 2.3 percent and 0.4 percent, respectively, of all deaths.[31] (There are an additional 1000 cases [0.7 percent] in which euthanasia is performed without the patients' explicit, current consent.[31] Such cases are neither sanctioned in the Netherlands nor permitted by the current proposals for legalization of physician-assisted suicide in the United States.) About 80 percent of deaths by physician-assisted suicide or euthanasia in the Netherlands involve patients with cancer, representing 6 percent of all deaths from cancer.[30,31] Extrapolating the Dutch rates to the United States suggests that approximately 62,000 Americans (2.7 percent of the 2.3 million who die in the United States each year) might choose physician-assisted suicide if it were legalized and carried out with the explicit, current consent of the patients. Patients with cancer are also likely to be the primary users of physician-assisted suicide in the United States.[25,26]

PROPORTION OF LIFE SHORTENED BY PHYSICIAN-ASSISTED SUICIDE

Although predicting the exact date on which an individual patient will die is impossible, physicians are fairly accurate in predicting the time of death on a population basis, especially for patients who die of cancer.[16,32] Dutch physicians estimate that 17 percent of patients receiving euthanasia or a physician's assistance with suicide at the patients' explicit request had their lives shortened by less than one day, 42 percent by one day to one week, 32 percent by more than one week to four weeks, and 9 percent by more than one month.[30,31] Thus, more than 90 percent of Dutch patients who died as a result of physician-assisted suicide or euthanasia at their own explicit request had their lives shortened by 4 weeks or less, with an average life reduction of less than 3.3 weeks.

THE COSTS OF MEDICAL CARE FOR DYING PATIENTS

Determining the costs of medical care at the end of life and how much would be saved by legalizing physician-assisted suicide is made difficult by several problems with the available data. It is speculative to assume that patients who might commit physician-assisted suicide would consume resources at a rate similar to that of patients who do not; such patients may be considerably different from average decedents in terms of health status, psychology, and sociodemographic characteristics, using more (or fewer) health care resources at the end of life.[25] Also, the best data available in the United States on the cost of medical care at the end of life come from Medicare, which provides mainly acute care for the elderly and disabled.[33,34] Studies have come to various conclusions about whether these Medicare data can be extrapolated to decedents under 65 years old.[35-38] According to recent Medicare data, for a beneficiary who dies of cancer after receiving conventional care, $30,397 (in 1995 dollars) is spent on medical care in the last year of life.[39,40] Fully 33 percent of the last year's costs ($10,118 in 1995 dollars) are spent in the last month of life, and 48 percent ($14,507 in 1995 dollars) in the last two months of life. (The available data do not define costs in any smaller increments of time.)

ESTIMATED COST SAVINGS FROM LEGALIZING PHYSICIAN-ASSISTED SUICIDE

Assuming that (1) 2.7 percent of patients who die each year (62,000 Americans) would choose physician-assisted suicide, (2) these patients would forgo an average of four weeks of life, and (3) the medical costs in the last month of life for each patient who dies are $10,118 (in 1995 dollars), we estimate that legalizing physician-assisted suicide and euthanasia would save approximately $627 million in 1995 dollars (Table 1). This amount is less than 0.07 percent of total U.S. health care expenditures.

OVERESTIMATION AND UNDERESTIMATION OF COST SAVINGS

This calculation may produce a considerable overestimate of savings. In six ways, the calculation is biased to inflate the savings. First, we assumed that U.S. physicians would fulfill their patients' requests at the same rate that Dutch physicians do. Yet in the Netherlands 53 percent of physicians have provided assistance with suicide or administered euthanasia, and just 4 percent state that they would neither do so nor refer a patient to another physician who would.[29,31] In contrast, surveys of American physicians suggest that a substantial majority would refuse to provide assistance with suicide, even if it were legalized.[25,26,41,42] Unless legalization greatly altered physicians' practices, having fewer American physicians willing to assist in suicide would probably mean that fewer American patients would receive such assistance.

Second, we estimated the average amount of life

TABLE 1. Estimated Cost Savings from the Use of Physician-Assisted Suicide by Patients with Cancer Who Receive Conventional Care (in 1995 Dollars).

Percent (No.) Who Would Use Physician-Assisted Suicide	End-of-Life Health Care Costs			
	Average Medicare costs — Part A and Part B		Twice the average Medicare costs — Part A and Part B	
	In Last Mo of Life ($10,118)	*In Last 2 Mo of Life ($14,507)*	*In Last Mo of Life ($20,236)*	*In Last 2 Mo of Life ($29,014)*
	dollars			
2.7 (62,000)	627 million*	899 million	1.25 billion	1.80 billion
3.4 (78,000)†	789 million	1.13 billion	1.58 billion	2.26 billion
5.0 (115,000)	1.16 billion	1.67 billion	2.33 billion	3.34 billion
7.0 (161,000)‡	1.63 billion	2.34 billion	3.26 billion	4.67 billion

*This amount represents the most reasonable estimate of cost savings.

†This percentage is the proportion of all cases of euthanasia and physician-assisted suicide in the Netherlands, including the cases of euthanasia in which patients did not provide current consent. The number extrapolates the Dutch percentage to the U.S. population.

‡This percentage is the proportion of all dying patients who make inquiries about or request euthanasia or physician-assisted suicide in the Netherlands. Approximately one third of such inquiries and requests are answered or honored. The number extrapolates the Dutch percentage to the U.S. population.

forgone by patients who die as a result of physician-assisted suicide at four weeks, which may be too high. The average time forgone by Dutch patients who receive euthanasia with their consent is less than 3.3 weeks, with 59 percent forgoing 1 week of life or less. Clearly, the more life forgone, the greater the projected savings. In addition, Dutch physicians estimated that 8 percent of the patients who died as a result of physician-assisted suicide or euthanasia would have lived longer than six months[29,30]; such patients are not "terminally ill," as defined by Oregon's law governing physician-assisted suicide and most American proposals for legalization, and thus would not be permitted to receive a physician's assistance with suicide in the United States.

Third, we calculated the savings by using the costs of care for patients with cancer and generalized these costs to all patients who might choose physician-assisted suicide. Yet because of the intensity of their care, patients with cancer have some of the highest costs at the end of life.[33,34] Patients with other diseases, such as multiple sclerosis or amyotrophic lateral sclerosis, who might choose physician-assisted suicide are likely to have lower overall medical costs and thus are likely to represent less money saved.

Fourth, when calculating the costs at the end of life, we used the costs for patients receiving conventional care for their cancers. The medical expenditures for patients who receive hospice care during the last two months of life are substantially lower than those for patients receiving conventional care ($9,548 vs. $14,507 in 1995 dollars), suggesting that the savings from physician-assisted suicide would be less for patients receiving hospice care.[31,40-42]

Fifth, recent surveys indicate that some terminally ill patients in the United States have died as a result of physician-assisted suicide or euthanasia, although it is impossible to determine precisely how many.[25,26,43] The cost savings realized from these cases in which death was hastened are already accounted for in the health care system and are double-counted in our calculation.

Finally, we have not included the additional costs that legalizing physician-assisted suicide would entail. Proposals for legalization include the requirement that a second physician confirm that the patient is terminally ill and understands the implications of requesting a physician's assistance with suicide. Some proposals would mandate a psychiatric evaluation of patients making such a request. Others, such as Oregon's Death with Dignity Act (Measure 16), require referral of patients for counseling if they might have depression or another psychiatric disorder. Measure 16 also requires the state to assemble statistics on the use of physician-assisted suicide. There is likely to be litigation, such as investigations and prosecutions of physicians who violate the safeguards. All these activities would increase the medical and legal costs, thereby reducing the net savings from physician-assisted suicide.

Conversely, several considerations suggest that these calculations may underestimate the potential savings from physician-assisted suicide. Our use of Medicare costs at the end of life might have caused us to underestimate the total health care costs and therefore the potential savings. According to some, the average Medicare costs for care at the end of life do not accurately reflect the costs for all dying patients, especially for patients in tertiary care facilities. Also, Medicare Part A and Part B do not cover all health care costs; indeed, substantial costs, predominantly nursing home costs, are not included.[34,40] However, in the Netherlands, euthanasia and physician-assisted suicide are quite rare among patients in nursing homes — just 2 percent of all cases — suggesting that the absence of nursing home costs from these calculations does not produce a large underestimate.[30,31]

In addition, in the United States, family members provide substantial care for dying patients, adding to the overall costs of care at the end of life.[44] Because there are no studies that accurately quantify the financial costs of family care for dying patients, such costs are not usually computed in the assessments of health care costs at the end of life.[40] By ending patients' lives earlier, physician-assisted suicide would reduce the costs associated with family care. There is currently no way to quantify these savings.

To acknowledge the uncertainty in these estimates, Tables 1 and 2 present analyses of the savings in various circumstances, varying the proportion of the population that might choose physician-assisted suicide, the amount of life forgone, and the expenditures for medical care at the end of life. The lower bound of savings assumes that 2.7 percent of dying Americans (62,000) might choose physician-assisted suicide, forgoing four weeks of life and using hospice care at the end of life. These assumptions produce a savings of $336 million (Table 2). Conversely, the most inflated assumptions are that 7.0 percent of dying Americans (161,000) might choose physician-assisted suicide, forgoing an average of eight weeks of life at twice the average Medicare expenditures ($29,014). These assumptions produce savings of $4.67 billion.

MANAGED-CARE PLANS AND COST SAVINGS FROM PHYSICIAN-ASSISTED SUICIDE

Although the total national savings from the legalization of physician-assisted suicide might be small, there is concern that price competition might still tempt managed-care plans to encourage the practice. Several of the amicus briefs submitted to the Supreme Court raised this specter: "It is certainly plausible and perhaps even likely that budget-minded health care organization managers and their physician-employees would press their dying patients toward exercising [a right to receive a physician's assistance with suicide]" and "agonized and depressed patients would elect to have their deaths facilitated since their relievable suffering went unalleviated because of their health providers' financial imperatives."[23,24] In the abstract this claim seems implausible, since one of the principal ways managed-care plans save money is by enrolling healthier members, including healthier Medicare beneficiaries, who are less likely to be terminally ill. Nevertheless, it may correspond to the motives of some managed-care executives and certainly seems to express public suspicions. How much would managed-care plans save by encouraging the use of physician-assisted suicide?

TABLE 2. ESTIMATED COST SAVINGS FROM THE USE OF PHYSICIAN-ASSISTED SUICIDE BY PATIENTS WITH CANCER WHO RECEIVE HOSPICE CARE (IN 1995 DOLLARS).

PERCENT (NO.) WHO WOULD USE PHYSICIAN-ASSISTED SUICIDE	END-OF-LIFE HEALTH CARE COSTS			
	AVERAGE MEDICARE COSTS — PART A AND PART B		TWICE THE AVERAGE MEDICARE COSTS — PART A AND PART B	
	In Last Mo of Life ($5,413)	*In Last 2 Mo of Life ($9,548)*	*In Last Mo of Life ($10,826)*	*In Last 2 Mo of Life ($19,096)*
	dollars			
2.7 (62,000)	336 million	592 million	671 million	1.18 billion
3.4 (78,000)*	422 million	745 million	844 million	1.49 billion
5.0 (115,000)	622 million	1.10 billion	1.24 billion	2.20 billion
7.0 (161,000)†	871 million	1.54 billion	1.76 billion	3.07 billion

*This percentage is the proportion of all cases of euthanasia and physician-assisted suicide in the Netherlands, including the cases of euthanasia in which patients did not provide current consent. The number extrapolates the Dutch percentage to the U.S. population.

†This percentage is the proportion of all dying patients who make inquiries about or request euthanasia or physician-assisted suicide in the Netherlands. Approximately one third of such inquiries and requests are answered or honored. The number extrapolates the Dutch percentage to the U.S. population.

One large managed-care plan currently enrolls approximately 1.7 million adults and has an annual budget of almost $4.5 billion. In 1995, approximately 13,000 of the enrolled adults died, including 3800 who died of cancer. Over the last six months of life, the mean cost for patients enrolled in this managed-care plan who died of breast cancer was $21,329 (in 1995 dollars), with about $9,500 spent in the last month of life.[45] Assuming that 2.7 percent of the patients who died would have chosen physician-assisted suicide (351 patients), forgoing an average of four weeks of life at an average savings of $9,500, the managed-care plan's expenditures would have been reduced by $3.3 million, or less than 0.08 percent of its total budget. For other managed-care plans that tend to have higher proportions of young, healthy patients with lower death rates, the absolute and relative savings are likely to be even smaller.

FAMILIES AND COST SAVINGS FROM PHYSICIAN-ASSISTED SUICIDE

Although the cost savings to the United States and most managed-care plans are likely to be small, it is important to recognize that the savings to specific terminally ill patients and their families could be substantial. For many patients and their families, especially but not exclusively those without health insurance, the costs of terminal care may result in large out-of-pocket expenses.[44] Nevertheless, as compared with the average American, the terminally ill are less likely to be uninsured, since more than two thirds of decedents are Medicare beneficiaries over 65 years of age. The poorest dying patients are likely to be Medicaid beneficiaries. Extrapolating from the Medicare data, one can calculate that a typical uninsured patient, by dying one month earlier by means of physician-assisted suicide, might save his or her family $10,000 in health care costs, having already spent as much as $20,000 in that year. Some patients using intensive medical services may incur considerably higher health care costs. If uninsured nonhospice patients with cancer were to choose physician-assisted suicide six months before their natural deaths — the earliest point permitted under current proposals — the average savings for the family could be $20,000. Although the overall national savings from legalizing physician-assisted suicide might be small, for many families — especially those of uninsured patients — the savings could be substantial. What savings level, if any, would motivate families to pressure patients into requesting a physician's assistance with suicide is a matter of speculation but one that cannot be ignored.

WHY ARE THE COST SAVINGS FROM PHYSICIAN-ASSISTED SUICIDE SO LOW?

The estimated cost savings from permitting physician-assisted suicide are lower than many people expect. One reason for this disparity is the frequent overestimation of how much is spent on medical care at the end of life. One commentator claimed that "some 70 to 90% of our health care dollar is spent on the last few months of life."[17] Others have suggested that the costs of care for dying patients account for almost 30 percent of all health care expenditures.[10] In fact, each year about 10 percent of expenditures for medical care involves patients who die.[40] The less spent on patients who die, the smaller the cost savings from physician-assisted suicide.

Another reason may be that people overestimate the number of Americans who die each year. Less than 1 percent of Americans die each year. Of these, many would be unable or ineligible to request a physician's assistance with suicide, even if it were legalized: newborns with serious birth defects, minors, victims of trauma, persons who die suddenly from myocardial infarctions or strokes, and patients with dementia. More important, if Americans were to choose physician-assisted suicide at the same rate as the Dutch choose euthanasia, only 0.027 percent of Americans might choose physician-assisted suicide if it were legalized. Put another way, more than 99.97 percent of Americans would continue to receive the usual health care at the usual cost. Because physician-assisted suicide would not affect the health care provided to the vast majority of Americans, it would not substantially reduce overall health care costs.

Finally, physician-assisted suicide is not an option most people would be likely to choose much before their "natural deaths." As the Dutch data demonstrate, the average amount of life forgone by all patients electing euthanasia or physician-assisted suicide is less than four weeks.[30,31] Although the care given in the last four weeks of life accounts for a considerable proportion of health care costs, it still represents only 33 percent of all medical expenditures during the last year of life and an even smaller fraction of lifetime health care expenditures.[39,40] Considering the small fraction of Americans who would choose physician-assisted suicide, the small fraction of life they would forgo, and the small fraction of total health care expenditures associated with their care, the savings that would result from the legalization of physician-assisted suicide represent a very small fraction of total health care expenditures.

CONCLUSIONS

Drawing on data from the Netherlands on the use of euthanasia and physician-assisted suicide and on available U.S. data on costs at the end of life, this analysis explores the degree to which the legalization of physician-assisted suicide might reduce health care costs. The most reasonable estimate is a savings of $627 million, less than 0.07 percent of total health care expenditures. What is true on a national scale is also likely to be reflected in the potential savings for individual managed-care plans. Physician-assisted suicide is not likely to save substantial amounts of money in absolute or relative terms, either for particular institutions or for the nation as a whole.

We are indebted to Dr. Paul van der Maas, Dr. Miles Brown, Dr. Jane Weeks, David Guberman, Dr. Jay Jacobson, Dr. Jeff Botkin, Dr. David Green, Dr. Leslie Francis, Evelyn Kasworm, and Jan Van-Riper for helpful ideas and criticisms of the manuscript.

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The Heart of the Matter

Proponents and opponents of Medical Aid in Dying have staked out their territory. These are caring, hardworking, and responsible citizens who have explored the factual, experiential, and emotional aspects of the proposed legislation.

The proposed Minnesota End-of-Life Option Act, HF1930 and SF 1830, legalizes terminally ill, mentally capable adults with a prognosis of six or fewer months to live, the option to request, obtain, and self-ingest medication to die peacefully during sleep if their suffering becomes unbearable. The Act carries with it strict written protocols and safeguards, patterned after a similar bill in Oregon where not a single case of abuse has been documented for twenty-five years. No one involved in the process is required or coerced to participate. These protocols are the heart of the matter.

The 2023 Minnesota State Fair Poll shows 73.2% of State Fair Goers— a total of 5,844 in-person responses that cross all party lines, all geographics, all circumstances for people with disabilities, and all religions— *desire this proposed legislation*. And, what about those who answered “no” or were “undecided”? If this option was not for them, might they have considered listening to an expanded heart and offering this end-of-life care to someone who was just like them—another loved one, co-worker, friend, neighbor, or total stranger? This is the heart of the matter.

With great interest, I followed the interim hearing of the House, Health, Finance and Policy Committee, held on January 25, 2024. Poignant, respectful, and passionate testimony expressed both sides of the issue. During floor discussions, the opposition didn’t want to rush into anything—citing the potential for incorrect diagnoses or miracle recoveries, the possibilities of future medical breakthroughs, and focused guarantees. These circumstances involve pure speculation. Speculation does not serve real time, excruciating suffering that is happening for terminally ill patients right now. Most hospices recognize that the pain level of twenty-five percent of terminally ill patients cannot be relieved by any available medication. These Minnesotans can’t wait. We need balanced, heart-championed options.

Have we honestly considered another’s circumstances? What might it be like to live as a person who is terminally ill with unimaginable pain—hour after hour—knowing that Voluntarily Stopping Eating and Drinking (VSED) was the only recourse? Our fears may prevent us from a candid assessment. Can we meet our fears of what others might think, of heart wisdom equating to weakness, or of making the wrong decision? Can we be courageous and think beyond ourselves? These questions are the heart of the matter.

Let us step back from these influences to feel and think as a united Minnesota House and Senate, making autonomy in death for terminally ill individuals an unquestionable, positive right. Imagine the joy and tenderness patients would feel while surrounded by loving family and friends, peacefully connecting with their inmost heart, contented with the consciously dying process, and releasing their excruciating suffering on their own terms. Offer a choice. If not for you, for someone else. Pass the Minnesota End-of-Life Option Act. Heart matters.

Barbara Krause

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Written Testimony from Susie Collins Against the H.F. 1930/S.F. 1813 Proposed Physician-Assisted Suicide Bill

My name is Susie Collins of Shorewood (Excelsior), MN. This is my written testimony that I would like all MN House Representatives & Senators to read stating that I am vehemently opposed to the radical, unethical H.F. 1930/S.F. 1813 Physician-Assisted Suicide Bill!

It is sickening to see how many of you lawmakers are against life at any stage for certain individuals & if this Physician-Assisted Suicide Bill is adopted into law, you will have even more blood on your hands than you already have! It is not up to the government to make laws that legalize & encourage euthanizing our people who may be terminally ill, disabled, mentally unfit, elderly, unwanted or in any other state of health. You are not God & human beings are not dogs or cats that can be put down when they are deemed sick, dying, etc. We, human beings, are made in the image of God & we have a human soul. I am Catholic & we are taught that suffering is redemptive & purifying. By killing someone by assisted suicide or any other way, you are hurting that person who is suffering more because the suffering may be there for them to endure to lessen their time in purgatory so to be received into heaven sooner. The suffering can also be used to mitigate the wrath of God for the atrocious things being done by others in our world, etc. Ending a life prematurely has a negative impact on all of humanity, not just the person who dies. You are also putting physicians, nurses & other healthcare workers in a terrible position where they would be asked to end the lives of their patients rather than trying to save their lives.

You never know when a miracle will occur. My father, James Markley, was one of those miracles. He came to live with us after he was put in hospice by his VA Medical Doctors. He received the finest care with the hospice team, the Minneapolis VA Medical Center & our family. Papa graduated out alive after 6 months in hospice (only 5% have this happen) & lived a total of 4 ½ years from the time he had entered hospice! He died a peaceful man who was given the time to be with his family & get his affairs in order & the suffering he endured I'm sure helped us all & united him with Jesus on the Cross. Under this horrific bill, my dear father would have probably been given pills to end his life because it is less expensive to kill a human being than for the insurance companies & our government to pay to treat them & keep them alive!

Please do not pass this bill. It is morally & ethically wrong & those who endorse it will be judged harshly by God.

Respectfully,

Susie Collins, Shorewood (Excelsior), MN

MN House Commerce Committee
Written Testimony HF1930
State Office Building, Room 10
March 18, 2024

As a person with a disability, I have serious concerns about how HF1930 would affect the safety and well-being of vulnerable persons, such as the elderly and those with disabilities.

Although this law currently applies only to people with a terminal illness, ***guidelines in other places have expanded from terminal illness to include people with disabilities***.

In 1980, I became paralyzed in a car accident, I spent the next year and a half in various hospitals. During that time, I fell into a deep depression, and I just wanted to die. But I'm so grateful that assisted suicide was not available, and that those around me gave me what I really needed – good medical care, counseling, access to disability services, and lots of prayer and loving support.

Based on my experience, I see at least two troubling consequences of HF1930.

First, people may be ***denied access to disability services***, such as sufficient PCA care and certain needed medical equipment. In Canada, Christine Gauthier, a paralyzed veteran, requested a wheelchair ramp. She was told that they could not provide a ramp, but they could offer her medical aid in dying.

Or perhaps more serious, they may be ***denied life-saving medical treatments***. Decisions about medical procedures seem to be shifting from doctors and patients to bureaucrats whose job it is to save money. It will become more and more tempting to deny expensive—but needed—medical care in favor of much more economical physician assisted suicide.

Second, if people are not able to get the medical care and services they need to survive, and instead are offered physician assisted suicide, some will likely ***choose suicide out of desperation***. Or worse, they may be ***pressured by others*** to choose such a course.

Once we open the door to this type of legislation, there is no way to guarantee the safety and well-being of our most vulnerable citizens. I respectfully ask you to please vote no on HF1930.

Jean Swenson 64B
MA Counseling Psychology
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3/15/24

RE: support of HF 1930

Dear Committee Chair Stephenson and Members of the House Commerce Finance and Policy Committee:

I write in support of HF 1930

As a surgeon with nearly 40 years accompanying my patients with head and neck cancers from diagnosis to cure or through every step leading to death, I took an oath to do no harm and to be an advocate for my patients. My role as healer at the end of life is to provide comfort and care, respect the patient's values and respond to their needs. This includes supporting their decision to utilize medical aid in dying. Many believe the suffering at end of life is primarily pain, but for my patients there is much more – disabling and disfiguring surgery, worsening airway compromise with air hunger and asphyxiation, ongoing bleeding and weeping body fluids from lesions extending through the skin, and the foul smell of necrotic and infected tissue which can be so severe that one patient could not see his grandchildren not wanting them to remember him for the odor that permeated his house.

Please support HF 1930 as our best next step to alleviate the suffering of Minnesotans living and dying every day.

Thank you for your good work!

Sincerely,
Michael Tedford, MD
3932 Abbott Avenue South
Minneapolis

Every year at the Minnesota State Fair, attendees are surveyed on a variety of issues. Regularly, an overwhelming percentage of Minnesotans vote in favor of expanded end-of-life options. As life-long Minnesota residents now in advancing years we urge your support of the End-of-Life Option Act (HF 1930) during the current legislative session. After ten years of legislative inaction, the time is NOW for legislative approval of this most fundamental aspect of an individual's liberty and personal autonomy.

Minnesotans should have the freedom to choose end-of-life care that reflects their values, priorities, and beliefs.

For us, this issue is personal. My wife and I experienced first-hand the need for the Minnesota End-of-Life Option Act and want this choice available to us should the need ever arise. Specifically, several years ago my wife's uncle was diagnosed with incurable lung cancer which metastasized throughout his body. He was in excruciating pain for months prior to his death. All treatments were unsuccessful, and the health provider discharged him from the hospital with a prognosis of only months left to live, and refused to prescribe pain sufficient pain medication because they were concerned he may become addicted (as a dying man!). My wife's uncle died a horrible death in great agony while family members stood by helpless to relieve his suffering for months.

Ten states and the District of Columbia authorize medical aid in dying, providing decades of experience and data showing that the practice works safely as designed. No "slippery slopes!" We want to see Minnesota become the first in the Midwest to authorize this legislation. Access to a peaceful death should not depend on where you live, or on what a legislator's private beliefs may be on the matter. It should be a matter of bodily autonomy and personal choice at every stage of life!

Enough states have model protocols in place that are demonstrably effective at making certain that individuals who make an end-of-life choice are protected. Please lend your support during this legislative session to ensure the legislation becomes law in Minnesota.

The Minnesota End-of-Life Option Act provides protections for both the patients and the health care providers. It is completely optional; no one is required to participate, and at least two clinicians must confirm that patients qualify and are acting of their own volition. The option is only available to an adult who has six months or less to live, is able to make an informed health care decision and is able to take the medication themselves.

Give terminally ill Minnesotans the option to die on their own terms. Vote to support the End-of-Life Option Act (HF 1930) in the current legislative session.

Sincerely,

Mr. James R. Reynolds and
Mrs. Nancy M. Reynolds
4455 W 7th St Winona, MN 55987-1603
jreynold@hbci.com