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Minnesota Citizens Concerned for Life
www.mccl.org

The Hon. Sen. Sheran and Members of the Health, Human Services and Housing Committee:

Minnesota Citizens Concerned for Life (MCCL) urges you to oppose S.F. 1880, which would legalize assisted suicide in Minnesota. As a nonprofit organization of more than 70,000 members, MCCL has worked since 1968 to protect innocent citizens from threats to human life, including euthanasia and assisted suicide.

S.F. 1880 poses serious risks to vulnerable lives. These risks include the following:

Abuse. Persons faced with a serious diagnosis can become targets for abuse from caregivers, health care providers, insurance companies and heirs. The abuse of people with disabilities and the elderly is rising. An heir or abusive caregiver may steer someone toward assisted suicide, witness the request, pick up the lethal dose, and even give the drug. No witnesses are required at the death—there are no safeguards at all once the drug has been dispensed.

S.F. 1880 would also lead to other kinds of pressure and coercion. After legalization, public and private insurers have a financial incentive to steer patients toward suicide rather than life-extending treatment. Some Medicaid patients in Oregon have been denied expensive treatment and offered assisted suicide instead.

Misdiagnosis. The bill relies on correctly diagnosing that a patient has less than six months to live. But such predictions are inexact and often mistaken. Physicians make their best estimates of the outcome of cancer or other diseases, but they are not infallible. Many people we know have lived for years and even decades after receiving a six-months-to-live diagnosis. In both Oregon and Washington, patients receiving lethal prescriptions have lived more than 1,000 days before dying by suicide—that means they lived years beyond the (mistaken) six-month diagnosis. Moreover, the bill's definition of "terminal illness" does not exclude chronic conditions that would cause death if left untreated. A person with diabetes, who simply needs insulin to live, could qualify for assisted suicide under S.F. 1880.

No protection for the mentally ill. The bill does not require that a patient undergo psychiatric evaluation before receiving the lethal prescription. (The decision to refer for evaluation is left to the prescribing physician.) Yet as a study published in the *American Journal of Psychiatry* concluded, "The desire for death in terminally ill patients is closely associated with clinical depression—a potentially treatable condition—and can also decrease over time."

In Oregon and Washington, only a tiny fraction of assisted suicide patients first receive counseling. A *British Medical Journal* study of patients in Oregon found that "the current practice of the Death with Dignity Act may fail to protect some patients whose choices are influenced by depression from receiving a prescription for a lethal drug." Suffering people deserve treatment and support, not killing.

Many disability organizations and medical groups oppose legalization. As the American Medical Association warns, "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." In agreement with these organizations, MCCL opposes the legalization of assisted suicide and urges you to vote against S.F. 1880.

Kristy Graume

From: Soneral, Steven (DO) <steven.soneral@parknicollet.com>
Sent: Monday, March 14, 2016 1:43 PM
To: Kristy Graume
Subject: SF 1880

Dear Members of the Minnesota State Senate and the Health, Human Services, and Housing Committee,

I am a board-certified Family Physician, and I am writing this letter to express **strong opposition** to S.F. #1880.

Physician-assisted suicide has no place in the practice of ethical medicine. Both the American Osteopathic Association (AOA) and the American Medical Association (AMA) have released position statements in opposition to it. In accordance with the AMA, "physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."

It is my privilege to serve as a physician and to holistically care for the physical, emotional, and spiritual health of my patients. In humility, and on their behalf, the sovereignty to decide the timing of death is not mine. Well-trained, compassionate, holistic physicians understand the complexities of end-of-life care. The issues leading to a desire of a person to end one's own life are likely to be a result of many variables, not a solitary issue with suffering. When the complexity of human end-of-life arises, our responsibility is to care for all of the physical, emotional, and spiritual needs of our patients, not to extinguish lives. Reductionism to the point of undignified euthanasia is an abhorred thought if considered within the realm of healthcare. With respect to my patients, the dignity of all Minnesotans, and for the holistic well-being of our state, please disapprove this bill.

Sincerely,

Steven Soneral, DO
Diplomat of the American Osteopathic Board of Family Physicians
300 Lake Drive East, Chanhassen, MN 55317

From: David Sorley <drdsorley@gmail.com>
Sent: Saturday, March 12, 2016 8:03 AM
To: Kristy Graume
Cc: Sen.Tony Lourey; Sen.Melissa Wiklund
Subject: I oppose SF 1880

Dear committee members,

As a Minnesota citizen, University of Minnesota trained physician and promoter of community health, I oppose SF 1880 since it permits a physician to prescribe life-ending medications. This is in direct contradiction of the Hippocratic oath which I took in 1969 and still live by. *"I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."* Hippocratic Oath

I regret that your hearing is scheduled while I am travelling in India promoting community health and therefore will not be able to again speak against this bill. I believe that SF 1880 also against my Christian belief that God alone is the giver of life and that it is wrong to assist in taking life.

Please do not permit this bill to pass your committee.

Sincerely yours,

David L Sorley MD, MPH
1125 Edgewater Ave
Arden Hills MN 55112

Phone number in India: 91-98211-20364
Phone in Minnesota after 3/17/2016: 651-765-0101

Kristy Graume

From: bradley@mtaas.org
Sent: Friday, March 11, 2016 4:14 PM
To: Kristy Graume
Subject: Testimony on SF 1880 for Committee members

Dear Members of the Health, Human Services and Housing Committee,
I take exception to the polling on assisted suicide.
I have found (serving 60 fair booth days) that about half of the public thinks they are in favor of such a law, that is until they learn about the flaws in the laws that create new paths of elder abuse with immunity. Once they learn that a predatory heir may steer the signup process and then forcibly administer the lethal dose without oversight, they all said, "I am not for that!".
Anyway all of these Oregon Model bills have the same flaws that eviscerate flaunted safe guards.
For example how many times have you nodded your head when the proponents declared that the lethal dose must be self-administered?
Well, read the language of the law/bill and you will find that there is no means provided to insure that marketing point. **For example "self-administrate" was mentioned 11 times in the 8 page Minnesota SF 1880 and yet there was no means provided to confirm that the lethal dose was forced on not, who would know if they struggled.**
In fact what is provided is that there may be no investigations allowed after the death (page 6 of 8 Subd. 12.
In addition allowing a stranger that claims to know how the person communicates may speak for them eviscerates all the intended safeguards, page 1 of 8 (e).
Along with allowing predatory heirs and staff to witness even as other family members are not required to be contact.

This is a very dangerous public policy that by their own records in OR and WA is establishing poisoning as the "medical standard of care" for people that have "feelings" of fear of the loss of autonomy.
We are all at risk of abuse by these poorly composed laws/bills.

At your service,
Bradley Williams
President
MTaas dot org
Hamilton, MT 59840
406 531 0937

Kristy Graume

From: Andria Canty <Andca@live.com>
Sent: Monday, March 14, 2016 8:25 PM
To: Kristy Graume
Subject: SF 1880-Assisted Suicide Bill

Greetings Kristy,
RE: SF 1880

I was just informed by the St. Paul Dioceses that this bill applies to Assisted Suicide. Mark me down as a strong opposer please!!! It might interest you to know that I am the daughter of the Late Mabel L. Canty. She was a fine woman who worked for the House of Representatives-St. Paul, for several years.

Upon her emergency arrival at St. Joseph's hospital December 9, 2014 she was in critical condition, having aspirated at the Assisted Living Facility-- White Pines in Mendota Heights. She was intubated at the facility (Even that handling I have challenged). Nevertheless, her ER Dr. Patel said that she "Couldn't properly vent my mother, after hours of working on her".

Dr. Patel gave me an ultimatum. Stating " If I didn't call for them to stop efforts, then she would write the order for them to do so". Granted the Dr. had given my mother a few injections to keep her heart going; and couldn't seem to stabilize mom, so that she could transport her in for an MRI-More definitive image than an X-Ray of her lungs. Moreover, Mom and I had met about a month and a half prior to that night with her Nurse Practitioner at Minnesota Oncology to amend her Directive for Full Code. Please be aware subsequent to our meeting with the Nurse Practitioner, on an occasion of Care; a different nurse met privately with my mother and got her to sign a DNR. Within the clauses of the updated directive mom insisted on two conditions 1) If quality of life was badly jeopardized she asked that I let her go and 2) If the Doctor said that her quality of life was vegetative, permit the Doctor to let her pass. I was left to follow my mother's wishes under the duress of the Physician.

To this day I ponder did Dr. Patel really do all that she could, or was my mother just another statistic? Did I do the right thing in following the Doctors advise? Was there any possibility that a few days time she would have stabilized? Did I buy the lie?

The down side yes is that my had lung cancer, and her chemotherapy treatment at that time was aggressive. During our recent meeting with her oncologist, we were given a prognosis of 6 months to a year. Only God knows the truth, for which I have asked forgiveness In the chance that I made a wrong decision.

Just as respecting Life from the womb demands dignity, so does death! What would it have been to have sustained mom's intubation until a reasonable chance a peaceful and natural death could have been given not only to Mabel L Canty, but to everyone?

On behalf of my mother Mable L. Canty, I hope that she is doing some of her finest work for the House of Representatives in death, even greater than she did in life.
Kristy, please share this testimony!

From: Paul Post <rppost@citlink.net>
Sent: Saturday, March 12, 2016 3:47 PM
To: Kristy Graume
Subject: Physician Assisted Suicide Bill

Dear Ms. Graume: I am unable to attend the hearing on this topic tentatively scheduled for this coming Wednesday. I want to write to voice my opposition to any bill that would legalize physician assisted suicide. This practice contradicts our role as healer and would harm the trust between a physician and his/her patient. This would be difficult to control and has often led to a slippery slope (Netherlands and Belgium) where after a few years, not only those who are terminally ill, but eventually those with disabilities (whether young or old) are included in those eligible for physician assisted suicide. Also, the argument that it is necessary to relieve suffering is not really valid, with the availability of many options for pain relief with modern and compassionate hospice care. Please pass on this opposition at the hearing this Wednesday.

R. Paul Post, MD
Family Physician
30901 Minnesota Ave.
Lindstrom, MN 55045

Kristy Graume

From: Jim <schweppes@peoplepc.com>
Sent: Monday, March 14, 2016 10:31 AM
To: Kristy Graume
Subject: SF 1880 and physician-assisted suicide bill

I ask the Senate Health, Human Services and Housing committee to reject the SF 1880 and physician-assisted suicide bill. No government at any level has the right to approve physician assisted suicide or suicide in general. The unalienable right to life stated in the Declaration of Independence is one of the basic rights of personhood. It is not a right granted to people by government, but one endowed to man by man's creator. Government is instituted to protect this unalienable right, not to violate it.

I lost both of my parents to cancer. My family and I honored their lives by caring for them with compassion, mercy and love until they ultimately died. It is not compassionate, merciful or loving to cut short a life no matter how difficult it may become. Life is a gift to be cherished at all stages despite any difficulties we may encounter.

The founders of our country pledged their Lives, Fortunes and sacred Honor to enshrine and protect the self-evident truths and unalienable rights placed at the heart of our republic. As elected leaders of our state, you are tasked and obligated to uphold this unalienable right to life just as our founding fathers did. To do any less is an affront to all of us, including yourselves.

James Wallrich
1243 Danforth Street
St. Paul, MN 55117
651-489-4338

Sarah Coleman – SF 1880 Testimony

My name is Sarah Coleman and I have been working with my fellow Macalester student Emmet Hollingshead in advocacy of this bill being passed. In the fall of last year, we took a class on argument and advocacy of policy, and we decided to focus our efforts on the Compassionate Care Act. After submitting our letter to Project Pericles's Debating for Democracy event and attending a conference in New York, we were given a grant to continue our work in supporting this bill. Over the past year and a half, we have become passionate in the fight for providing Minnesotans with autonomy and self-determination in their end of life care, something that this bill will truly ensure. I can say from experience with my grandmother's passing in November of 2014 that witnessing a loved one make independent decisions at all stages of their life is a source of great comfort to both the patient in question as well as their grieving family. The Compassionate Care Act will allow terminally ill Minnesotans to act in sovereignty and liberty during a time in their lives where these aspects of decision making are most crucial.

Minnesota Senate Health, Human Services and Housing committee
Chair: Kathy Sheran; Vice Chair: Melissa Wiklund;
Ranking Minority Member: Michelle Benson

Re: S.F. 1800 Minnesota Compassionate Care Act of 2015
Date: March 16, 2015, 12:00 / 4:30 P.M.
Location: Room 1200 Minnesota Senate Building

In opposition to S.F. 1800 Minnesota Compassionate Care Act of 2015

Kirk C. Allison, Ph.D., M.S.
Director,
Program in Human Rights and Health,
School of Public Health, University of Minnesota

Contact Information:
Program in Human Rights and Health
University of Minnesota School of Public Health
420 Delaware Street SE, MMC 197
Minneapolis, MN 55455
Tel. 612-626-6559
Email: alli0001@umn.edu

Chair Sheran, Vice Chair Wiklund, Ranking Member Benson, and distinguished Committee members:

I appreciate the opportunity to think together with this committee and those gathered here regarding S.F. 1800. My name is Kirk Allison and I direct the *Program in Human Rights and Health* in the School of Public Health. I am a faculty affiliate with the *Center for Holocaust and Genocide Studies* and former Chair of the *American Public Health Association's Ethics Special Primary Interest Group*. I have had the privilege of being a Visiting Preceptor at the *Hennepin County Medical Examiner's Office*.

I have published concerning assisted suicide and public health,[1] on disability,[2] the rhetoric of rationing,[3] and on the history of lethality in medicine and public health.[4] I teach on health and human rights, global health, health disparities, vulnerable populations and related contexts and practices. Here I am speaking for myself.

- Today and through media we have a window on suffering and fears at the end of life and the need to address this suffering compassionately, which means to share in suffering alongside - as I witnessed caring for my father who had metastatic cancer including bone cancer - and not abandon.

- Do we lack compassionate care in Minnesota when palliative care is at its most developed, centuries, even millennia removed from Greek physicians who, with very few pain control measures, swore "I will give no deadly *pharmakon* to any one if asked, nor suggest any such counsel",[5] a policy still held by the American Medical Association?[6]

- We have heard moving accounts by and about Brittany Maynard and her battle with glioblastoma - the same condition of my friend Pierce Rodman Miller with whom I spoke on Sunday. Diagnosed in September 2009, his tumor made him immediately eligible for requesting a lethal prescription. He lives 5 years later given innovative treatment.

- Note: The qualifying 6-month prognosis window in Oregon[7] & in the present bill S.F. 1880 does not include benefit of treatment. Eligible would be:
    - All insulin-dependent with type 1 diabetes.

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[1] Allison KC (2010). Public health, populations and lethal ingestion. *Disability and Health Journal* 3:56-70.

[2] Allison KC (2013). What sorts of people should there be? From descriptive to normative humanity. *International Journal of Disability, Community and Rehabilitation* 5(2). Allison KC (2009). Human security, social cohesion and disability. *Review of Disability Studies*. 5(3):3-9.

[3] Dowd B, Allison K (2013). Improving the rhetoric of rationing. Health Affairs Blog. June 24-25, 2013.

[4] Allison KC (2011). Race hygiene, eugenics and the Holocaust: Antecedents and consolidations. *Routledge History of the Holocaust*. JC Friedman, ed. New York and London: Routledge. 45-58.

[5] "ούδώσω δὲ οὐδὲ **φάρμακον** οὐδενὶ αἰτηθεὶς **θανάσιμον**, οὐδὲ ὑφηγήσομαι συμ βουλίηντοιήνδε" - Oath of Hippocrates

[6] AMA. Opinion 2.211. Physician Assisted Suicide. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page

[7] ORS 127.800-127.995.

  - All on dialysis or with pancreatic cancer.
  - Jeannette Hall, declared terminal in 2000, yet alive.[8]
  - Despite <6-months prognosis, in Oregon "duration (days) between 1st request and death" ranged from 15 to 1009 days (nearly 3 years).
  - The *Washington Post* reports wide variation by state in individuals leaving hospice alive with 15-20% in Washington and Oregon ("15 percent has been typical, often because a patient's health suddenly improves").[9] All are eligible for a lethal prescription given the hospice benefit's statutory definition.

Much of the discussion we hear is in terms of individual autonomy and control, however the effects of such laws or not simply local but also general.

Brittany Maynard's videos are powerful and moving. But they may also be moving in unintended ways.

- British Colombian physician Will Johnstone reports a December 2014 emergency appointment with a 20 year old with no terminal diagnosis who was "acting oddly and talking about death":[10]

> During the appointment, I asked the young man if he had a plan. He said "yes" that he had watched Ms. Maynard's video, that he was very impressed and identified with her and that he thought it was a good idea for him to die like her. He also told me that after watching the video he had been surfing the internet looking for ways to obtain suicide drugs.

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[8] Affidavit of Jeanette Hall, Leblanc v. Canada (2013). https://choiceisanillusion.files.wordpress.com/2013/05/jeanette-hall-affidavit.pdf.

[9] Peter Whorlskey and Dan Peter, "Rising rates of hospice discharge in U.S. raise concerns about quality of care," *Washington Post*, 6 August 2014 http://www.washingtonpost.com/business/economy/leaving-hospice-care-alive-rising-rates-of-live-discharge-in-the-us-raise-questions-about-quality-of-care/2014/08/06/13a4e7a0-175e-11e4-9e3b-7f2f110c6265_story.html

[10] Will Johnston, MD, "My young adult patient became actively suicidal after watching a Brittany Maynard video." *Euthanasia Prevention Coalition Newsletter*, 166, 9/2015: p.4. http://www.epcc.ca/wp-content/uploads/2015/09/166-September-2015RGB.pdf

- Assisted suicide laws have passed first in states with very high baselines and generally increasing suicide rates.[11]

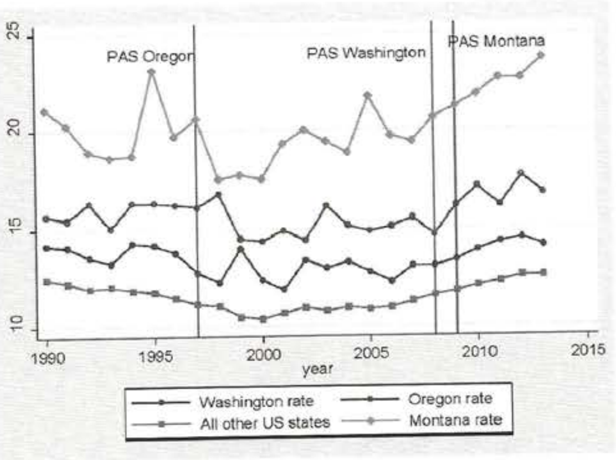

Fig. 2. Nonassisted suicide rates per 100,000 residents, PAS and non-PAS states, 1990–2013. Vermont is excluded because PAS was legalized in 2013 and no PASs were recorded in that year. The vertical lines indicate the timing of the legalization/decriminalization of PAS in each state. PAS, physician-assisted suicide. [12]

- Investigating Oregon, Washington and Montana from 1990-2013, including state time trends, UK authors Jones and Paton found total suicides significantly increased by +4% under 65 years and by +14.5% over 65 without a corresponding decrease in non-assisted suicide. Authors note such laws may normalize all suicide culturally supporting uptrends in those states.

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[11] Centers for Disease Control and Prevention (2013). "Suicide among adults aged 35-64 years - United States, 1999-2010." *Morbidity and Mortality Weekly Report (MMWR)* 3 May 2013 / 62(17):321-325. Per increases: Oregon 27.3/100K (+49%); Washington State - change not significant; Wyoming 31.1 (+79%); Vermont 19.8 (+58%); California 15.0 (+17%).

[12] Jones DA, Paton D (2015). "How does legalization of physician-assisted suicide affect rates of suicide?" *Southern Medical Journal* 108(10):559-605.

The association between PAS and total deaths by suicide is stronger for the older-than-65 group. There is no evidence that PAS is associated with significant reductions in nonassisted suicide for either older or younger people. Furthermore, estimates of the determinants of the mean age at suicide do not suggest that on average PAS leads to delays in nonassisted suicide.

It should be noted that the rise in overall rates of death by suicide and the absence of a fall in rates of nonassisted suicide are both net effects and do not necessarily mean that legalizing PAS has no suicide-inhibiting effects of the kind outlined by Posner and others.[19–21] Rather, the results suggest that if such inhibitory mechanisms exist, they are counteracted by equal or larger opposite effects. Drawing on resources from the social learning theory, Stack and Kposowa demonstrate that "persons socialized in nations with relatively high rates of suicide are more likely to be exposed to suicidal role models, which provide positive definitions of suicide."[3] Such mechanisms increase the level of individual approval of suicide and therefore reinforce the high rate of suicide within the culture. This is analogous to the effect of media reporting that "normalizes" suicide.[9,10,27] It may be that legalizing PAS also provides positive role models who help normalize suicide more generally.[28]

- Since 1998 in Oregon 25% of those requesting a lethal prescription were concerned with "inadequate pain control or concern about it"; 3% "financial implications of treatment"; 41% "burden on family, friends/caregivers"; 48% "losing control of bodily functions"; 79% "loss of dignity";[13] 90% "less able to engage in activities making life enjoyable" and 92% "losing autonomy"[14].

- These include physical, social and psychological concerns.

(Unlike Belgium, the Netherlands & Switzerland where psychiatric conditions or even being tired of life are eligible for physician assisted suicide or euthanasia, only physical, terminal illness is considered eligible in specific states.[15])

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[13] Asked first in 2003.

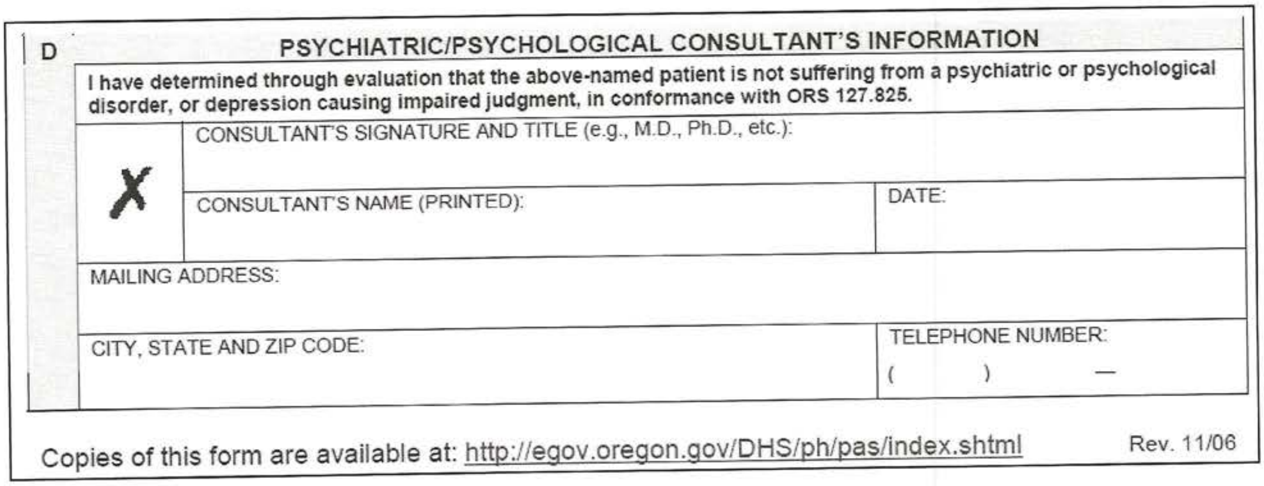
[14] Oregon Health Authority (2016). *Oregon Death with Dignity Act 2015 Data Summary.* Oregon Public Health Division, 4 February 2016, p.6. Subsequent summary statistics from this source. https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf

[15] Rachel Aviv, "The Death Treatment: When should people with nonterminal illness be helped to die?" *The New Yorker*, 22 June 2015. http://www.newyorker.com/magazine/2015/06/22/the-death-treatment.

Clinical depression and hopelessness in such contexts is not unusual. Hopelessness, involving meaning as well as prognosis, appears a stronger predictor of suicidal ideation than depression with terminal illness,[16] and depression more than pain.[17]

- Given this it is surprising only 5% in Oregon have been referred for psychological/psychiatric evaluation.[18]

- If referred for psychological evaluation, Oregon and Washington State's "Psychiatric /Psychological Consultant's Compliance Form" is a 'push-form' whose signature block is prefilled with an X indicating competency.



D **PSYCHIATRIC/PSYCHOLOGICAL CONSULTANT'S INFORMATION**

I have determined through evaluation that the above-named patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, in conformance with ORS 127.825.

X CONSULTANT'S SIGNATURE AND TITLE (e.g., M.D., Ph.D., etc.):

CONSULTANT'S NAME (PRINTED):

DATE:

MAILING ADDRESS:

CITY, STATE AND ZIP CODE:

TELEPHONE NUMBER:
( ) —

Copies of this form are available at: http://egov.oregon.gov/DHS/ph/pas/index.shtml Rev. 11/06

In Belgium women from ages 31 to 70 request euthanasia/assisted suicide for psychiatric reasons at over 3x the rate of men. Tienpont L et al. "Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study." *BMJ Open* 15(5): 1-9. http://bmjopen.bmj.com/content/5/7/e007454.full. An notable commentary with cautionary lessons from Netherlands and Belgium by two general proponents: Lerner BH, Caplan AL (2015). "Euthanasia in Belgium and the Netherlands: On a Slippery Slope?" JAMA Intern Med. 175(10):1640-1641. http://archinte.jamanetwork.com/article.aspx?articleid=2426425. Certainly there is no reprise of the 1942 *American Journal of Psychiatry*'s debate on killing severely mentally ill in U.S. institutions. Joseph J (2005). "The 1942 'euthanasia' debate in the American Journal of Psychiatry. History of Psychiatry." 2005 Jun;16(62 Pt 20:171-9.

[16] Chochinov HM et al.(1998). "Depression, hopelessness, and suicidal ideation in the terminally ill." *Psychosomatics* 39(4):366-370.

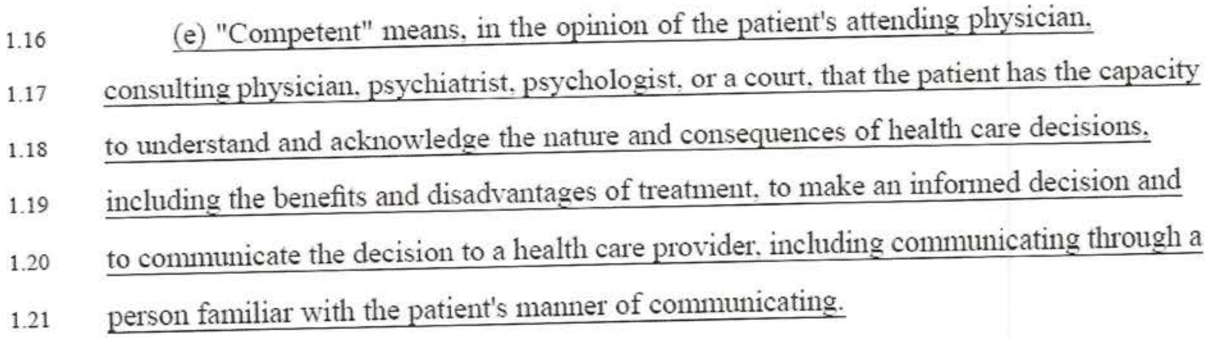
[17] Emmanuel EJ, Fairclough DL, Daniels ER, et al. (1996). "Euthanasia and physician-assisted suicide: attitudes and experience of oncology patients, oncologists, and the public." Lancet 347:1805-1810.

[18] 52 of 991 through 2015.

- There is no box for non-competency nor a reporting procedure for non-competency. A patient could shop 5 different psychiatrists with a 6th declaring the patient competent without any record or paper trail between the first five or notification of an oversight body.

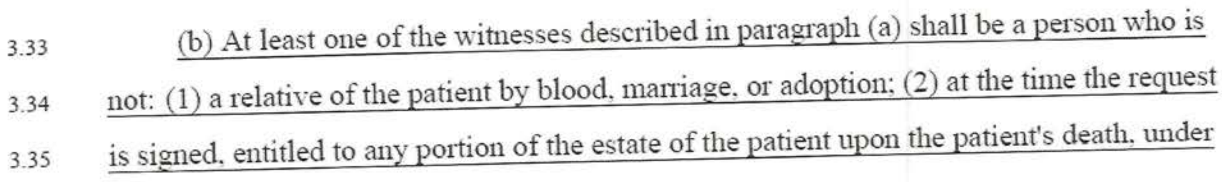
- There is no independent filing to the health authority, only through the referring doctor.

- Definitions of competency in Oregon, Washington, California and Minnesota (below) are compatible with untreated clinical depression and existential hopelessness: all that is required is understand that ingesting a lethal pharmacon will result in death amidst alternatives.



(e) "Competent" means, in the opinion of the patient's attending physician, consulting physician, psychiatrist, psychologist, or a court, that the patient has the capacity to understand and acknowledge the nature and consequences of health care decisions, including the benefits and disadvantages of treatment, to make an informed decision and to communicate the decision to a health care provider, including communicating through a person familiar with the patient's manner of communicating.

- For severely impaired patients the request for the lethal prescription can be made through a proxy – which presents a specific danger of representation. Not surprisingly the vast majority of disability advocacy organizations oppose such legislation.[19] Additionally, of two witnesses, one may be an heir to the estate and the other could be an interested boyfriend or girlfriend.[20]



(b) At least one of the witnesses described in paragraph (a) shall be a person who is not: (1) a relative of the patient by blood, marriage, or adoption; (2) at the time the request is signed, entitled to any portion of the estate of the patient upon the patient's death, under

- "Undue influence" is chargeable, but never defined.

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[19] E.g. listing 14 groups, Not Yet Dead (s.d.), "Disability groups opposed to assisted suicide laws." http://notdeadyet.org/disability-groups-opposed-to-assisted-suicide-laws

[20] See also generally *The MetLife Study of Elder Financial Abuse: Crimes of Occasion, Desperation and Predation against America's Elders* (2011). https://www.metlife.com/assets/cao/mmi/publications/studies/2011/mmi-elder-financial-abuse.pdf

any will or by operation of law; or (3) an owner, operator, or employee of a health care facility where the patient is receiving medical treatment or is a resident.

A witnesses designated by a residential care facility may or may not be protective, depending on circumstance.

(d) If the patient is a resident of a residential care home, nursing home, or skilled nursing facility at the time the written request is made, one of the witnesses shall be a person designated by the home or facility.

In S.F. 1800 (below) as in Washington State, the physician is required to falsify the death certificate, listing the terminal illness, not the lethal agent as cause of death.

(b) The attending physician may sign the qualified patient's death certificate that shall list the underlying terminal illness as the cause of death.

Having thus corrupted physicians and public health vital records, the falsified and untraceable death certificate is propogated into national mortality databases.

- Washington State's "Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys: Compliance with the Death with Dignity Act"[21] requires like falsification, plus the manner of "death must be marked as 'Natural'".

  Ironically, "in order to maintain a perfect system of registration" (Note 1) the rules proscribes 11 materially accurate terms regarding the context and cause of death, and specifically prohibits mention of the secobarbitol or pentobarbitol which would be the clear cause of death in any toxicology report (the latter also being used in state executions in fifteen states).[22]

  (Note: In the Netherlands death certificates for *hulp bij zelfdooding* (assisted suicide) are

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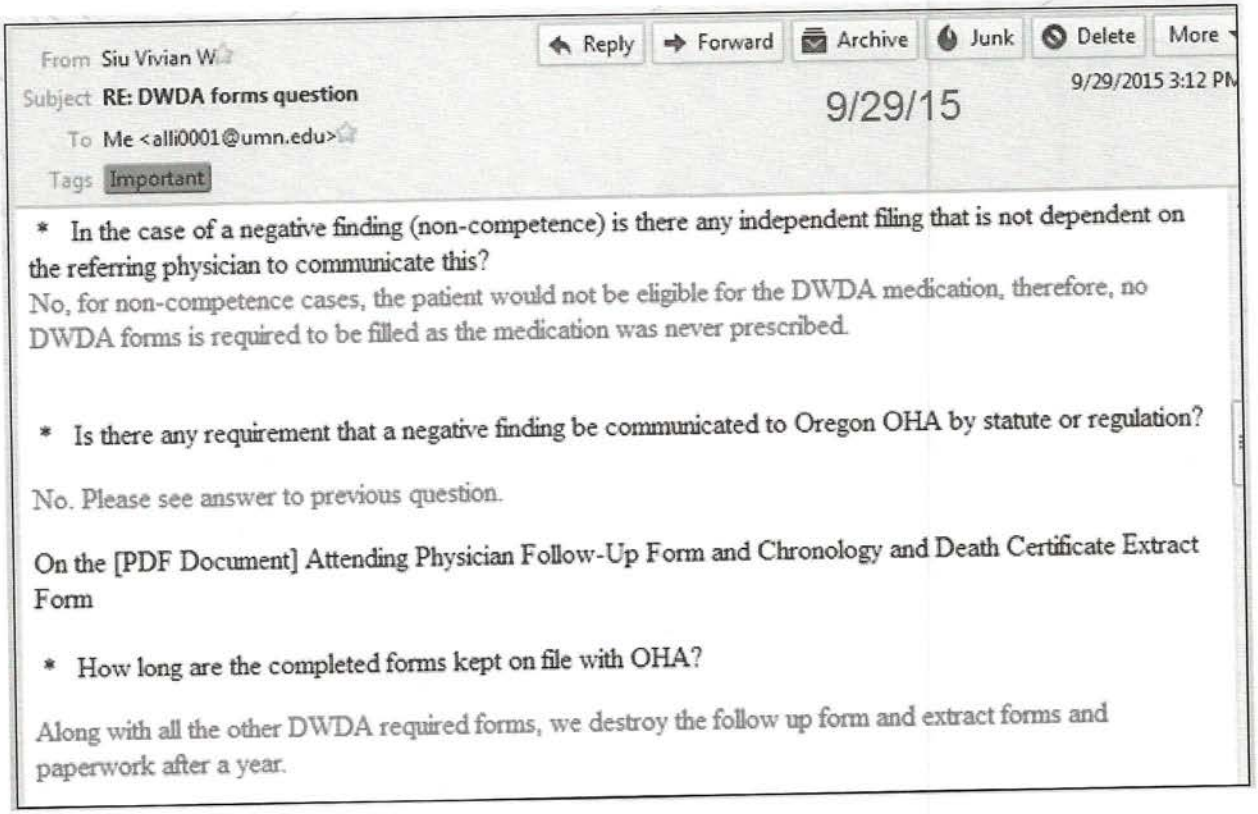
[21] "Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys: Compliance with Death with Dignity Act" http://www.doh.wa.gov/portals/1/Documents/5300/DWDAMedCoroner.pdf

[22] Deathpenaltyinfo.org. http://www.deathpenaltyinfo.org/state-lethal-injection.

recorded as 'unnatural' with the lethal agent listed as cause of death.[23])

Concerning possible malfeasance, Dr. Katrina Hedberg, who oversees Oregon's data collection, states: "We are not given the resources to investigate and not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves."[24]

- Yet, the Oregon Health Authority destroys all case-specific, patient and physician-linked documentation after one year, making future forensic reconstruction and accountability impossible.[25]



From Siu Vivian W
Subject **RE: DWDA forms question**
To Me <alli0001@umn.edu>
Tags Important

9/29/2015 3:12 PM

9/29/15

* In the case of a negative finding (non-competence) is there any independent filing that is not dependent on the referring physician to communicate this?

No, for non-competence cases, the patient would not be eligible for the DWDA medication, therefore, no DWDA forms is required to be filled as the medication was never prescribed.

* Is there any requirement that a negative finding be communicated to Oregon OHA by statute or regulation?

No. Please see answer to previous question.

On the [PDF Document] Attending Physician Follow-Up Form and Chronology and Death Certificate Extract Form

* How long are the completed forms kept on file with OHA?

Along with all the other DWDA required forms, we destroy the follow up form and extract forms and paperwork after a year.

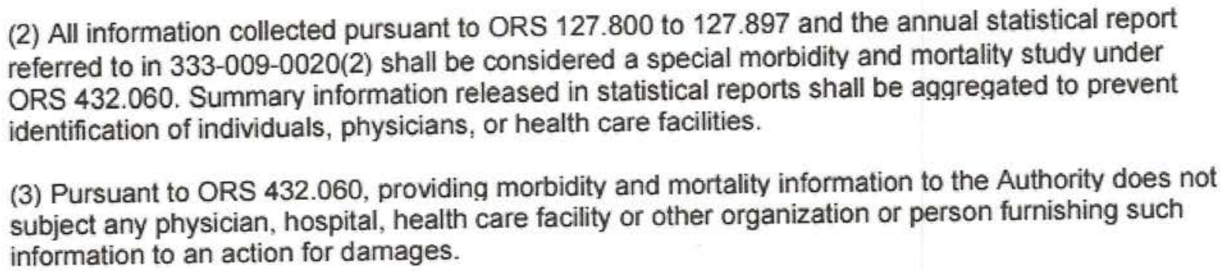
---

[23] Personal communication from Prof. Guy A.M. Widdershoven, Professor, Philosophy and Ethics of Medicine; Head of the Department of Medical Humanities, VU University Medical Center, Amsterdam, after University of Minnesota lecture "Ethical reflection in end of life decisions: A Dutch perspective," 18 May 2015, noting the lack of transparency of American practice.

[24] DHS news release, "No authority to investigate Death with Dignity case, DHS says," March 4, 2005.

[25] Email correspondence with the Oregon Health Authority, 29 September 2015. See also Oregon Health Authority, "Frequently asked questions about the Death with Dignity Act". https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/faqs.aspx

- Under administrative rules,[26] documents and sources related to Oregon's statute are classified as a 'special mortality stud' and are declared nondiscoverable and inadmissable "to any proceeding".



(2) All information collected pursuant to ORS 127.800 to 127.897 and the annual statistical report referred to in 333-009-0020(2) shall be considered a special morbidity and mortality study under ORS 432.060. Summary information released in statistical reports shall be aggregated to prevent identification of individuals, physicians, or health care facilities.

(3) Pursuant to ORS 432.060, providing morbidity and mortality information to the Authority does not subject any physician, hospital, health care facility or other organization or person furnishing such information to an action for damages.

ORS 432.060 (renumbered ORS 413.196 (2013)), "Confidentiality and inadmissibility of information obtained in connection with epidemiologic morbidity and mortality studies", establishes that

> "(1)(a) All information procured by or furnished ot the Oregon Health Authority […] in connection with special epidemiologic morbidity and mortality studies, is confidential, nondiscoverable and inadmissble in any proceeding and is exempt from disclosure under ORS 192.410."

Thus, while Oregon's Health Authority has no mandate, authority or budget to investigate malfeasance no outside agency has right of discovery to investigate. Catch-22.

Furthermore,

> "a person communicating information in connection with special epidemiologic morbidity and mortality studies pursuant to this subsection may not be examined about the communication or the information"

- insulating actors from scrutiny, discovery and accountability (be it a physician with an unusually large percentage of patients ending their lives).[27]

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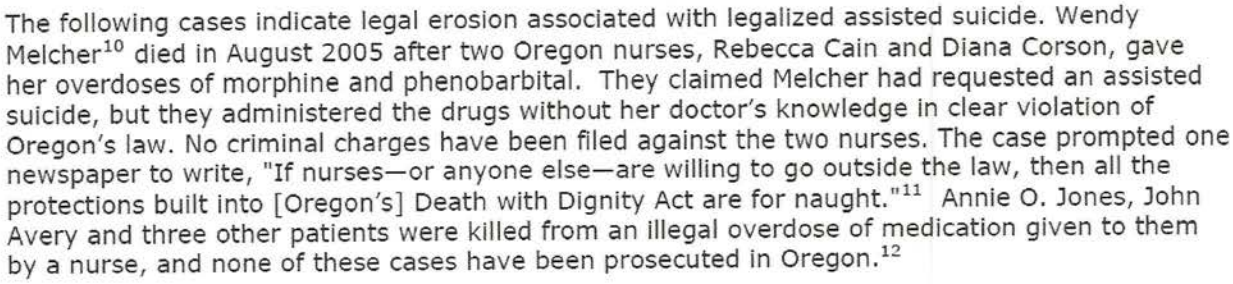
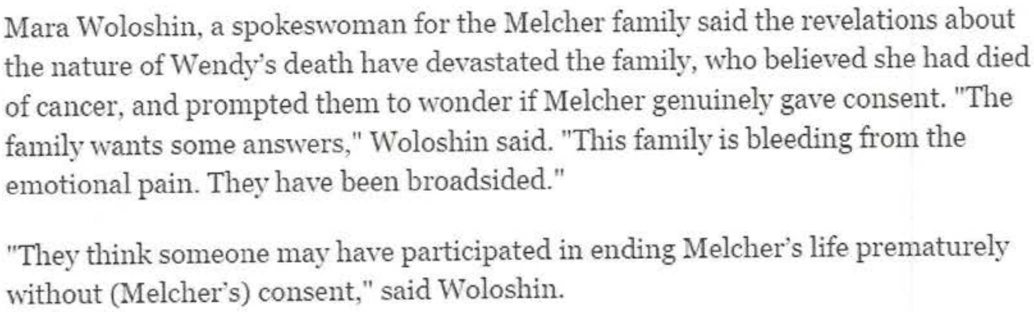
[26] DIVISION 9 - REPORTING REQUIREMENTS OF THE OREGON DEATH WITH DIGNITY ACT 333-009-000 to 333-009-030. https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/rules.pdf.

- Several cases, questionable to clearly criminal, have not lead to prosecutions in Oregon.[28] This includes nurses providing overdoses without physician involvement. The Board of Nursing concealed the event from police for over a year.


The following cases indicate legal erosion associated with legalized assisted suicide. Wendy Melcher[10] died in August 2005 after two Oregon nurses, Rebecca Cain and Diana Corson, gave her overdoses of morphine and phenobarbital. They claimed Melcher had requested an assisted suicide, but they administered the drugs without her doctor's knowledge in clear violation of Oregon's law. No criminal charges have been filed against the two nurses. The case prompted one newspaper to write, "If nurses—or anyone else—are willing to go outside the law, then all the protections built into [Oregon's] Death with Dignity Act are for naught."[11] Annie O. Jones, John Avery and three other patients were killed from an illegal overdose of medication given to them by a nurse, and none of these cases have been prosecuted in Oregon.[12]


Mara Woloshin, a spokeswoman for the Melcher family said the revelations about the nature of Wendy's death have devastated the family, who believed she had died of cancer, and prompted them to wonder if Melcher genuinely gave consent. "The family wants some answers," Woloshin said. "This family is bleeding from the emotional pain. They have been broadsided."

"They think someone may have participated in ending Melcher's life prematurely without (Melcher's) consent," said Woloshin. [29]

Oregon and Washington provide little protection, lack accountability, and sacrifice integrity.

The Minnesota bill emulates. Instead we should robustly support extended palliative care and family support.

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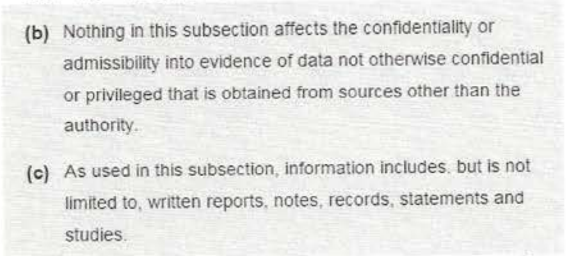
[27] It is scant comfort that


(b) Nothing in this subsection affects the confidentiality or admissibility into evidence of data not otherwise confidential or privileged that is obtained from sources other than the authority.

(c) As used in this subsection, information includes, but is not limited to, written reports, notes, records, statements and studies.

given that the health authority is repository and destroyer of records.

[28] Not Dead Yet Washington (s.d.). "Some Oregon assisted suicide abuses and complications." http://courses.washington.edu/lsj434/documents/14_Oregon_abuses.pdf

[29] White H (2007). Nurses investigated in Oregon assisted suicide case - killed patient without a physician. Lifesite.com. https://www.lifesitenews.com/news/nurses-investigated-in-oregon-assisted-suicide-case-killed-patient-without-

Kristy Graume

From: Kevin Murphy MD <KMurphy@gillettechildrens.com>
Sent: Monday, March 14, 2016 12:20 PM
To: 'kristy.graume@senate.mn'
Cc: Gordon.Harvieux@EssentiaHealth.org; Daniel.Skorich@EssentiaHealth.org
Subject: Letters: phys assis suicide

Dear Kristy:

I unable to attend the Senate Committee Hearing on SF 1880 (MN Compassionate Care Act).

I wish to support the letters by my physician colleagues below (not repeated for the sake of brevity) in opposition to SF 1880. As Medical Director of Gillette Specialty Healthcare Northern Minnesota, I am particularly concerned about the potential abuse of the suicide law and the likely rise in pediatric suicide rates in Northern Minnesota. We see over 3000 patient visits per year of children and adults with specialty care needs who in my opinion would not be helped by this proposed law and will likely be hurt by it for reasons specified in the letters below. Please share my concerns with the committee if possible. Please tell the committee also that we are all just "1 car accident away" from being a special needs child or adult and at risk for being hurt further by SF 1880.

Thank you very much,

Kevin Murphy MD,
Medical Director
Gillette Specialty Healthcare, Duluth, Minnesota

From: Harvieux, Gordon J. [mailto:Gordon.Harvieux@EssentiaHealth.org]
Sent: Monday, March 14, 2016 11:40 AM
To: Skorich, Daniel N.
Cc: Beery, Nancy K.; Bertin, Shana M.; bigelow, kim; bishop sirba; Bronson, Michael A.; cady r; chiu, andrew c; Chiu, Andrew C.; Christian, Krisa K.; colling alisha; DeFrance, Lori L.; eckman, mark; Erickson, Robert V.; Eyer, Steven D.; fightlin m and m; Foley, Gary P.; Fox, Julie A.; fr Eli Gieske; Fr Kevin Gordon; Fr Mike Schmitz; Fr Peter Muhich; freeman todd lindsey; Glickstein, Jonathan S.; goodwin, david; goodwin, monica; Gunnarson, Theresa M.; Henson, Bruce E.; Holsinger, Jill R.; jahnke, pamela; janczak anna; Jennings, George L.; jennings, ml and len; Johnson, Scott W. (MD, OB/Gyn); kleinschmidt tim; kole, john; lafovor karlee; lavan jessica woodward; lenz, jay; Lushine, Karen A.; malecha, matt; mark monte (mmonte@slhduluth.com); mcmahon shawn; mcnaney david; Messer, Michael M.; Michael Bronson; miller roger; Miller, Catherine J. (Peds); monte, mark; Kevin Murphy MD; murphy kevin camille; Nelson, Thomas M.; plachta, mark; rengel jeff; Renier, Hugh P.; Rich, Timothy P.; rowe, mike sara; Ryan, Ed; sanford, paul; schroeder renee; seeba, joe and dona; severson paul; severson, erik; Shuey, Thomas F.; skalko christine; soukup, dennis; staber, lisa; Stephan, Kevin T.; tim egan; treacy, kevin; trout michele; tudor, gabriel; Twomey, Patrick A.; vouk william; wambach, angie; williams laurie; zbaracki mary
Subject: Re: phys assis suicide

Since we're piling on, here's mine. Forgive it's length. The best part is at the end.

Dear Senators,

My name is Gordon John Harvieux, M.D. I am a practicing pediatrician in Duluth, Minnesota and have been so for the past 21 years. I am writing to testify in strong opposition to SF 1880, the senate bill that would legalize physician-assisted suicide.

I think the most common myth surrounding physician-assisted suicide is that it's intent is to decrease pain and suffering. However, the most recent data from 2015 from the State of Oregon clearly shows that the most common reason for people to engage in physician-assisted suicide was that they were "less able to engage in activities making life enjoyable," followed by "loss of autonomy" and "loss of dignity" (96%, 92%, and 75% respectively)(https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx). In addition, depressed patients are four times more likely to request euthanasia or physician-assisted suicide. However, the most recent data from the State of Oregon also show that only 3.8% of the patients in 2015 were referred for psychiatric evaluation (reference above). As bioethicist Dr. Ezekiel Emanuel states, "In this light, physician-assisted suicide looks less like a good death in the face of unremitting pain and more like plain old suicide. Typically, our response to suicidal feelings associated with depression and hopelessness is not to give people the means to end their lives but to offer them counseling and caring." ("Four Myths About Doctor-Assisted Suicide" by Ezekiel Emanuel, New York Times, October 27, 2012)

In addition, there is nothing within Bill SF 1880 that would prevent a patient from doctor shopping until they receive the legal medicines which they seek. In analyzing the current Oregon data for 2015 (see Oregon Public Health URL listed above) regarding the duration of the doctor-patient relationship, the median length of relationship in weeks was nine, with some patients only having a relationship with the physician for one week before the lethal medicine was prescribed. Similarly, there is nothing in the proposed bill that can protect a patient from explicit or implicit family pressures to commit suicide or personal fears of "being a burden".

Within the medical community, many nationally prominent disability rights organizations oppose the legalization of assisted suicide. Other key opponents include the World Health Organization, the American Medical Association and it state affiliates, the American College of Physicians, the National Hospice and Palliative Care Organization, and the American Cancer Society. (Disability Rights Education Defense Fund - "Why Physician Assistant Suicide Must Not Be Legalized")

The Bill SF 1880 is also problematic due to it being poorly written with multiple unrealistic statements. For example, Lines 7.22 & 7.23 ridiculously declare that the attending physician must lie: the attending physician signing the death certificate "shall list the underlying terminal illness as the cause of death" as opposed to the prescribed drugs which directly caused the person's death. In addition, the fantasy lines 10.10 and 10.11 state "any action according to the section does not constitute causing or assisting another person to commit suicide."

Most importantly, some have argued that if this bill is passed into law, it will be just another option for people: "It's there if you want to use it, but you certainly don't have to." This attitude, however, ignores the damage to society caused by legalized physician-assisted suicide.

One example of damage to society resulting from this would be fear, bias, and prejudice against those it disabilities. As shown above, the major reasons for people to engage in physician-assisted suicide include loss of autonomy and lack of enjoyment of previous activities; this leads to fears of disability and loss of autonomy. "Many thousands of people with disabilities who rely on personal assistance have learned, needing help is not undignified, and death is not better than reliance on assistance... Have we gotten to the point that we will abet suicide because people need help using the toilet?" (Diane Coleman, "The Real Hemlock Society") Similarly, "The public image of severe disability [is that it's] a fate worse than death… Legalizing assisted suicide means that some people who want to die will receive suicide intervention, while others will receive suicide assistance. The difference between these two groups of people will be their health or disability status, leading to a two-tiered system that results in death to the socially devalued group." (Coleman, J.D., "Not Dead Yet," *The Case*

Against Assisted Suicide – For the Right to End-of-Life Care, Kathleen Foley and Herbert Hendin, eds. (Baltimore: The Johns Hopkins University Press, 2002), p. 221.)

An additional damage to society is that the legalization of physician-assisted suicide will increase the likelihood of suicide within the general population. In Oregon, the first state to formally legalize assisted suicide, the suicide rates have skyrocketed – even excluding those from physician-assisted suicide. Oregon now has one of the highest suicide rates in the country, and it is the second leading cause of death amongst Oregonians aged 10 to 24. A "corollary is that a growing body of sociologic data demonstrates that when vulnerable people see suicide as a "good" from which the state no longer provides protection, suicide rates generally rise." (http://www.ncbcenter.org/page.aspx?pid=1263&storyid2509=262&ncs2509=3)

The logic of legalizing physician-assisted suicide is totally counter to the Minnesota efforts to reduce suicide in our state. The Minnesota Department of Health details the state wide plan (released in September 2015) for suicide prevention in Minnesota. The plan has a goal to reduce suicide by 10% in the next five years and 20% in the next 10 years, ultimately working towards zero deaths.

As a pediatrician, I can say without hesitation, the number of children in my practice who require treatment for depression and suicidal ideation has increased dramatically in recent years. Young people of northern Minnesota already face alarming rates of suicide and depression. If these vulnerable young people see that the medical community and the State of Minnesota accept suicide as a viable option, the rates of suicide for our own young people will rise, just that they have done in the State of Oregon.

Instead of advocating for legalization of physician-assisted suicide, we should focus our energy on improving care for the dying – improving access to high-quality palliative care or hospice, improving mental health services for those with chronic conditions, and working to ensure the dignity of all patients – but especially those with chronic or terminal illness.

Sincerely,

Gordon J. Harvieux, M.D.
Pediatrician

On Mar 14, 2016, at 11:29 AM, Skorich, Daniel N. <Daniel.Skorich@EssentiaHealth.org> wrote:

This is the letter that I wrote for the committee to review.
dns

From: Skorich, Daniel N.
Sent: Monday, March 14, 2016 9:19 AM
To: 'kristy.graume@senate.mn'
Subject: FW: phys assis suicide

Dear Kristy: I unable to attend the Senate Committee Hearing on SF 1880 (MN Compassionate Care Act). Please submit the document below as written testimony against this Bill. Thank you.

Daniel N Skorich MD.

Dear Senators:

I write this in opposition to SF 1880, the so called MN Compassionate Care Act.

As a physician from Duluth MN, I have dedicated my career to serving the health needs of people in all stages of life, including end of life. This Bill is a paradigm shift in terms of how we approach the suffering of those who are nearing the end of their life. If we are determined to help people in the final stages of life, we can do better than offer them physician-assisted suicide.

These are some of the reasons to oppose this bill:

1. The bill mandates that the self-administration of a lethal dose of drug is 'not suicide'. If the legislature were to mandate that the means of death was self-inflicted gunshot, instead of drug-induced , would it still 'not be suicide'? The use of euphemisms such as "Compassionate Care", instead of physician-assisted suicide is a affront to truth. Demand truth in legislation.
2. The bill mandates that the official death certificate reflect the patient's disease process (for example, metastatic lung cancer), and not that the person died of self-inflicted drug overdose. In other words we are asked to lie about the immediate cause of death. Demand truth in legislation. Why is this important? If our society wants to be able to study the effects of physician-assisted suicide on the population in general, we will not be able to retrieve the necessary data from death certificates.
3. The bill mandates that any state worker cannot use the word suicide when discussing this bill, and states that they will be punished for doing so. Yet it doesn't spell out what the punishment might be, or why a state worker cannot mention the word suicide.
4. Minnesota has a strong history of promoting suicide prevention through various programs. Isn't it ironic that we are now promoting suicide in certain situations? Ask yourself why suicide should be prevented on one hand and promoted on the other.
5. It is well recognized that people suffering from terminal illness are frequently depressed to the point of being despondent. Yet in Oregon, in 2015, only 5 of the 215 people prescribed suicide drugs were sent for formal psychological testing. Demand better treatment for depression prior to offering life-ending drugs.
6. Oregon's Death with Dignity law, upon which the Minnesota law is based, offers yearly statistical analysis of the people who are prescribed death drugs. These statistics show that about half of the patients who are prescribed the drugs actually are reported to take the drugs. What happens to all of the unused drug? We do not know. In addition, Oregon's Annual Report indicates that there is a large percentage of people who fall into the category "unknown" regarding possible complications of drug administration. There needs to be much better and detailed reporting. I would urge all Legislators to critically read the Oregon Annual Report regarding their Death with Dignity Law.
7. Although SF 1880 states that it is a bill designed to alleviate undo suffering of the terminally ill, the vast majority of people in Oregon who use this method of ending life state that psychosocial concerns such as loss of autonomy, loss of dignity, and inability to do enjoyable activities are the main reasons that they want to end their life. Shouldn't we do more in terms of palliative and end of life care, instead of authorizing legalized suicide?
8. Oregon statistics indicate that the majority of people who use assisted-suicide are elderly educated Caucasian's with financial means. Do we really need to promote another law that helps 'ease the suffering' of educated white folk? At the least, this bill is discriminatory: at the worst it is racist.

Thank you for your concern. Please oppose this bill.

Daniel N Skorich MD

From: Susan Windley-Daoust <swindley@smumn.edu>
Sent: Tuesday, March 15, 2016 8:39 AM
To: Kristy Graume
Subject: Written statement for SF1880 hearing Wednesday, Mar 16.

Good afternoon. My name is Dr. Susan Windley-Daoust, and I have studied, explored, and taught physician assisted suicide as an ethicist at Saint Mary's University of Minnesota (Winona) for 15 years.

I am strongly against this proposed bill (SF 1880) and will tell you why. One thing I note in my students who support PAS is that their support for this measure is rooted in ignorance. They do not know that when a person receives word that he or she has six months or less to live, they qualify for palliative care/hospice under medicaid automatically, at no cost. They also do not understand that enormous advances have been made in the quality of palliative care: no one need die in pain. They have not thought of the problems that occur when medical staff, who take a vow to do no harm, would be legally obliged to prescribe medication that ends a person's life--even against conscience. They have not thought about how difficult it is to assess a person's mental state when making such a request. They have not thought of the implications that occur when a fiscal "short run" is created by saving money through PAS: that there would be subtle or not so subtle pressure to choose in a way that saves money. They do not realize that 14 national organizations that advocate for disability rights are on record against this legislation, wherever it appears in the USA and the Western world, because they realize it would impact people living with disabilities in disastrous ways.

People who are against this legislation are not without compassion. If anything, the PAS movement demonstrates that the medical community needs to better educate people on the possibilities of living well with palliative care, and continually improving palliative care. We who are against PAS are against unnecessary pain, and through personally supporting that person though their dying, deeply respecting their human dignity. Indeed, I have never seen as much compassion in my life as in the dying of friends and family, manifest through hospitals, chaplains, churches, and communities. But not all choices are equal, or compassionate. We cannot, as a state, support the intentional ending of a person's life in practice and through funding. To do so undercuts our commitment as Minnesotans to the right to life.

Best regards,
Susan Windley-Daoust

(I am the associate professor and Chair of Theology at Saint Mary's University of Minnesota, and am willing to be contacted by this by phone or email. 507 457 1995, swindley@smumn.edu)

--

Susan Windley-Daoust, Ph.D.

Associate Professor and Chair of Theology
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Brentwood, TN 37024-3326

p: 615-322-7099 e: wjriley@bellsouth.net

March 15, 2016

Via email to: sen.kathy.sheran@senate.mn

Senator Kathy Sheran
Chair of the MN Senate Committee on Health, Human Services, and Housing
95 University Avenue W., Room 2103
St. Paul, MN 55155

Dear Senator Sheran,

The American College of Physicians (ACP), the largest medical specialty organization and the second-largest physician group in the United States, and the Minnesota Chapter of ACP write to inform you of ACP's opposition to "The Minnesota Compassionate Care Act." This is a physician-assisted suicide bill. ACP does not support the legalization of physician-assisted suicide (PAS) and does not support PAS as an appropriate action (see the ACP Ethics Manual https://www.acponline.org/running_practice/ethics/manual/manual6th.htm#euthanasia and position paper https://www.acponline.org/running_practice/ethics/issues/policy/pa_suicide.pdf). Terms such as "aid-in-dying" used in the bill are confusing and obscure what is at stake when physicians are asked to facilitate suicide. We are deeply sympathetic to the concerns and fears patients and their families have at the end of life. However, PAS is not the answer and in fact, ACP sees it as abandonment of the dying patient, not compassionate care. It is not the role of the physician to give individuals the means to bring about their own death—the medicalization of suicide.

The physician must fulfill her or his ethical obligations and always act in the best interests of the patient as healer, comforter and trusted advisor. Legalization of PAS undermines trust in patient-physician relationships and trust in the profession of medicine. Proponents of PAS claim it is an act of compassion in keeping with the physician's role as comforter. However, this argument incorrectly assumes that physicians can only provide comfort for certain patients through facilitating suicide. In fact, physicians can and do provide comfort to dying patients. It is a lack of awareness of these services and a perceived concern that patients will not have access to this care that helps drive interest in PAS. We need to ensure that all patients know they will be well cared for at the end of life rather than promote suicide.

The highest priorities for care of dying patients should be the alleviation of pain and other symptoms, and strong support for the patient's right to refuse treatment, including life-sustaining treatment. Patients often fear pain at the end of life, but physicians have an ethical obligation to treat pain with competence and compassion. Vigorous management of pain at the end of life is ethically acceptable, even when the risk of hastening death is foreseeable, if the intent is to relieve pain: the ACP Ethics Manual states that "…the physician may appropriately increase medication to relieve pain, even if this action inadvertently shortens life" (see https://www.acponline.org/running_practice/ethics/manual/manual6th.htm#eol). The option of vigorous pain control has been consistently supported by US courts, including the US Supreme Court, and PAS has been distinguished from the right to refuse treatment by the courts as well (see especially Washington v. Glucksberg, 117 S.Ct. 2258 (1997) and Vacco v. Quill, 117 S.Ct. 2293 (1997)).

We note the paradox of legalization of PAS in a country where there is no general right to health care, and find PAS especially troubling in an environment of cost control and continuing disparities in health care.

We hope you will join ACP in advocating that society should encourage those who seek suicide with a physician's help to instead be provided with the care and compassion that can alleviate their suffering. No Minnesotan, or any other American, should have to fear an undignified or pain-filled life or death.

Providing the best medical care to patients throughout and at the end of life requires our full attention. In this way, physicians can fulfill their ethical responsibilities and give dying patients and their families the care, compassion, and comfort they need and deserve.

Sincerely,

Wayne J. Riley, MD, MPH, MBA, MACP
President, ACP

John B. Bundrick, MD, FACP
Governor, ACP Minnesota Chapter
1043 Grand Ave. #215
St. Paul, MN 55105
Minnesota.acp@gmail.com

The American College of Physicians is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 143,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

From: vvmi.larson@gmail.com on behalf of Barry Larson <MNgeriatric@gmail.com>
Sent: Saturday, March 12, 2016 3:48 PM
To: Sen.Kathy Sheran; Kristy Graume; Sen.Melissa Wiklund; Sen.Michelle Benson; Sen.Tony Lourey; Sen.Sean Nienow; Sen.Julie Rosen; Sen.Carla Nelson
Cc: drpaulklim@gmail.com
Subject: I am writing to OPPOSE SF1880.

Dear Honorable Senators Sheran, Wiklund, Benson, Hayden, Eaton, Hoffman, Marty, Nelson, Nienow, R

I am writing to OPPOSE SF1880. My name is Dr. Barry Larson. I work in family medicine/geriatrics in the
Genevive. I have drawn on the work of Dr. David Stevens, an ethicist from Bristol, TN (MD, MA of the An
Medical Ethics) below and have added my own comments.

Allowing doctors to give lethal prescriptions to their terminally ill patients is dangerous.

It is dangerous for physicians. It wrongly assumes all physicians are ideal moral agents. Physicians are u
stress, workloads and costs pressures as well. It takes no great skill and very little time to write a lethal pr
consummate skill and lots of effort to provide good end-of-life care. Allowing lethal prescriptions also give
much power as they literally would be judge, jury and assistant executioner in end-of-life cases. We don't
that kind of power in any other setting. The power is not in the patient's hands despite signing a form an
By carefully choosing how I describe their disease and prognosis, I could convince someone that taking a
was a good idea without ever saying the words "physician-assisted suicide." Remember, suicide is not ille
Minnesota. This is not about giving patients the so-called "right to die" but about giving physicians the rig
that right become an implicit responsibility? My fear is that it will. The distinction between physician as
labors to relieve suffering by treating the reasons for the suffering and attacking the suffering itself, and o
directly end a patient's life will be lost. And much will be lost with it.

It is dangerous for families. I work full time in long term care. Could you imagine going to visit your paren
in the nursing home and finding their bed empty? When you ask, you find that their physician had given th
prescription and they have taken their life without saying anything to you. What a formula for guilt, anger,
sadness in those left behind. Allowing this will also cause enormous dissension in many families, as had
Europe where this has been allowed much longer. It adds an air of legitimacy to the already underreporte
abuse and devaluing the very ones who birthed us and respected our lives enough to give of themselves
themselves much on our behalf. One elderly woman was quoted in a newspaper to say, "...when I started
about three years ago, it irritated my daughter...She began to question me about my financial matters and
won't leave much of an estate for her... She became very rude...Then suddenly, one evening, my daught
was okay for old people to commit suicide...So here I sit, day after day, knowing what I'm expected to do.

It is dangerous for patients. The so-called "right to die" will become the duty to die. Some bioethicists are
there is a duty to die. Dr. John Hartwig teaches students at East Tennessee State University's medical sc
students brought it to Dr. David Stevens' attention in Bristol, TN and gave him his handout where Hartwig
people have a duty to die to not be a burden to the next generation. Dr. Stevens went to his lecture wher
thing and he asked when that duty kicked in. Without hesitation, Stevens relates Hartwig said, "at age 75.
squads worth of 80 and 90-some year old Marines are gathering on Iwo Jima as I write this for the 70th ar
historic battle. Who would possibly tell these brave men who gave so much and watched many of their c

everything for the cause of freedom that they have overlived their “usefulness” by 15 or 20 years?? Is th
becoming as a people?? May it not be so.

The most common reason the elderly take their lives is depression. Studies show that doctors recognize i
the terminally ill even though they respond well to antidepressant drugs. Though 95 percent of the elderly
are depressed, the safeguards proposed in legalization laws don’t require a consultation by a psychologis
now after spending a practice life seeking to root out depression and asking about risk factors or plans re
order to treat the suffering inherent in the illness, I am supposed to simply cooperate with those very diso
end the life of the patient as the “ultimate cure”? It doesn’t make medical, ethical, or moral sense. But t
danger for patients is that economically the prescription of a handful of lethal pills is cheap. Real care co
always get what they need/want, including assisted suicide if it is legalized. Who really is at risk under a
of physician assisted suicide are those for whom society will pay to keep alive and for whom care will be
more economical to push and prod and “make the case” for those without means to take the active step
suffering – and society’s responsibility to them – once and for all. A slippery slope? You
bet.

I agree with Dr. David Stevens as well that “allowing doctors to give lethal prescriptions is dangerous for
logical place to draw the line if you allow it. If it is “right,” how can you deny it to anyone who is suffering?
lawsuit after it becomes law to expand it. Doesn’t the patient who is terminal but can’t swallow have a righ
After physician-assisted suicide was legalized in The Netherlands in the mid-1970s, they found that patie
had complications 25 percent of the time. They vomited the pills up or woke up the next day not dead. Th
had a right to die well from their suicide, so they allowed doctors to be in attendance and give a lethal inje
right.” They then realized if the justification was “suffering,” they couldn’t deny it to the chronically ill who
years, or to the newborns who would suffer from a congenital defect for a lifetime or to the psychiatric pat
say mental suffering was any less that physical suffering? The “helping” role of the physician in bringing
and becomes more active as suffering is identified in the increasingly dependent who “certainly can’t be d
right.” The room is growing increasingly warm and claustrophobic…

Additional red flags abound. The notion of safeguards such as physician certification that a patient only h
to live should a disease process take its natural course are inaccurate over half the time. Such certificati
of the current hospice benefit certification process and is reasonable in that context. However, not uncor
stepped up level of good care and management of a patient’s symptoms, the patient stabilizes and gradu
no longer in need of that level of service or at least not until the disease process reasserts itself. That is t
of being wrong on ones prognosis in that context, and it is a rather happy consequence. If one is wrong
the context of certifying assisted suicide however, the implication is obvious – it will never be known to be
owner of that dire prognosis will be irrevocably dead. The “good intent” malpractice standards that seen
in assisted suicides gone wrong in those places where it is legal and the dearth of real record keeping su
underlying diseases and not suicide as the cause of death in PAS cases should give no one the illusion t
meaningful and tracking problems will be easy once the law is in play.

My fear is that the real casualty of a physician assisted suicide bill will be the physician patient relationshi
Western medicine for years was the Hippocratic oath, which proscribed – not prescribed – the use of sub
express aim was to bring about death. It is chronological snobbery and error to assume we are more en
because we are more modern and technologically advanced. The right focus for our efforts are the very
espoused by that ancient Greek –to use and share knowledge towards the elimination of suffering, not su
individuals. More and better research, good drug laws, palliative care training for more physicians, and
patients and their families to foster optimum physical, emotional and spiritual support at the end of life are
not the easy way, but it is the proper way and gives hope of avoiding much in the way of pitfalls and unint
consequences for physicians, patients and society. Thank you for your consideration.

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Kristy Graume

From: Skorich, Daniel N. <Daniel.Skorich@EssentiaHealth.org>
Sent: Monday, March 14, 2016 9:19 AM
To: Kristy Graume
Subject: FW: phys assis suicide

Dear Kristy: I unable to attend the Senate Committee Hearing on SF 1880 (MN Compassionate Care Act). Please submit the document below as written testimony against this Bill. Thank you.

Daniel N Skorich MD.

Dear Senators:

I write this in opposition to SF 1880, the so called MN Compassionate Care Act.

As a physician from Duluth MN, I have dedicated my career to serving the health needs of people in all stages of life, including end of life. This Bill is a paradigm shift in terms of how we approach the suffering of those who are nearing the end of their life. If we are determined to help people in the final stages of life, we can do better than offer them physician-assisted suicide.

These are some of the reasons to oppose this bill:

1. The bill mandates that the self-administration of a lethal dose of drug is 'not suicide'. If the legislature were to mandate that the means of death was self-inflicted gunshot, instead of drug-induced , would it still 'not be suicide'? The use of euphemisms such as "Compassionate Care", instead of physician-assisted suicide is a affront to truth. Demand truth in legislation.
2. The bill mandates that the official death certificate reflect the patient's disease process (for example, metastatic lung cancer), and not that the person died of self-inflicted drug overdose. In other words we are asked to lie about the immediate cause of death. Demand truth in legislation. Why is this important? If our society wants to be able to study the effects of physician-assisted suicide on the population in general, we will not be able to retrieve the necessary data from death certificates.
3. The bill mandates that any state worker cannot use the word suicide when discussing this bill, and states that they will be punished for doing so. Yet it doesn't spell out what the punishment might be, or why a state worker cannot mention the word suicide.
4. Minnesota has a strong history of promoting suicide prevention through various programs. Isn't it ironic that we are now promoting suicide in certain situations? Ask yourself why suicide should be prevented on one hand and promoted on the other.
5. It is well recognized that people suffering from terminal illness are frequently depressed to the point of being despondent. Yet in Oregon, in 2015, only 5 of the 215 people prescribed suicide drugs were sent for formal psychological testing. Demand better treatment for depression prior to offering life-ending drugs.
6. Oregon's Death with Dignity law, upon which the Minnesota law is based, offers yearly statistical analysis of the people who are prescribed death drugs. These statistics show that about half of the patients who are prescribed the drugs actually are reported to take the drugs. What happens to all of the unused drug? We do not know. In addition, Oregon's Annual Report indicates that there is a large percentage of people who fall into the category "unknown" regarding possible complications of drug

administration. There needs to be much better and detailed reporting. I would urge all Legislators to critically read the Oregon Annual Report regarding their Death with Dignity Law.

7. Although SF 1880 states that it is a bill designed to alleviate undo suffering of the terminally ill, the vast majority of people in Oregon who use this method of ending life state that psychosocial concerns such as loss of autonomy, loss of dignity, and inability to do enjoyable activities are the main reasons that they want to end their life. Shouldn't we do more in terms of palliative and end of life care, instead of authorizing legalized suicide?
8. Oregon statistics indicate that the majority of people who use assisted-suicide are elderly educated Caucasian's with financial means. Do we really need to promote another law that helps 'ease the suffering' of educated white folk? At the least, this bill is discriminatory: at the worst it is racist.

Thank you for your concern. Please oppose this bill.

Daniel N Skorich MD