To whom it may concern:

My name is Tod Worner and I am a practicing internal medicine physician in the Minneapolis area. I live in Plymouth, MN and vote in District 43A. I am opposed to the proposed bill legalizing physician-assisted suicide.

I find myself in a curious position. As a physician who has spent decades trying to heal patients, I find myself imploring my duly elected representatives *not* to usher in the most seismic cultural and ethical transformation in modern medical practice — the act of taking life instead of comforting or saving it.

As you know, there are currently ten states (to date) in which physician-assisted suicide is legalized (California, Colorado, Oregon, Vermont, New Mexico, Maine, New Jersey, New Mexico, Hawaii, and Washington) and Washington, D.C. Montana has legalized it by court ruling. Furthermore, a number of them have weakened residency requirements so as to encourage a grim form of medical suicide tourism. Physician-assisted suicide is also legalized (to date) in Canada, Belgium, Luxembourg, Spain, Germany, Switzerland, and the Netherlands. Pediatric euthanasia has already been carried out in Belgium, the Netherlands, and is being pursued by interest groups and legislators in Canada, among other locales. And now, alas, physician-assisted suicide is, once again, knocking on Minnesota’s door.

Lest we find ourselves reassured by a burgeoning tendency to legalize this dark practice, let me borrow from Mark Twain when he said, “Whenever you find yourself on the side of the majority, it is time to pause and reflect.”

Indeed.

George Orwell once sighed, “We have now sunk to a depth at which restatement of the obvious is the first duty of intelligent men.”

And so let me begin.

As a physician, my daily practice is to heal the sick and prevent disease. In so doing, I try to uphold the dignity of each patient — treating them with respect while working in partnership to achieve a rich quality in concert with a reasonable quantity of life. Of course, I recognize the value of autonomy to afford patient choice, but that means a choice insofar as it simultaneously comports with the practice of safe, sound and ethical medicine. To be sure, patient choice must be just and the care they receive beneficent, but that same choice must not *—*by slippery euphemism and crafty manipulation, emotional appeal and legal maneuverings — I repeat, *must not* compel a physician to commit a maleficent act, especially one that runs against centuries of common law and customs, statutory law and social contract, as well as the sacred conscience and sound judgment of the physician in the relationship.

So what does this mean when it comes to physician-assisted suicide?

In a few words, it means that a patient has many rights, but he does not have the right to demand that I assist him in killing himself any more than he can demand I prescribe him unnecessary narcotics, unwarranted antibiotics, or ill-considered surgery. To demand these measures indiscriminately would be to violate the dignity of the patient with risky (or fatal) outcomes as well as compromise my dignity (and conscience) as a trained and seasoned physician to thoughtfully consider the best care for the patient.

That is why, as a physician, I am opposed to physician-assisted suicide. Furthermore, allow me to offer these three arguments against this concerning practice:

*1. Physician-assisted suicide fundamentally transforms the very nature of the physician-patient relationship.*

When Julius Caesar illegally led his army into Italy in defiance of the Roman Senate, he had to pass through a river known as the Rubicon which separated Italy from the province of Gaul. When he *“crossed the Rubicon”* and became a traitor to his state, he uttered *“the die is cast”* and knew there was no going back. Once medicine has transformed itself from a vocation whose first and only priority is to heal and comfort into a profession that is willing to kill, we will have “crossed the Rubicon.” We will have wandered away from the oath to *“First, do no harm”* and to *“give no deadly medicine to any one if asked, nor suggest any such counsel.”* Henceforth, the consequences would be both unintended and grave to patients, physicians, and society. We must stop, once again, and reconsider just what it means to be physicians, to be healers. And we must remember what it means to be human. If we forget the fundamental, uncompromising, and ineradicable value intrinsic to human life, can we still call ourselves physicians?

*2. Physician-assisted suicide is a solution in search of a problem.*

The popular press, judicial activists and enterprising legislators have grown increasingly sympathetic to the physician-assisted suicide movement. As such, anecdote after anecdote highlight people with grave medical maladies offering poignant interviews or writing last letters articulating their sincere fears of unremitting pain and incomparable suffering. They see *only two alternatives*: one is to suffer a prolonged, painful, and humiliating death, while the other is to proactively commit “dignified” suicide under the sympathetic eyes of their physician. That’s it. What is striking, however, is how little conversation there is about Palliative Care and Hospice. Designed fully around the notion of providing dignity, autonomy and symptom management in the face of terminal illness, Palliative Care and Hospice provide extraordinary end of life care to the very people who feel they have no fate but suffering ahead. These physicians and clinicians are well-trained and deeply committed to the care of those very patients that physician-assisted suicide advocates specifically target. In over two decades of practicing internal medicine, I have had a number of patients enroll in these services. I have yet to find *one family* who didn’t gratefully describe the profound dignity, loving kindness, and tender management of pain, anxiety and symptoms they witnessed in the waning days of their loved one’s life. Surely, that is not to say that there can’t be patients with symptoms that could be difficult to manage. But does that mean that we should then move to a widespread, systemic legalization of physician-assisted killing? With the oft untapped and unrecognized virtues of Palliative Care and Hospice, I think we are rushing to provide a dangerous solution desperately in search of a problem.

3. *When considering the fallout from physician-assisted suicide, the slippery slope is real.*

Invariably, when legislation such as physician-assisted suicide is considered, concerns are raised about the slippery slope — that is, the unintended consequences and abuses that result from permitting such a policy at all. “Enlightened minds” that “know better" shake their heads and tut-tut that our concerns are overreactions. *“We would have safeguards against abuses,”* we are told, *“We would craft laws protecting minors or the mentally ill or the demented or the handicapped or others without terminal illness from ever being considered for physician-assisted suicide.” “It would be a rare event.” “Economics (a patient’s draining resources, the burden on the medical system) would never be a factor in a merciful act devoted to preserving the dignity of the individual.”*To be sure, all of these reassuring arguments sound good and have been made in countries and states that have legalized physician-assisted suicide. And, too often, they have been wrong. People with mental illness and no terminal disease have been allowed to die. Minors in Belgium and the Netherlands have died under this policy. Physicians have been more aggressive in utilizing this option in the ill, but not terminally ill. Patients have reported fear of being hospitalized lest they become victims to a crusading doctor’s zeal. Exploding costs for end of life care and budgets groaning under the weight of the perpetually ill have a conscious or unconscious impact on a system where physician-assisted suicide is an option. And as far as being rare, according to the BMJ’s Journal of Medical Ethics (10/27/2023), there was an over sixteen-fold increase in physician-assisted suicide cases in Oregon from 1997 to 2022 while there was a drop in coinciding psychiatric assessments (evaluating the patient’s emotional state for such a decision) from 31.1% to 1.1%. The author of the paper, David Albert Jones, concludes, “We now have twenty-five years of data from Oregon and data from an increasing number of other states with similar laws. However, the more we know, the less reassuring the ‘Oregon model’ of assisted suicide seems to be.” Nonetheless, those promoting this law will reassure us. “We’ve thought of these concerns and, if need be, we will enact further laws to protect patients from abuse.” To this reasoning, I would ask, *“How will the small laws protect us, when the big law (against physician-assisted suicide) has been able to fall?”* When it comes to the institutionalization of physician-assisted suicide, mark my words, telling us that “everything will be okay” is a misguided, if not dangerous, philosophy.

For the last twenty-four years, it has been an honor and privilege to practice internal medicine. I love my patients, enjoy my colleagues, and cherish my calling. But that calling will fundamentally change if we devolve from a vocation that heals to a vocation that kills.

Most of what I have written today in opposition to physician-assisted suicide is fairly obvious. And I am here, simply and sadly, to restate it.

In having to do so, it is hard *not* to ask,*“What are we becoming? What does it mean to heal?”*

Heaven help us if we don’t know the answer.

Thank you for your time and consideration.

Tod Worner, MD