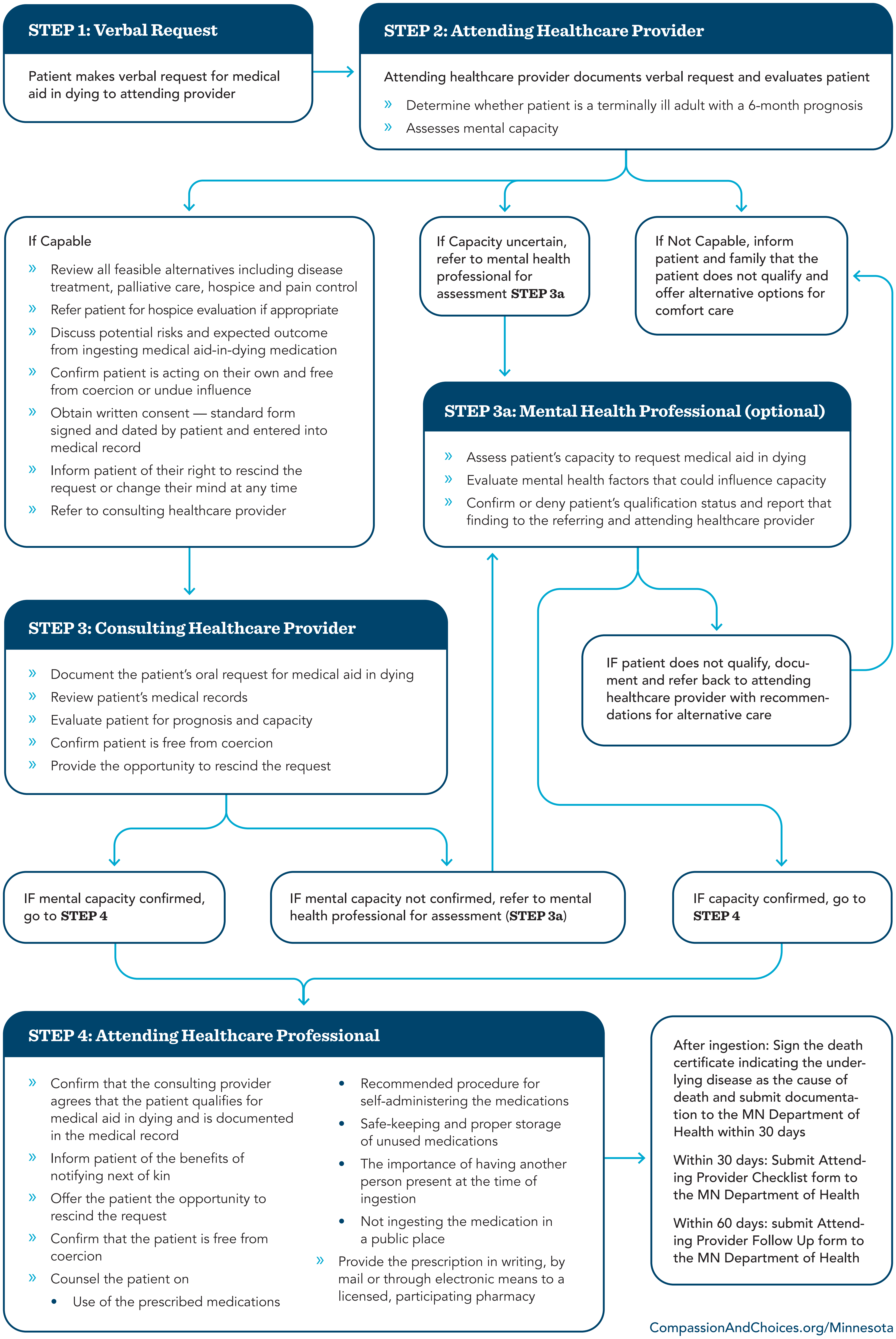
Medical Aid-in-Dying Steps

compassion & choices | MN



STEP 1: Verbal Request

Patient makes verbal request for medical aid in dying to attending provider

STEP 2: Attending Healthcare Provider

Attending healthcare provider documents verbal request and evaluates patient

- Determine whether patient is a terminally ill adult with a 6-month prognosis
- Assesses mental capacity

If Capable

- Review all feasible alternatives including disease treatment, palliative care, hospice and pain control
- Refer patient for hospice evaluation if appropriate
- Discuss potential risks and expected outcome from ingesting medical aid-in-dying medication
- Confirm patient is acting on their own and free from coercion or undue influence
- Obtain written consent — standard form signed and dated by patient and entered into medical record
- Inform patient of their right to rescind the request or change their mind at any time
- Refer to consulting healthcare provider

If Capacity uncertain, refer to mental health professional for assessment **STEP 3a**

If Not Capable, inform patient and family that the patient does not qualify and offer alternative options for comfort care

STEP 3a: Mental Health Professional (optional)

- Assess patient's capacity to request medical aid in dying
- Evaluate mental health factors that could influence capacity
- Confirm or deny patient's qualification status and report that finding to the referring and attending healthcare provider

IF patient does not qualify, document and refer back to attending healthcare provider with recommendations for alternative care

STEP 3: Consulting Healthcare Provider

- Document the patient's oral request for medical aid in dying
- Review patient's medical records
- Evaluate patient for prognosis and capacity
- Confirm patient is free from coercion
- Provide the opportunity to rescind the request

IF mental capacity confirmed, go to **STEP 4**

IF mental capacity not confirmed, refer to mental health professional for assessment (**STEP 3a**)

IF capacity confirmed, go to **STEP 4**

STEP 4: Attending Healthcare Professional

- Confirm that the consulting provider agrees that the patient qualifies for medical aid in dying and is documented in the medical record
- Inform patient of the benefits of notifying next of kin
- Offer the patient the opportunity to rescind the request
- Confirm that the patient is free from coercion
- Counsel the patient on
  - Use of the prescribed medications
  - Recommended procedure for self-administering the medications
  - Safe-keeping and proper storage of unused medications
  - The importance of having another person present at the time of ingestion
  - Not ingesting the medication in a public place
- Provide the prescription in writing, by mail or through electronic means to a licensed, participating pharmacy

After ingestion: Sign the death certificate indicating the underlying disease as the cause of death and submit documentation to the MN Department of Health within 30 days

Within 30 days: Submit Attending Provider Checklist form to the MN Department of Health

Within 60 days: submit Attending Provider Follow Up form to the MN Department of Health

CompassionAndChoices.org/Minnesota

DISABILITY RIGHTS OREGON

February 14, 2019

To Whom It May Concern:

My name is Bob Joondeph. I am the Executive Director of Disability Rights Oregon (DRO). I have held this position since 1991. DRO is the Protection and Advocacy program for Oregon, providing legal based advocacy for individuals with mental and physical disabilities throughout the state.

I have been a licensed attorney in Oregon since 1976. Our staff includes ten other attorneys, paralegal/investigators, intake specialists, benefits planners and support staff. DRO is mandated under federal law to investigate complaints of abuse or neglect of individuals with disabilities including inappropriate actions taken to hasten the death of an individual.

In the years since passage of the Oregon Death with Dignity Act (the Act), DRO has received very few complaints from disabled Oregonians about the Act. All of the complaints we have received have focused on the concern that the Act might discriminate against persons with disabilities who would seek to make use of the Act but have disabilities that would prevent self-administration, thereby denying these persons the ability to use the Act. DRO has never to my knowledge received a complaint that a person with disabilities was coerced or being coerced to make use of the Act.

Yours truly,

Bob Joondeph
Executive Director

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 disability 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

3/9/24

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

Professor Camosy Testimony Against in Opposition to H.F. 1930
END OF LIFE OPTION ACT
Judiciary Finance and Civil Law Committee– Public Hearing March 12, 2024

Dear Chairwoman Becker-Finn 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 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 is 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 to 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."

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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.
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https://www.nejm.org/doi/full/10.1056/NEJMms1700606.
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https://www.dutchnews.nl/news/2020/06/doctor-cleared-of-murder-in-euthanasia-case-says-she-would- do-it-again/
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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.
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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

March 12, 2024 House Judiciary, Finance, and Civil Law 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 abuse, any complaints filed or penalties administered. 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

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
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651-315-3570

March 10, 2024

To the House Judiciary and Civil Law Committee:

Working as a hospice nurse and now provider for more than 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/ SF 1813.

Chiara Johnson, APRN, resident of District 53A

-Minnesota House Judiciary Finance and Civil Law committee – 3/12/2024-

On 2/12/2024 the Minnesota Medical Association (MMA) made public the following statement regarding the legislative proposal on end of life options, which included the following statements: “The adopted MMA policy deliberately articulates neither support for nor opposition to physician aid-in-dying out of respect for the diversity of viewpoints of Minnesota physicians. The policy, instead, establishes boundaries and safeguards to guide MMA analysis of any physician aid-in-dying proposals. At its core, the MMA policy recognizes the sacred trust inherent in the patient – physician relationship; a relationship that must be protected through all the stages of life, including the dying process.”

“The policy further notes that the MMA will oppose any aid in dying legislation that fails to adequately safeguard the interest of patients and physicians. Such legislative safeguards include but are not limited to the following:

-Must not compel physicians or patients to participate in aid-in-dying against their will.

-Must require patient self-administration.

-Must not permit patients lacking decisional capacity to utilize aid-in-dying.

-Must require mental health referral of patients with a suspected psychological or psychiatric condition.

-Must provide sufficient legal protection for physicians who choose to participate."

"The policy further notes that all physicians who provide care to dying patients have a duty to make certain their patients are fully aware of hospice and palliative care services and benefits."

"It is the assessment of the MMA, that the current legislative proposal, authored by Rep. Mike Freiburg and Sen. Kelly Morrison, MD, meets the core safeguards defined in MMA policy. Should the legislation advance this year, the MMA will continue to ensure that such safeguards remain in place."

"On behalf of the MMA, we appreciate the opportunity to provide you with clear and accurate information about the MMA's position on this important proposal."

Laurel Ries, MD-MMA president
Kimberly Tjaden, MD, MPH-MMA Board Chair
Janet Silversmith – MMA CEO

Along with the approval of the MMA, the Minnesota End of Life Options Act satisfies Biomedical Ethics based on it's foundational principles:

-Patient autonomy (self-determination)

-Physician to provide full and accurate medical information so as to achieve informed consent

-Beneficence (do good)

-Non-maleficence (do no harm)

-Justice (equal access, equal treatment for similar conditions)

HF 1930 is nearly identical to every medical aid-in-dying law currently authorized in 10 states plus Washington DC and covering 75 million US citizens. Now with 105 years of collective experience with medical aid-in-dying, it is possible to say with confidence that this law works about as well as a laI can work, because the opponent’s fears have not materialized.

HF 1930 encourages the full offering of options to address management of suffering, no matter how severe, which can occur during the dying process by validating the sanctity of the individual doctor-patient relationship. The bill also protects from civil or criminal prosecution providers and patients who follow the law, and also is fair to the providers who opt out.

What is value of the Minnesota End-of-Life Options Act as it relates to the end of a human life?

-For the terminally-ill patient it encourages the full discussion about impending death and the dying process by physicians, patients, and families.

-It results in awareness of the tension between the choices of quality of life or length of life.

-It's consistent with the foundational ethical principle of the autonomy of the fully-informed patient.

-It validates the terminally-ill patient’s concern about the potential severity of suffering during death and dying and allows the vulnerable patient ultimate control of the management of his or her suffering.

-It allows the terminally-ill patient to face the inevitable reality of death without the loss of hope.

-It's about validation of the life the terminally-ill person has lived.

Please pass HF 1930.

David Plimpton, MD

March 10, 2024

TO: House Judiciary Finance and Civil Law Committee Members
FROM: Christina Ogata, resident of House District 33A

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

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.

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

Sunday, March 10, 2024

Dear Representative Borgerding and Members of the House Judiciary and Civil Law Committee,

I ask that you oppose HF 1930, the bill to legalize assisted suicide. In the state with some of the best healthcare in the world, we should be working to improve care and not to endanger the poor, the elderly, veterans, and the vulnerable with this dangerous legislation.

Among other things, this bill:

- Endangers people who are disabled, the poor, the elderly, and vulnerable adults through its lack of appropriate safeguards
- Allows non-physicians to prescribe death-inducing drugs
- Does not require a mental health evaluation before life-ending prescription is written
- Distorts the role of healthcare professionals as healers who seek to "do no harm," and undermines the trust between doctor and patient, by requiring all doctors who assist those with terminal conditions to advise the patient that assisted suicide is a treatment option

I invite you to read this one-pager, which provides more details on why this legislation should be opposed.

Thank you for reading and considering my letter. I look forward to hearing from you.

Sincerely,

Sam Patet
8672 Bechtel Avenue
Inver Grove Heights, MN 55076

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

March 4, 2024

Representative Anna Borgerding
Mn House of Representatives
St. Paul, MN

RE: HF 1930 Written Testimony

Dear Ms. Borgerding:

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

Michael Blissenbach Testimony Against H.F. 1930
Judiciary Finance and Civil Law Committee– Public Hearing March 12, 2024

Dear Chairwoman Becker-Finn 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 Disability 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

TESTIMONY OF ANNETTE HANSON, MD

443-885-0964
hanson1072@gmail.com

To: *House Judiciary Finance and Civil Law Committee*
Representative Jamie Becker-Finn, Chair
Representative Cedrick Frazier, Vice Chair

From: Annette Hanson, MD
Date: March 12, 2024
Re: HF 1930
Position: **OPPOSE**

Dear Chair Becker-Finn, Vice Chair Frazier, and Members of the Committee,

I am a forensic psychiatrist practicing in the state of Maryland and have been studying the issue of assisted suicide or aid-in-dying for several years since a bill was first introduced in my state in 2015. I provide education and training with regard to the assessment of decision-making capacity, and I also provide clinical care in my state's correctional facilities. As a result of this experience I have realized the risk and inadequacy of certain aspects of these laws.

Based upon existing data from the states of Washington, Oregon, and Colorado, I have calculated that statutory safeguards must be approximately 90% accurate in order to prevent the unlawful deaths of unqualified patients. One proxy measure of safeguard accuracy is adherence with required reporting procedures. An investigative report of ten years of data in Washington and Oregon, done by the Des Moines Register in 2016, found that in 40% of reported cases the reports were missing key data, giving an accuracy rate of only 60%. (1) Similarly, during the first year of the law in Colorado, nine of 69 cases were not reported by physicians, for an accuracy rate of 87%. Twenty-two cases had no written request, for an accuracy rate of 68%. Forty-two cases were missing the consultant's evaluation, for an accuracy rate of 39%. Only one patient received a mental health evaluation. In spite of this clear failure to submit mandatory reports, all prescribing physicians attested that they followed the law. ***Statistically this means that disqualified individuals are currently dying unlawfully and with no means to detect or investigate the deaths.***(2)

Of more concern is the fact that at least one non-psychiatrist in Colorado has prescribed lethal medication through telehealth for three patients for whom the sole diagnosis was anorexia nervosa.(3) This internist is licensed in 21 states, to include 16 states in which the practice is a crime. ***There is presently no mechanism to detect the illegal prescription of lethal medication across state lines through telehealth.*** Furthermore, even among mental health professionals, few clinicians are qualified to manage and treat anorexia nervosa. Inadequate care should not be a grounds for assisted death.

Assisted suicide laws undermine state suicide prevention efforts, and are particularly harmful to people living with mental illness. In my own state of Maryland, where assisted suicide remains a crime, I am personally aware of two cases in which patients in our forensic hospital requested lethal medication from their doctor. One of those requests was made on the day that the Maryland bill failed to pass by one vote, an event that was covered widely in the media. A third patient has submitted two written requests for euthanasia. ***Clearly, the media attention given to assisted suicide bills have inspired people with mental illness to request lethal medication in my state.*** This experience is consistent with research on death-with-dignity laws, which has demonstrated that legalization leads to an increase in overall suicide rates particularly among women and the elderly (4-5).

This bill has implications for residents of state psychiatric hospitals and prisons. In 2020 there were 149 prisoners serving life or life without parole in Minnesota. More than 1200 of Minnesota prisoners are older than fifty years of age.(6) If this bill passes, the state will need to consider how or if assisted suicide will be provided in these facilities and also in state psychiatric hospitals. People with mental illness confined to psychiatric hospitals still retain the right to make medical decisions, and many have co-existing medical conditions. The U.S. Supreme Court case Estelle v. Gamble held that a state institution cannot be deliberately indifferent to a serious medical need; thus, assisted suicide could not be categorically denied to institutionalized patients if it is deemed a legitimate medical intervention.(7) Simultaneously, the federal Civil Rights of Institutionalized Persons Act (CRIPA) creates an affirmative duty to prevent suicide in state institutions.(8) ***This policy would create a legal "lose-lose" situation for state-employed physicians working in those facilities in that either refusal to provide assisted suicide or failure to prevent suicide could be a violation of federal civil rights law.***

Given these concerns, this bill is both premature and a danger to public health.

Thank you for your time and consideration of this testimony,

Annette Hanson MD

Annette Hanson, MD

References:
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2. Colorado End-of-Life Options Act, Year One 2017 Data Summary. Available at: https://drive.google.com/file/d/1-kBXgAFzHl6kcfsvtLHfOQ94Unk9mDa-/view. Accessed February 27, 2022

3. Gaudiani J, Bogetz A, Yager J. Terminal anorexia nervosa: three cases and proposed clinical characteristics. Journal of Eating Disorders. 10(1):23, 2022

4. Jones D, Paton D. How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide? Southern Medical Journal. 108 (10): 599–604, 2015

5. Jones D. Euthanasia, Assisted Suicide, and Suicide Rates in Europe. Journal of Ethics in Mental Health. Open Volume 11, 2022. Available at: https://jemh.ca/issues/open/documents/JEMH%20article%20EAS%20and%20suicide%20rates%20in%20Europe%20-%20copy-edited%20final.pdf Accessed March 25, 2022

6. Minnesota Department of Corrections. Adult Prison Population Summary. Available at: https://mn.gov/doc/assets/Adult%20Prison%20Population%20Summary%201-1-2021_tcm1089-467125.pdf Accessed March 5, 2024

7. Estelle v. Gamble. 429 U.S. 97 (1976)

8. Civil Rights of Institutionalized Persons Act. 42 U.S.C. §1997 et seq.

The limited scope of physician assisted suicide has eventually expanded in every country that has legalized it, now pushing the boundaries of morality to include killing people experiencing persistent depression and hopelessness. God have mercy on the societies that abandon the sad and hopeless to death. These people need Healthcare, not the darkness of death. We damage our own goodness every time we callously allow someone to die. No matter what those pursuing death and their doctors say to rationalize suicide, it is unnatural and self-destructive for us to stand back and allow the death of another human being.

Patrick Johnson

Plymouth MN

March 9, 2024

Dear Committee member:

I write to you regarding HF 1930 because Physician Assisted Suicide (PAS) strikes very close to home for me. I was the caregiver for my late wife when she was diagnosed with terminal cancer. As such, for years my late wife and I had to grapple with life and decisions about her care.

As a long time caregiver to multiple cancer patients, including my wife and daughter, I believe HF 1930 is poor public policy because:

1. It damages the doctor-patient relationship and turns the doctor into a killer instead of a healer;
2. It pressures patients to choose PAS over viable treatment options;
3. It requires healthcare providers to discuss PAS in more circumstances than HF 1930 assumes; and
4. It incorrectly assumes a high degree of certainty in a matter that is entirely uncertain

Imagine you walk in to your doctor's office thinking you have a treatable infection and being told you are terminally ill. Instantly, your mind shuts down and can only grasp the simplest of concepts. This is what happened to my wife and me the day she was diagnosed with stage 4 colon cancer.

Now imagine while in this state of shock with a brain that is not functioning at regular capacity, your doctor says, “You have treatment options, but, by the way, let's talk about suicide because you're going to die in six months.” He doesn't actually know if you are going to die in six months, and he doesn't know if your treatments will cure you, give you months or years, or do nothing for you. But what you, the patient, hear is that your doctor thinks you are guaranteed to die--soon.

The day my late wife was diagnosed with terminal cancer was surreal. She was a 32 year old newlywed, and finding out she had stage 4 colon cancer was a bolt from the blue. My late wife and I were in shock for weeks. At no point for weeks, maybe months, were we thinking clearly. What's more, we were thrust into a whole new world that we knew nothing about and had to make decisions about things about treatments we couldn't even spell.

As we shuttled from appointment to appointment to make sense of things, HF 1930 would have had my wife's doctors come in and tell her to kill herself. In fact, not only would they tell her she should kill herself, but the doctors would give her the drugs with which to kill herself.

Doubtless, many think that is not what is actually happening, but that is how it works in the patient's mind. There is only so much one can absorb in that kind of mental state. HF 1930 mandates patients must be told about one and only one treatment option – suicide. Discussing other treatments is optional, but the doctor must talk about PAS. That is coercive because these people are at their most vulnerable.

Further, HF 1930 states that a failure to discuss PAS means there is no informed consent to any other treatment. That means that, if the doctor fails to suggest PAS, any life saving treatment the doctor performs thereafter is a battery, which is an intentional tort. Unlike a claim for medical malpractice, which is a type of negligence, an intentional tort is not protected by any entity or even covered by insurance.

As a result, HF 1930 would compel each and every doctor to err on the side of protecting himself and discuss PAS even where it is not mandated. After all, just because the doctor thinks the patient will live for years does not mean that will necessarily happen. All it takes is for one patient to die within six months and suddenly the doctor is looking at losing his house, career, and ability to help other patients if the doctor has not discussed PAS. That is a foolish risk for a reasonable person to take.

The fact is, six months out, no doctor has the faintest idea about a life or death prognosis, but HF 1930 assumes a certainty about life expectancy that does not exist. "Prognostic error is widespread, [sic] only around 20% of estimates are accurate." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070876/#ref2. It is not until the patient has two weeks or less to live that the doctor has a better than 50/50 chance of being anywhere close to the ballpark when it comes to life expectancy. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC88964/#B2.

The only accurate information a doctor can give you are odds or a range. Every terminal patient hopes to be in the group that defies the odds; someone must be in that 12% who lives for five years. I personally know many who have defied the odds, and they are an inspiration both to other patients and to doctors. HF 1930 takes that hope away from all of us by fooling us into believing there is no hope.

This is horribly destructive to the patient. Sure, hepatic arterial infusion or Flourouracil or radiofrequency ablation may all be highly effective treatment options, but for those who are new to the cancer world, those are meaningless. When you are overwhelmed with all the medical jargon and forced to make choices about things you don't understand, you naturally gravitate toward the one term you do understand, which in this case is suicide. That is not giving the patient a choice; that is pressuring the patient to give up on life. If you want to make someone depressed and susceptible to suicidal thoughts, forcing every doctor to say suicide should be considered is a great way to make sure suicide happens.

After being told she was going to die, my wife went on to live for almost two more years, years in which she got to participate in the lives of her nieces and nephews, go to the weddings of dear friends, travel the world with her husband, celebrate Christmas with her family, and touch the lives of those around her. This is why you need your doctor on your side, to help you have those experiences. Your doctor is supposed to be your healer. We should not turn our healers into our killers.

Very Truly Yours,

Daniel Reiff

Support for End-of Life Options Act
HF 1930
1/25/2024

Good afternoon and thank you for holding the public hearing for this legislative bill.
My name is Jane Cowles and I live in St. Paul. I support the passage of this bill. (End-of-Life Options Act, HF 1930.)

I know that I am going to die………I just do not know when or how.

IF I have a disease & diagnosis that qualifies me to apply for the medication to end my life, I want to have the prescription on hand. That will bring peace of mind, a sense of relief.
If I determine I am no longer able to bear the pain and anguish of the disease, the option is available.
I do not know if would use the prescription. I know I want the choice.

I am the 3rd generation of a family that has discussed the value and importance of autonomy with end of life……living. Yes, living until I die, with my values, having discussions with my medical team and connection with my family and loved ones.
I stand before you, expressing the values and hopes of my parents, Sage & John Cowles, who began discussing and educating this community for this type of legislation in the early 2000's. It is time for our elected officials to pass this bill into law, reflecting the values of a strong majority of citizens all over this state.

Thank you for your time, open mindedness and thoughtful considerations.

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 12, 2024

Rep. Jamie Becker Finn and members of the House Judiciary and Civil Law 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.[1] 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 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-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*

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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

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.[2]

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 testimony was rendered utterly false a mere one day after it was submitted. 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.[3] 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 himself is a zealous advocate of expansion in this direction.[4] He posted to his Medical Futility Blog, "California Makes Big Move on Medical Aid in Dying," approvingly.[5] 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.[6] 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:

> 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.[7]

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

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[2] 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

[3] 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

[4] 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

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

[6] Thaddeus Mason Pope, JD, PhD, Lisa Brodoff, JD, Medical Aid in Dying to Avoid Late-Stage Dementia, " https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/jgs.18785?domain=author&token=VA68TTBJN9VDRCRMRPIP

[7] 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.

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.[8]

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 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, than make those corrections to actually allow people to use it. So that is what we've been discussing.[9]

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[8] 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

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

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.”[10] 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.”[11]

There is much here that I have not covered. To cite a couple of examples, 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. There is also 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.[12] You will hear plenty of testimony on other problems with this legislation, particularly from others in the disability rights community.

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. Please do not put Minnesota—and the rest of the nation—on this path. Please reject HF 1930. Thank you.

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[10] 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

[11] 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

[12] 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

Testimony in support of the Minnesota End-of-Life Options Act
From the Minnesota Clergy for End-of-Life Options
March 12, 2024

Thank you for the opportunity to express my support for the End-of-Life Options Act.

A dear friend of mine died 66 days ago in Vermont where medical aid-in-dying is legal. Her name was Lynda Bluesteen. The cause of death was ovarian and Fallopian tube cancer. I knew Lynda because she was an active lay leader in her local church and an enormously active and effective volunteer for the denomination at which I worked, the Unitarian Universalist Association.

In many ways Lynda's end-of-life journey was like many others with cancer.

From the moment she was diagnosed, she did all the things one does when dealing with such an awful disease. She had surgery. She had radiation. She had chemotherapy. But after 2 ½ years of treatment, it became clear that the cancer was not going away. The cancer was killing her.

So, Lynda had a heart-to-heart conversation with her doctor about her end-of-life trajectory and this is what she said:

> *"I want the right to have a say in the timing and manner of my death when I reach the point where my disease or the pain and suffering it causes robs me of the quality of life that is essential to me."*

She went on to say,

> *"I have witnessed bad deaths – my mom's and my dad's. My mother, who also had cancer, died in my arms, in a too-large hospital bed, suffering and frightened. Five years after mom passed, I sat at the bedside of my father as*

> *he gasped for air and went in and out of consciousness. Neither of my parents wanted their precious final hours to turn out the way they did. I don't want that for me either."*

Then she continued with the intensity of purpose Lynda had become known for:

> *"When the end comes, I want to leave this world on my own terms. I want medical aid-in-dying. I want to take a pill or drink a liquid that will enable me to fall asleep and die peacefully shortly thereafter. I want my family surrounding me."*

Her doctor was sympathetic. He gave Lynda a prescription for a medication that would end her life. Lynda had the prescription filled and at the time that seemed right for her, which turned out to be 66 days ago, she consumed three ounces of liquid that led to become unconscious within minutes and led to her peaceful death within an hour.

When Lynda died, she was surrounded by her husband, her two children and two of her grandchildren. It was exactly as she had hoped.

Please pass this legislation which gives people, like my friend Lynda, an escape from a painful death if they so desire. You have the power to reduce the suffering of those who choose this option.

Rev. Harlan Limpert
Co-Founder and Leader, Minnesota Interfaith Clergy for End-of-Life Options
925 Nine Mile Cove South
Hopkins, MN 55343
612-669-0574

I write in total support of the Minnesota End-of-Life Act, HF 1930.

I speak for myself, my family, for thousands of families like ours, and especially for my two terminally ill sisters who fervently ask you to help them obtain the right to die with dignity.

I present you three points:

Many chronic/terminally ill patients wish to end their suffering.

> Perhaps you personally have had the terrific good luck not to have had a seriously chronically ill family member who is in almost constant pain?
> Or one sedated or full of painkillers most of the time? You are most fortunate indeed.
>
> But if you have or had one, you may have had the wrenching misfortune of having that ill relative ask you if you could help end her suffering, end her life?
> Thousands of family members have been or currently are in this situation, including mine, caring for two terminally ill sisters who wish to be able to choose to die.

Not just for their sakes.

> Let's not fool ourselves. Many of us may or will be in this situation ourselves in the near or distant future, given medical advances that allow physicians to keep us alive longer, maybe not always for the better. If that is your desire, fine, it is your perfect right to go on living for as long as machines can keep you alive. For myself, as for many other Minnesotans, "life at all costs is not living. It can mean enduring chronic pain, losing hope and yes, expending incredibly financial costs, bankrupting self, family, Medicaid, and our state. It's all too much—our whole family is stretching to the limit emotionally, not to mention financially.
>
> We family members feel helpless, because we are. We've explored all the semi-legal and some illegal ways to help our sisters die, because they have asked us and we love them. None of the methods worked out, some due to the particular medical situations of my sisters, too complicated to go into

here. The banned methods out there were too iffy, too scary, or too hard to execute. Many would make criminals of us all too.

You know the saying walk a mile in someone's moccasins? In this context, the sentiment for caring and empathizing would be: spend a year in a terminally ill patient's hospital bed. confined to bed, spoon-fed, dressed and washed by others, and yes, the ultimate indignity, diapered.

MN didn't have to reinvent the wheel here.

The authors of this bill have learned from enlightened states that have gone before. MN can join the ten US states (and DC) that have had the good sense, compassion and the will to help their desperate constituents who are too sick to plead directly before all the committees and legislators, leaving us—their relatives and friends--(feeling) helpless and almost hopeless to petition on their behalf.

Our state is not alone. The work on medical assistance in dying or "death with dignity" bills--the details, specs limits and safeguards have all been done by the compassionate and progressive states and countries that have passed laws already. They have documented that the laws <u>work</u> providing options for the terminally ill. The states with such laws find no scenarios playing out of abuse or misuse.. These bills have not "promoted suicide," they do not require any sick individual to take any action whatsoever. Instead, they grant permission to those who rationally, but desperately, seek relief where any relief has to this point has been banned.

The emotional costs to terminally ill patients is incalculable.
Families are also emotionally exhausted, not to mention financially. In our family, currently we continue to patch together the labors of family, friends and part-time home health aides to the tune of $40,000 a year. One family recently documented the cost of more skilled health care aides needed 24-7 for a more advanced case of what my one of our sisters suffers, also $40,000 but a month, not a year. Note that these costs do not include any of the staggering medical bill costs, just home health care.

I beg you to learn from states with already enacted laws and be moved by petitions like mine here in MN.

We Americans are so proud of upholding the rights of the individual. Let us show some respect for the dignity of the dying by letting the terminally ill not the state determine their own fate.

Please contact me with any further information or assistance I could provide.
Your constituent,

Suzanne Walfoort
145 Wildwood Avenue
Birchwood, MN 55110
Suzanne.walfoort@metrostate.edu
651-338-8890

world without
GENOCIDE
AT MITCHELL HAMLINE SCHOOL OF LAW

March 12, 2024

To Members of the House Judiciary, Finance, and Civil Law 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 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.

This option 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

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

875 Summit Ave, St. Paul, MN 55105 ◆kennedy@worldwithoutgenocide.org◆ 651-695-7621

Medical Aid in Dying Talk-11/9/2023

Medical Aid in Dying/Minnesota End of Life Options Act, or as our opponents call it, “Physician-Assisted Suicide”

Based on federal and state law, we have the legal right to control our health care and make choices that are consistent with our beliefs, values and goals.

What are our End-of-Life Options?

Pursue life sustaining treatment

Refuse treatment even though it will hasten death

Discontinue treatment that has already been initiated

Hospice or Palliative Care (Palliative Care is also called Comfort Care)

Hospice is a formal, government funded program for people with an anticipated life expectancy of six months or less, when cure is no longer an option, and the focus shifts to symptom management and issues about quality of life. It is composed of an interdisciplinary team of professionals (RN, MD, social worker and chaplain) trained to address physical, psychosocial and spiritual needs of the person and support family members.

Palliative or Comfort Care is the medical practice of providing comfort, ie control of pain, discomfort, hunger, thirst, nausea, shortness of breath, or anxiety and can be provided at any time during one's life.

VSED-the acronym stands for Voluntarily Stopping Eating and Drinking.

This choice is legal in every state, is a method to hasten death which generally occurs between 10 and 14 days after complete cessation of eating and drinking and is generally supported by Hospice Services that are not faith-based.

Sedation to Unconsciousness also called Palliative Sedation.

The intention of the physician is to use medication to render the patient unconscious and therefore unaware of their suffering but not to cause the patient's death, however hydration and nutrition are stopped and death generally is the outcome. The physician is in control of relieving the patient’s suffering.

Medical Aid in Dying-not yet available in Minnesota but it is available to 22% of the US population. In Medical Aid in Dying the terminally-ill patient controls the management of his or her suffering.

Definition

Medical Aid in Dying is a medical practice in which a terminally ill adult, with six months or fewer to live, who retains decision-making capacity, may voluntarily ask for and receive a prescription for a lethal dose of medications they may self-administer (swallow) for a peaceful death, if and when their suffering becomes unbearable.

Minnesota End-of-Life Options Act

The Medical Aid in Dying bill, currently named the Minnesota End-of-life Options Act has been introduced to every legislative session since 2015, but has yet to be debated or voted on in either chamber. Polling data shows strong bipartisan support among Minnesota voters and those who attend at the Minnesota State Fair.

Who Qualifies?

Adult – 18 years of age or older

Terminally ill-six months or fewer to live

Retains decision making capacity—able to communicate health care decisions.

Able to self-administer

What is Decision-making Capacity?:

Ability to understand recommendations and consequences of medical decisions as they relate to that individual.

Ability to make decisions.

Ability to communicate decisions.

Cognition is consistent and rational-

Memory is intact.

Free from coercion

Medical Aid in Dying, based on the Oregon's 1997 Death with Dignity Act, is now authorized for 22% of US population

Oregon-voter referendum

Washington State-voter referendum

Montana-Montana State Supreme Court Decision

Vermont-first by legislative action

California

Colorado

Washington DC-City Council vote

Hawaii

Maine

New Jersey

New Mexico

In 2023 the Nevada Legislature passed a Medical Aid in Dying Bill, but it was vetoed by the new Republican governor.

Medical Aid in Dying is NOT Suicide (opponents call this Physician Assisted Suicide)

Medical aid in dying

- Patient has a terminal illness
- Patient is mentally capable
- Patient is interested in self-preservation. They want to live and have endured every treatment to control the disease process and prolong life, but in reality they are dying from the underlying disease.
- Death is peaceful
- Death is planned, often with family present
- Death favors normal uncomplicated grief in survivors

Suicide

- Patient is physically healthy, no terminal illness
- Mentally impaired – major depressive disorder, psychosis, active substance use disorder, acute stressors
- Self-destructive:
  - death may be violent, self-inflicted gunshot or hanging
- Impulsive:
  - alone

May cause:

guilt, anger and prolonged complicated grief in survivors

Who qualifies for made if End of Life Options Act is authorized in Minnesota

- Adult – age 18 or older
- Terminally-ill
- Retains decision making capacity
- Able to self administer the medicine
  - Has to be able to at least drink through a straw
- No Minnesota state residency requirement

Protections/Safeguards:

- No health care professional, hospital, healthcare system, or pharmacy is required to participate
- Liability protection- when health care professionals follow the steps outlined in the law, they are protected from criminal and civil liability
- No impact on life insurance policy
- Does not save money for health insurance companies
- Process is voluntary/controlled by patient
- Has to be self-administered
- Aiding and abetting suicide is still a felony in every state

102 years of collective experience in all authorized states-no documented abuse or coercion, no legal action initiated, no physician disciplined by a state medical licensing board.

Nearly all patients are on hospice with multiple health care observers: RN, social worker, chaplain, physician)

Physician signs the death certificate indicating the underlying disease as the cause of death.

Minnesota Survey (August 2016) by Stanley Greenberg and his group, a highly regarded polling service from Washington DC, in which they interviewed 509 likely Minnesota voters.

All demographic groups show a majority in favor of MAID.

In 2017, the Minnesota Medical Association's Board of Trustees voted to change from opposition to a neutral position regarding Medical Aid in Dying following internal polling of the MMA membership which showed 59% doctors favored MAID, 12% we're uncertain, and needed more information and only 29% of responding Minnesota doctors were in opposition.

A survey by the Minnesota House of Representative at the Minnesota State Fair this year, 2023, showed 73% of the fairgoers who responded favored Medical Aid in Dying.

Addressing Misinformation and Disinformation:

Claim	Data

Increased suicide rate	Wrong: OR rates=national rates
Slippery slope to euthanasia	No evidence in any state
Undermines Hospice and Palliative Care	Actually appears to improve the utilization of Hospice
Used against disabled persons	No evidence that this is true

Oregon Data (2022): The law works about as well as a law can work.

Oregon data is representative of outcomes in other authorized states.

Between 1997 and 2022, in Oregon, 3712 individuals received a prescription for Medical Aid in Dying and 2454 ingested the medication (66%) and died. This is a pattern also noted in other states.

In 2022 in Oregon 431 individuals received a prescription for MAID and 246 individuals died after swallowing the medication.

4 out of every 1000 deaths are related to MAID

Of the patients who qualified for Medical Aid in Dying

64% had cancer

12% had heart or lung disease

10% had a progressive neurodegenerative disorder such as ALS, (also called Lou Gehrig's disease) or multiple sclerosis.

91% enrolled in hospice

92% died at home

The demographics of those who requested and qualified for Medical Aid in Dying:

96% white which also holds in the diverse state of California

49% have at least a bachelors degree

85% were 65 years of age or older

No coercion reported, no physician disciplined by state medical licensing board and no legal action taken.

What are the End of Life Concerns of people choosing MAID?

Decreasing ability to participate in activities that make life enjoyable: 89%

Loss of autonomy: 86%

Loss of dignity: 62%

What can you do?

If you favor Medical Aid in Dying call, write or email your state senator and state representative, irrespective of party affiliation, yours or your state legislator's, and ask for hearings in committees in both chambers of the Minnesota End-of-Life Options Act when the 2024 legislative session opens on February 12th.

Urge friends who favor Medical Aid in Dying to do the same.

If possible attend hearings at the MN Capitol on Medical Aid in Dying to show support, as the opposition will attend in large numbers, are well organized and well funded

Sign up with Compassion & Choices and follow their emails

If you have financial capacity, donate to Compassion & Choices

David B Plimpton, MD

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. 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

March 12, 2024

Dear House, Judiciary Finance and Civil Law Committee:

Re: 1930 SEC 14 (b) Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, euthanasia, mercy killing, homicide, murder, manslaughter, elder abuse, or neglect, or any other civil or criminal violation under the law.

If it is not suicide, then what would one call it? How could assisting, hastening a patients death be considered meeting the "medical standard of care"?

Suicide according to one internet definition is: "The act or an instance of intentionally killing oneself".

According to God's law (Mosaic law) – murder is prohibited. Suicide is self-murder, thus prohibited.

I find it disturbing how the lines of moral distinctions are blurred in this proposed bill. If passed, it will likely lead to increased suicides among other "non-qualified" individuals throughout MN as evidenced by statistics from other states that have approved lethal doses of "medication" to end one's life.

Confusion, lack of knowledge and misinformation would spread the practice of suicide.

One can "define" a difference between administering a lethal dose, as in euthanasia, and prescribing a lethal dose but would there be a difference? The State of MN through Physicians would be making the strong suggestion to society that killing oneself is the right thing to do. When a person is considered in a "terminal phase", why wait?

Why choose palliative or hospice care which can provide medication to ease pain? These options provide comfort, emotional and spiritual support - *why not choose care instead of hastening death?*

Yet the State would be choosing to encourage people to die sooner. To make a fatal decision quickly. It really should be called the "End your life Option Act".

I urge you to vote NO.

Thank you, Linda Stanton

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 11, 2024

Dear Rep. Anna Borgerding and members of the Judiciary and Civil Law 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 evaluate their mental capacity. I would argue that anyone going through a terminal illness has some level of depression and/or anxiety and therefore, 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.

Written Testimony for Judiciary & Civil Law Committee Hearing on HF 1930
March 10, 2024

Re: Lack of effective safeguards, especially *after* the lethal medication has been prescribed

Dear Legislators,

I have been an internal medicine physician in Rochester for over 35 years, taking care of patients with serious illness – including many at the end of life and in hospice care. I'm writing from that perspective in opposition to HF 1930 as an individual citizen and not representing the views of my employer or any other organization.

The stories that we have heard surrounding this issue have been deeply moving for me, just as they have been all too often with many of my patients, and I've felt this even more acutely when I walked alongside my sister in her struggle with cancer, until it took her life in 2019.

But it's hard to imagine forging ahead with legalization of this proposed solution when the medical community at large continues to have grave concerns about it.
In recent years the two largest groups of doctors in the nation, after extensive study and vigorous debate, and under intense pressure to change their position, decisively *reaffirmed* their opposition to Physician Assisted Suicide (a term used only for sake of clarity, without intent to stigmatize anyone). The American College of Physicians, representing internal medicine, did so in 2017 and the AMA (representing all specialties) did so in 2019, by a vote of 392-162 in their House of Delegates. Clearly, many of my colleagues have deep reservations when it comes to this practice.

But apart from the core ethical and professional concerns, there are issues with implementation as well.

Estimates of life expectancy can be inexact, and many of us have patients who have outlived their prognosis, on occasion even by a few years. Separately, patients and their families struggle with the tough and complex decisions that must be made in the face of serious illness, and understandably may change their minds. It can be a very fluid situation. The desire to die will often fluctuate and can be influenced heavily by coexistent depression, level of symptom control and other factors. But once the lethal dose is ingested, all opportunities for what might have been are lost forever.

In fact, the **lack of any effective safeguards surrounding the ingestion of the lethal dose** represents one of the greatest weaknesses of this bill. There is **no legal requirement that a witness be present**, nor that the patient be competent or reaffirm informed consent at the time of ingestion. The CEO of Compassion and Choices testified at a House hearing for a previous version of this bill in 2019. During her testimony, she conceded (under questioning) that her group **struggled to provide effective safeguards at the time of ingestion** but were unable to do so without infringing on patient privacy and autonomy. This is one of the reasons that the AMA confirms that this practice would be "difficult or impossible to control". While Section 13 outlines penalties for coercion and other abuses, these would be very difficult to enforce, even if there were the willingness to prosecute (which heretofore has been virtually non-existent in Oregon and other states).

This bill seems motivated by a genuine concern to alleviate suffering and provide greater autonomy for the small number of patients who would choose this option. However, it would harm not only them but many others. The problem is heartbreaking and real, but this is not the solution. I urge you to oppose it.

Respectfully,

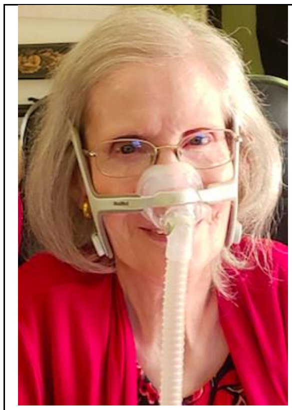
John B. Bundrick, MD MACP
Physician in Rochester, MN

NOT DEAD YET
The Resistance

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

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

March 12, 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

Written Testimony in Support of HF1930 End-of-Life Options Act

March 12, 2024; House Judiciary, Finance and Civil Law Committee

This time last year, my 84-year-old grandmother had already been in hospice for 13 days, and she still had 18 more to go. The stent in her stomach, inserted after half of her stomach was removed, had been replaced every six months for a decade and was slowly closing off as the tumor in her stomach grew to the size of a grapefruit. Bile from her liver was leaking into her body, her skin and eyes turned yellow, and then dark orange.

She was losing her 18-year battle with cancer. For 18 years, she had been poked and prodded in hospital after hospital, by specialist after specialist. Now, modern medicine had nothing left to offer her as she was too frail to go under anesthesia again. Hospice provided her "comfort" measures, but this gave her no psychological or physical comfort. She couldn't sleep, couldn't eat, and was plagued by cold spells and fits of pain. She was lucid for all those days, aware of her body's slow disintegration.

Every day when I visited her, she talked of dying. She was ready, she wanted to go, and every night when she went to sleep, she told me that she prayed she wouldn't wake up. She had lost the will to live, and lost the ability to live with dignity. There was nothing anyone could do about it.

This legislation allows terminal patients with stories similar to my grandmother, with less than six months to live, the ability to choose when the elements of life – as they define them – are gone. It gives people the *choice* to self-administer medication to end their suffering, and to allow them to leave this world with the dignity they have left. It gives people the ability to have autonomy over their bodies, a universal human right according to the United Nations.

There are protections against misuse – two physicians must confirm the terminal diagnosis, and the patient must be deemed mentally competent by both physicians. This **excludes** patients with Alzheimer's, or patients with any form of cognitive impairment. Across the world there are 74 million people who have this ability. In the US, there are 280 million people who can make this choice for themselves. In the ten states plus Washington, D.C. which have Medical Aid in Dying (MAID) bills, there have been **zero instances of misuse** of medication. ZERO.

Medicine is intended to heal the body and the mind, and when one's body is beyond repair, the true psychological and emotional healing comes from one's ability to have autonomy over their body. This bill doesn't force anyone to accept or ask for MAID – it simply provides choices for those who are suffering and would like to access it.

For those who do not wish to access MAID due to religious or cultural beliefs, they do not have to. And for those who do wish to access MAID, this bill allows them to have **dignity and autonomy** at the very end of their life course.

Please support this bill to assist people in healing.

Rachel Hall Beecroft
Communications Director, World Without Genocide
at Mitchell Hamline School of Law
875 Summit Avenue, St. Paul, MN 55105

16409 Canterbury Drive

Minnetonka, MN 55435

March 10, 2024

To the Honorable members of the House Judiciary, Finance and Civil Law Committee,

I am writing regarding the End-of-Life Options Act.

My mother and my husband died twenty years apart from pancreatic cancer. Both wished to make responsible and rational decisions over their end-of-life treatment. Because of the possible legal consequences for their caregivers and family members their dying wishes were denied. As a result, their lives ended in prolonged and excruciating pain, and lost dignity.

It is time to respect the decisions of terminally ill patients. I believe that the End-of-Life Options Act would have alleviated some of the anguish my mother and husband felt as they neared death.

I urge you to support HF 1930.

Sincerely,

Randi Markusen

Anna Borgerding:

I write in support of the MN End-of-Life-Options Act (HF 1930). Please include this personal testimony before the House Judiciary, Finance and Civil Law Committee's hearing on Tuesday, March 12, beginning at 8:30 a.m. in Room 5 at the State Office Building.

I was my mother's primary caregiver. We were very close and loved each other deeply and tenderly. Mom died at age 89 and 10 months. She had scoliosis with a curvature of the spine that greatly compromised her breathing, as well as had other medical challenges. After she fell in the nursing home, hit her head on the bedside table, and suffered a subdural hematoma, I drove her to the hospital and stayed with her constantly. Mom already had a health care directive. I was her 'agent.' It was her decision to reject brain surgery which might have left her in a 'vegetative state' and/or led to her death.

I invoked Mom's written health care directive preferences. Her choice was to reject brain surgery and return to the nursing home. It was her 'option' to use a legal amount of morphine for comfort care. We were blessed to share "I love you's" in the days leading up to her death. Mom died peacefully in my arms January 9, 2013. I continue to miss her every day.

Now I am 75 years of age. I have no children, no spouse, etc. While I regularly pray that I might have a peaceful death as Mom did, I highly doubt that will happen, even though I have a health care directive and health care agent. .

Most often the medical staff doesn't want to be bothered to try to reach the health care agent, nor consider it to be important. Medical staffs sometimes don't even attempt to 'read' a person's health care directive. When a person has an emergency at home, on the highway, or elsewhere and EMTs are called, EMTs also aren't concerned about one's end of life preferences. So what does medical staff do? Whether in a hospital or in an ambulance, they fear litigation and engage in all effort and skill to keep the person alive, not respectfully considering one's quality of life and written/documented end preferences.

Please support medical aid in dying for me! When I am in a terminal situation, without medical aid in dying, I suspect I will be connected to all life support procedures that will keep me alive, and also lead to terrible pain and suffering, that is void of any quality of life. Just 'existing' in a long-lingering death is no quality of life. It is disrespectful and de-humanizing. I do not want this for me. I suspect that members of this committee also do not want this agonizing experience.

I am a person who enjoys quality of life. At age 75 I continue to ride my bicycle when the weather cooperates, but also ride my indoor exercise bike when the outside weather is inclement. I play my trumpet every day!! I've played since age 8. That's a long time. I do 100 sit-ups, 6 out of 7 days every week. I do a 4 minute plank every other day. I walk (in addition to riding bicycle) at least 6500 steps every day. I also do other exercises daily. I read, write, study, and pray every day. Quality of life? Yes!

MY GREATEST FEAR IN LIFE IS: NOT having control over my end of life. Please help me to have as peaceful an end of life as my mother experienced. Do NOT force me to endure a long-lingering, painful death void of comfort, meaning, and peace. Please grant me autonomy and control over my dying, just as I've had autonomy and control over my long life. Please allow me to have medical aid in dying at my end time so I can transition peacefully in joining Gabriel in playing beautiful trumpet music in heaven. Now, that's quality of life!!!

Please compassionately support the MN End-of-Life Options Act.

Very sincerely,
Lois D. Knutson
218-830-2299
300 1st Ave. NE. Apt. 203
Austin, MN 55912

March 11, 2024

Dear Committee Chair Becer-Finn and Members of the House Judiciary Finance and Civil Law Committee,

My former partner has been in hospice care for almost a year now. He suffers from Lewy Body Dementia and is at this point unable to do anything but sit in a wheelchair. He cannot feed himself. He needs personal care around the clock. Most of the time he dozes, and occasionally he comes to and is frightened, confused and frustrated. Over the last weeks, he stopped recognizing me and our daughter, for whom his ordeal is a nightmare.

He started showing signs of dementia eight years ago, but had a few decent years during which he could have made a decision to end his life before it got this bad. I understand the concerns of the public, and the committee, about a law allowing people to die when they have a terminal illness. Great care should be taken so that such a law cannot be abused. But I assure you that the current state of affairs creates immense suffering for patients and their families; in my years of caring for my former partner, I have met many other people in the same position who can attest to this. It is my greatest nightmare that I may end up in a situation similar to my partner's, and that my daughter will have to go through this ordeal a second time.

Please support a law that will be the only relief for many, many families.

Sincerely,
Sigi Leonhard
Professor of German, Emerita
Carleton College

Members of the House Judiciary, Finance and Civil Law 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 she could no longer eat or drink. 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 with no water or food. Four weeks of a living hell. Four weeks of watching my mom literally disintegrate and decompose In front of our eyes, her body convulsing incessantly, while we begged and pleaded with her medical team to address her suffering. Her hospice team was at a loss as to what to do. There is nothing beautiful, sacred or peaceful about watching your mom die in this manner, stripped of all choice, control and dignity.

My sister and I were her voice then and exactly two years later we are still her voice. And the voice for many others 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.

Protection of the most vulnerable is often used by those who oppose MAID as an argument against this bill. 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. 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.

So by not passing this legislation, it will indeed be the most vulnerable who will continue to suffer

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 insurance companies 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 MAID upon their death. Every eligible person should have the freedom to make that decision for themselves. But that is the whole point, without MAID, there is no 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

*https://www.house.mn.gov/sessiondaily/Story/18032

To the House Judiciary, Finance and Civil Law 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

To the Honorable Anna Borgerding,

I work in a Twin Cities hospital. The most critical aspect of my job is to make suicide risk evaluations of emergency department patients. My responsibility is to do my best to prevent suicide. My physician colleagues, nurses, and other medical staff work hard in the emergency department to save the lives of patients. I am appalled that the MN legislature is considering legislation that would involve healthcare providers in the act of facilitating patients' deaths or be required to refer patients to other providers if they do not choose to facilitate the deaths of patients.

I think approving this legislation will have a terrible long-term effect on the trust between patients and providers. I can see vulnerable people choosing to not seek needed medical care because they do not know if the care providers will work for their good or encourage them to end their life. I can also see those communities, who already do not trust healthcare providers, being more untrusting.

I write to express my strong opposition to this legislation.

Sincerely,

Chet Mulholland

Roseville, MN

HF 1930

I am concerned over the continued devaluation of Life**.** **Why are we putting external factors on the value of a person?** Suicide laws like HF1930 have been used elsewhere for population control and to coerce the homeless or those with high medical needs to end their lives early. What will this do to a society? What will happen to society if we continue to encourage the hardening of one's hearts to the vulnerable? Why are we instilling an external sense of individual "worth"? **A person's value is not determined by what one produces but on the fact that ever human life is sacred and has intrinsic value and worth.**

LWV LEAGUE OF WOMEN VOTERS®
OF MINNESOTA

March 11, 2024

Chair and Representative Jamie Becker-Finn
House Judiciary, Finance and Civil Law
Room 5, State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd
Saint Paul, MN 55155

Re: Testimony in Support of HF1930

Dear Rep. Becker-Finn and members of the House Judiciary, Finance and Civil Law Committee,

The League of Women Voters Minnesota (LWVMN) supports HF 1930, the Minnesota End-of-Life Options Act. In 2022, LWVMN concurred with LWV Utah's "Death with Dignity" study that provided information about laws in the five states which allowed terminally ill persons to request physician aid in dying, and a history of death with dignity. With a ⅔ majority of delegates voting on behalf of our local Leagues, we adopted the following position statement in support of laws ensuring end of life options:

- Legislation that grants the option for a terminally-ill person to request medical assistance from a relevant, licensed physician to end one's life
- Legislation that includes safeguards against abuse for the dying and/or medical personnel

The strong membership support for end of life options suggests that HF 1930 aligns with our basic principles of equal access to healthcare and privacy in healthcare decision making.

We urge you to ensure that Minnesotans also have the freedom to make decisions about the end of their life according to their own values and priorities by supporting HF 1930.

Thank you for your public service.

Sincerely,

Sam Streukens

Sam Streukens, Civic Engagement Director - League of Women Voters Minnesota
sstreukens@lwvmn.org - 546 Rice Street, #200, St. Paul, MN 55103

11 March 2024

Dear Honorable Sir/Madam,

I write in opposition to the proposed legislation to legalize physician assisted suicide (HF1930 & SF1813). In my 39 years of practice, I've never had a patient request assisted suicide. As unrelieved pain is often cited as justification for this practice, it is my clinical experience that advanced palliative and hospice care are a more humane means of pain control and avoid placing the physician in the precarious position of choosing between killing and caring for his/her patients. The unanticipated result of such legislation is to create an environment in Heath Care where the patient's right to die becomes a duty to die. As a colleague of mine likes to say, "my patients ask me to take their hand, not their life." I whole-heartily agree with his perspective and urge you to withdraw this legislation.

Sincerely,

John I. Lane, MD
Professor of Radiology
Rochester, MN

March 5, 2024

IN SUPPORT OF: Minnesota H.F. 1930: End-of-Life Option

I have a terminal diagnosis of ALS, and any internet search of the disease will tell you that the progression of the disease is unique to each patient, and that death is prolonged, complicated and agonizing for all concerned.

Regardless of diagnosis, what we all hope for, for ourselves and our loved ones, is a peaceful death.

What is most important to me about HF1930 is that the bill makes it legal for me to talk to my doctor about the medication option for End of Life choices, without fear of harm to them or harm to me coming from the discussion. I am concerned about the legal liability to my health care providers and to my survivors for even bringing up the topic. I am wary of insurance companies who would look for a reason to deny the death benefits under my policy.

H.F. 1930 makes the decision **easier** because I can talk freely to a trained professional about ALL the options, instead of relying on word-of-mouth and my own haphazard research.

H.F. 1930 makes the decision **safer** because IF this is my choice for end-of-life, I can access the medication and medical support in ways that are legal and regulated.

H.F. 1930 makes the decision **transparent,** because no one has to hide the fact that they discussed it, no one has to "talk in code" to get their thoughts across.

H.F. 1930 gives medical providers, patients and survivors freedom from legal repercussions when they follow the carefully constructed guidelines of the bill.

Medical care at any stage of life, from birth to death, should be a personal and private decision between an individual (or their legal caregivers), and their medical team. HF 1930 puts medication among the options for end-of-life, but more importantly, it allows for the safe and open consideration of ALL options.

Sharon Born
Minneapolis, MN

As a full-time family medicine physician, I stand strongly in opposition to the Physician Assisted Suicide legislation (HF1930). The implications of HF 1930 are far-reaching and dangerous, not only for patients but for doctors.

As written, this bill will severely infringe on the conscience protections of providers. The bill states that, *"If a provider is unable or unwilling to fulfill an individual's request for medical aid in dying medication or to provide related information or services requested by the individual,* ***the provider must, upon request, transfer the individual's care."*** Shortly after, the bill also indicates that I, as a physician, cannot *"engage in false, misleading, or deceptive practices"* related to offering physician assisted suicide. Who is defining these terms? Would physicians like myself be charged with a gross misdemeanor and disciplined through the medical board for "false practices" if we decline to discuss this care option, or refer patients to other providers? In an age of a shrinking primary care workforce, provisions like this will assuredly **drive high-quality, caring healthcare providers away from primary care in the state of Minnesota**. It wouldn't stop with physicians; this will impact quality nurses and pharmacists alike who will not want to even have a hand assisting suicide in the patients for whom they are seeking to provide *real* "compassionate care."

An additional concern that should be noted by the Judiciary Finance and Civil Law Committee is the fate of unused medication and its ramifications on the general population. If this deadly dose of medication is prescribed and not used, the bill kindly asks that the medication is disposed of in accordance with state or federal guidelines. If the opioid epidemic of the 90s and 2000s has taught us anything, **once the medication is prescribed, there is no true way to control what is done with it.** How will this medication be tracked? How can there be assurance the medication will be properly disposed of rather than being passed around the general population? Do you want a state where deadly doses of medication are prescribed, never tracked, and possibly put in the wrong hands?

Finally, this is a bill that must be considered not only by its impact on those with terminal illnesses and physicians in Minnesota, but also by **its generational impact**. This type of legislation shapes future policy and perspectives. What world will your children or grandchildren live in? One where patients continue to be cared for with *true* compassion and dignity, especially in their hardest, most vulnerable moments? Or one where human beings view themselves as disposable or a burden on their family and society? Further, as other locations (Canada, the Netherlands, etc) where PAS is legal have already shown us, the 'slippery slope' argument isn't hypothetical—it's inevitable. It *starts* only in competent adults with terminal illness- then *in the next generation* it expands to youth and vulnerable adults. Oh, and suddenly having a terminal illness isn't so important.

Please don't open this Pandora's box for our state.

I respectfully urge you to oppose HF 1930.

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

humanlifealliance

11614 93rd Lane NE

Minneapolis, MN 55449

Dear Chair Becker-Finn and Members of the Committee,

Human Life Alliance is committed to building a culture where every life is valued. Our mission is to Inform and Inspire through education and by promoting life-affirming alternatives to abortion, infanticide, assisted suicide and euthanasia.

So-called "medical aid in dying" preys upon the discouragement and pain that individuals with chronic suffering experience. People with chronic and terminal diagnoses deserve better treatment than legislation that tells them they are a burden and their lives are not worth living.

Over the years, Human Life Alliance has heard from people who are in vulnerable medical situations themselves or are walking alongside loved ones. Mark Davis Pickup, who has spent his adult life navigating the challenges of multiple sclerosis, shared a note he wrote to his doctor urging him,

> Protect me from myself, or others, who would take my life before my natural death… I would not ask you to stop being my healer and become my killer, unless my mental state and faculties were impaired by depression or disease.[1]

No patient should worry that if they say the wrong thing to their doctor, he or she may help them end their lives instead of offering healing and support. No doctor should ever be placed in a position of violating the ethic of doing no harm to their patients and instead becoming an agent of death.

We also urge you to consider the ways that "safeguards" have been eroded, removed, and skirted in states that have embraced assisted suicide. In Oregon, only 1% of patients who sought assisted suicide in 2022 were even referred for psychological evaluation.[2] Suicidal ideation is not a sign of a healthy mental state. It is a clear sign of depression. These individuals were failed by the "safeguards" of a state that has embraced death as the "solution" to disease.

46% of patients seeking assisted suicide cited concerns about "becoming a burden" to their families or loved ones as a reason for their request.[3] The three most cited reasons for seeking assisted suicide were loss of autonomy, loss of ability to do things they enjoyed, and loss of

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[1] Mr. Pickup has also published his letter here: Pickup, Mark Davis. "A Letter to My Doctor Not to Kill Me." *Human Life Matters*, 16 Apr. 2016, www.humanlifematters.org/2016/04/a-letter-to-my-doctor-not-to-kill-me.html.

[2] *Oregon Death With Dignity Act 2022 Data Summary*, Oregon Health Authority Public Health Division, 8 Mar. 2023, www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.pdf.

[3] Ibid.

"dignity."[4] Needing care and assistance from others does not mean that a person no longer has dignity. Each one of us needs the help of those around us at some point in our lives. This does not mean we are not valuable—it means we are human. If we choose to become a society that treats vulnerable people as if they are disposable, the price will be our humanity.

Just over a year ago, professionals in a Medical Aid in Dying seminar in Canada acknowledged that they have patients who are seeking death because they are poor.[5] Here in the U.S., there are documented cases in assisted suicide states of insurance companies denying coverage for treatments and informing patients or doctors that assisted suicide is a covered option.[6] Assisted suicide is not a compassionate, it is predatory and exploitative.

Assisted suicide has far-reaching consequences. It ends valuable lives and communicates to others that their lives are not worth living. It creates opportunities for bad actors to use their influence to hasten the demise of people they consider inconvenient. And it sends a message to every segment of society that life is not sacred. Should we be surprised that Oregon, the first state to legalize assisted suicide, has a suicide rate 40% higher than the national rate?[7] We cannot cheapen life and then be shocked when people who are struggling to see their own value begin to question if their lives are worth living. We must do better than this.

At Human Life Alliance, we do not believe that suicide is the answer to suffering, nor do we believe that the appropriate response to someone who is depressed to the point of seeking to end their own life is to help them kill themselves. There is nothing compassionate about this legislation. There is nothing compassionate about telling people that their lives are not worth living.

In life,

Andy Aplikowski
Executive Director
humanlife.org

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[4] https://wng.org/roundups/assisted-suicide-on-the-rise-1617226720 Ibid.

[5] Briscoe, Joshua, et al. "'I Don't Want to Die' - New Revelations on How Canada Ushers the Vulnerable to Medically Aided Death." *The New Atlantis*, 19 Jan. 2023, www.thenewatlantis.com/publications/no-other-options.

[6] Richardson, Bradford. "Assisted-Suicide Law Prompts Insurance Company to Deny Coverage to Terminally Ill California Woman." *The Washington Times*, The Washington Times, 20 Oct. 2016, www.washingtontimes.com/news/2016/oct/20/assisted-suicide-law-prompts-insurance-company-den/. and Richardson, Bradford. "Insurance Companies Denied Treatment to Patients, Offered to Pay for Assisted Suicide, Doctor Claims." *The Washington Times*, The Washington Times, 31 May 2017, www.washingtontimes.com/news/2017/may/31/insurance-companies-denied-treatment-to-patients-o/.

[7] Valko N. Why are suicide rates climbing after years of decline? Linacre Q. 2017 May;84(2):108-110. doi: 10.1080/00243639.2016.1221305. Epub 2017 May 3. PMID: 28698703; PMCID: PMC5499219.

My name is Rebekah Taylor. I am a Licensed Independent Clinical Social Worker in the state of Minnesota. I have been employed as a hospice professional since 2015, both in leadership and frontline hospice social work roles. I am writing today in opposition to HF1930.

Every day, I serve the dying and their families. I accompany those diagnosed with terminal illness as they journey toward the end of their lives. I listen. I offer gentle counsel and education on what to expect. I hold space for the fears, regrets, and "I love you's" whispered before death. Every day, I witness struggle and beauty, loss and peace. Dying is complicated. It is not always easy, but it is sacred. Dying is an integral part of the human experience.

In Minnesota, we already have the resources we need to bring comfort and peace to those who are dying. Death with dignity is possible –with quality hospice care! With hospice care, doctors, chaplains, nurses, social workers, music and massage therapists, home health aides, and volunteers partner together to address holistically the emotional, spiritual, and physical pain that patients may experience at end of life. Needed medications for symptoms, equipment and supplies, resources, counseling, and advance care planning–all are available to patients on hospice care and are covered under Medicare and nearly all insurance plans.

Unfortunately, hospice care is underutilized in Minnesota and across the country. Barriers to accessing hospice remain, particularly within communities of color.[1] Further education on hospice, both for patients and medical professionals, is needed. Racial disparities, care for the uninsured and underinsured, and poor health literacy around serious illness must be addressed.[2] Our energies need to be focused on these issues and not on plans to bring a controversial practice with a limited research base and few patient protections to our state.

H.F. 1930 is deeply flawed. It does not require mental health evaluations for individuals requesting aid in dying. As a professional licensed to diagnose and treat mental illness in the state of Minnesota, this is appalling to me! In hospice, we often serve patients with mental health conditions. Clinical depression, in particular, could greatly impact a person's decision to end their life. There is also great potential for coercion in this bill. Unfortunately, with some regularity, I see family members and paid caregivers pressure patients to complete or change wills or sign Power of Attorney and Health Care Directive forms. What protections in this bill would prevent that from happening with aid in dying? If this bill were to become law in Minnesota, I greatly fear a future where the lives of vulnerable patients are considered expendable.

End of life options to relieve suffering exist in Minnesota! I say it again: death with dignity is already possible. Seasoned, compassionate professionals like myself are ready to offer care and relief to those who are dying. Neither prolonging life nor hastening death, we honor each moment, each smile, each tear, each story, each breath. Even in our dying, we live. How misguided it is to push for medical aid in dying when the gift of quality hospice care is not yet more widely known and shared! How shortsighted to seek an end to life when care and comfort for the living are close at hand! Dying is complicated. It is not always easy, but it is sacred. Please join me in opposition to H.F. 1930. Thank you!

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[1] National Hospice and Palliative Care Organization (NHPCO)
https://www.nhpco.org/nhpco-publishes-hospice-through-the-dei-lens-research-report/

[2] NHPCO
https://www.nhpco.org/wp-content/uploads/Medical_Aid_Dying_Position_Statement_July-2021.pdf

March 10, 2024

Minnesota House Judiciary Finance and Civil Law Committee

Dear Committee Members,

I am writing in support of House File 1930, Medical Aid in Dying. The bill is written to allow a person who is dying to choose a peaceful death or a suffering death.

My sister was diagnosed in March 2020 with stage 4, non-smoker lung cancer, metastasized to her bones. After 3 rounds of chemo – at first showing positive results and then massive spreading – her choice was a more aggressive chemo or hospice. She chose hospice allowing this painful disease to take its course.

My sister's four months of hospice care started with pain pills and antidepressants which numbed her pain. She progressively moved to more and stronger pain pills and I had to take over administration. The last two weeks she was switched to liquid meds administered every three hours. My once take-charge sister was now very thin and lethargic but every three hours as the meds worn off, she was still in pain.

Life is precious. My sister fought valiantly. She was very religious and met with her pastor weekly. Yet, with the pain and knowledge that her life was ending she begged for me to give her something so that she did not have to wake up again. Of course, I could not. If Medical Aid in Dying had been available, she would have taken that option.

This bill is for people who are DYING and KNOW they are dying. This bill allows those who are dying to decide how they want to spend their last days.

Please pass this bill.

Lynn Carlson
1255 Wilderness Run Road
Eagan, MN 55123

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

MINNESOTA
FAMILY COUNCIL

TRUE NORTH LEGAL

March 12, 2024

Judiciary Finance and Civil Law Committee
Minnesota State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

Chair Becker-Finn 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 also 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. If these rights were better understood and executed, assisted

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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.

suicide would likely not be a consideration by many. Again, with our wealth of resources, we should be prioritizing innovative policy solutions of care.

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 neighboring Canada, where assisted suicide is legal, the first people to bear the impacts of rationed healthcare will be those who are already vulnerable, such as folks with disabilities, the elderly, and historically marginalized communities, including people of minority groups and homeless individuals. 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 respondents, an "irremediable medical condition" would not be a variable in that scenario. In addition, 27% of survey respondents stated that poverty is sufficient reason to seek assisted suicide. Again, no medical condition was listed as 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 pills 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– 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	Renee K. Carlson
Acting Director of Public Policy	General Counsel
Minnesota Family Council	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.

To Chair Becker-Finn and Members of the Judiciary, Finance and Civil Law Committee,

Thank you for considering HF 1930, the MN End of Life Option Act. I hope you will vote favorably on this bill.

I'm a retired physician and support the right of human beings to control their lives to the end, particularly when pain and suffering cannot be controlled.
As an anesthesiologist, part of my job was to control pain. However, there are circumstances in which the pain of some terminally ill patients cannot be alleviated. They experience a painful, undignified death. That's why I support this legislation.

Prior to moving to MN five years ago, I lived in WA state where a similar law has been in effect, successfully, for years. I believe that residents of MN are entitled to the same type of protection for their personal dignity and bodily autonomy, if necessary, at the end of life.

I urge you to pass this piece of legislation.

Sincerely,

Michael M.H. Tan, M.D.
5855 Cheshire Parkway #2103
Plymouth, MN 55446

mtan@tandynasty.com
76 3.208-0132

MPhA
Minnesota Pharmacists Association

MSHP
MINNESOTA SOCIETY OF
HEALTH-SYSTEM PHARMACISTS

Date: Tuesday, March 12th, 2024

To: Representative Mike Freiberg
Senator Kelly Morrison

CC: Representative Becker-Finn

From: The Minnesota Pharmacy Alliance
The Minnesota Pharmacists Association
The Minnesota Society of Health-System Pharmacists

Re: HF1930 – The End-of-Life Option Act – 2nd Engrossment

The Minnesota Pharmacy Alliance (MPA), the Minnesota Pharmacists Association (MPhA), and Minnesota Society of Health-System Pharmacists (MSHP) represents pharmacists and pharmacies across Minnesota. MPA represents many types of pharmacists and pharmacy technicians from those working in health-systems, to regional and national chains, to pharmacists embedded in clinics and independently owned pharmacies. We are writing you today to share our support for the Author's amendment language to further modify Representative Freiberg's End-of-Life Option legislation.

We appreciate being able to work with you and all the stakeholders on this sensitive issue. Choosing to end one's life is a deeply personal decision that should only be made with the counsel of an appropriate licensed provider. Providers that choose not to participate in prescribing, administering, or dispensing medications that end a human's life should not be punished for this complex choice. They should also not be subjectively held to a standard that could make them criminally liable and so we very much appreciate the amendment language today that clarifies the responsibilities of a pharmacist, and in this case a compounding pharmacist that will prepare and dispense and counsel on the medications associated with medical-aid-in-dying.

Pharmacists have the right to conscientious objection and Minnesota law protects this right. MPA takes a neutral approach to this bill and medical aid in dying. We are aware that 11 other states do spell out in statute how, when, and where End-of-Life options can legally take place. We appreciate that your bill language considers some of the decisions and actions a pharmacist participating in the dispensing or administration of medications to end a life would need to take. We specifically want to write in support of the provider protections and immunities spelled out in Article 1, Section 8 of HF1930. Thank you for including them.

Here are the considerations, suggested changes and questions we have about the bill language as proposed to be amended.

HF1930 - 1st Engrossment bill language

> 9.30 Subd. 4.**Pharmacist responsibilities.**
> A pharmacist who receives a prescription for medical aid in dying medication may dispense the medication and any ancillary medications to the attending provider, to the qualified individual, or to an individual expressly designated 9.31 9.32
> 10.1 in person by the qualified individual. If dispensed, the medical aid in dying medication and any ancillary medications must be dispensed in person or, with a signature required on delivery, by mail service, common carrier, or messenger service. 10.2 10.3

The legislative language in subdivision 4, Pharmacist Responsibilities, articulates the authority to dispense the medication that would end the patient's life. When a licensed compounding pharmacist chooses to participate in dispensing the aid in dying medication, we appreciate the responsibilities being detailed in the bill language. We assume that the participating pharmacist would not be responsible for determining if all "qualifying individual" and end-of-life patient as defined has already been determined before dispensing the prescription and that ensuring that those steps have been taken and the legal criteria met.

> 10.18 **Subd. 6.**
> **No duty to fill a medical aid in dying medication prescription.**
> (a) A pharmacist may choose whether or not to fill a prescription for medical aid in dying medication.

We appreciate that the bill calls out the right of a pharmacist to be able to choose to not participate in the dispensing of aid in dying medications.

However, and Most importantly, we greatly appreciate that Subd. 6, (b) is being removed from the bill language.
Subd. 6 (b) is unnecessary and redundant.
The Minnesota Board of Pharmacy's MN rules 6800.2250: unprofessional conduct (see below) already addresses this. There are state and federal guidelines as well as statutes that cover professional misconduct. These rules and laws articulate penalties and disciplinary actions that the defined jurisdictions can take against pharmacists.

> *MN rules 6800.2250: MN rules 6800.2250: unprofessional conduct:*
> *6800.2250 UNPROFESSIONAL CONDUCT.*
> *Subpart 1. Prohibited conduct. Unprofessional conduct shall include, but is not limited to, the following acts of a pharmacist or pharmacy:*
> *A. The assertion or inference in a public manner of material claims of professional superiority in the practice of pharmacy that cannot be substantiated.*
> *B. The publication or circulation of false, misleading, or otherwise deceptive statements concerning the practice of pharmacy.*

C. Refusing to compound or dispense prescription drug orders that may reasonably be expected to be compounded or dispensed in pharmacies by pharmacists, except as provided for in Minnesota Statutes, sections 145.414 and 145.42.

C. Refusing to compound or dispense prescription drug orders that may reasonably be expected to be compounded or dispensed in pharmacies by pharmacists, except as provided for in Minnesota Statutes, sections 145.414 and 145.42.

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12.3 Sec. 8. ***[145E.30] IMMUNITIES FOR ACTIONS IN GOOD FAITH; PROHIBITION AGAINST REPRISALS.*** *12.4*

(a) No individual, including no provider, pharmacist, licensed mental health professional, or hospice provider employee, shall be subject to civil or criminal liability or professional disciplinary action, including censure, suspension, loss of license, loss of privileges, or any other penalty for engaging in good faith compliance with this chapter. 12.6 12.7 12.8

(b) No provider or health care facility shall subject a provider, pharmacist, or licensed mental health professional to discharge, demotion, censure, discipline, suspension, loss of license, loss of privileges, discrimination, or any other penalty for: 12.10 12.11

(1) providing medical aid in dying in accordance with the standard of care and in good faith under this chapter while engaged in the outside practice of the individual's profession and off the facility premises; 12.13 12.14

(2) providing scientific and accurate information about medical aid in dying to an individual when discussing end-of-life care options; or

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

(c) No individual shall be subject to civil or criminal liability or professional disciplinary action if, at the request of the qualified individual, the individual is present outside the scope of their employment contract and off the facility premises when the qualified individual self-administers medical aid in dying medication or at the time of death. An individual who is present may, without civil or criminal liability, assist the qualified individual by preparing the medical aid in dying medication, including opening medication containers, measuring the medication, or preparing an enteral dispenser containing the medication. The assisting individual is not permitted to assist the qualified individual by administering a prepared enteral dispenser to the qualified individual. 12.16 12.19 12.20 12.21 12.22 12.23 12.24 12.25 12.26

MPA appreciates the bill authors including the immunities language in Section 8 and would recommend that it be included as is. The immunity language will go a long way to assuring a compounding pharmacist that does wish to participate in the medical-aid-in-dying medication dispensing will not face any consequences for doing so. This language will also have the effect of ensuring that professional medical and pharmacists are involved in this very consequential decision process and patient choice.

18.12 ***Sec. 3. Minnesota Statutes 2022, section 609.215, subdivision 3****,*
18.13 Subd. 3.Acts or omissions not considered aiding suicide or aiding attempted
18.14 suicide.(a) A health care provider, as defined in section 145B.02, subdivision 6, who
18.15 administers, prescribes, or dispenses medications or procedures to relieve another person's
18.16 pain or discomfort, even if the medication or procedure may hasten or increase the risk of
18.17 death, does not violate this section unless the medications or procedures are knowingly 18.18 administered, prescribed, or dispensed to cause death.
18. 19(b) A health care provider, as defined in section 145B.02, subdivision 6, who withholds
18.20 or withdraws a life-sustaining procedure in compliance with chapter 145B or 145C or in
18.21 accordance with reasonable medical practice does not violate this section.
18.22 (c) A provider, as defined in section 145E.02, subdivision 13, or pharmacist who
18.23 prescribes or provides a medical aid in dying medication in compliance with chapter 145E

> *does not violate this section.*
>
> *EFFECTIVE DATE. This section is effective August 1, 2024, and applies to crimes committed on or after that date.*

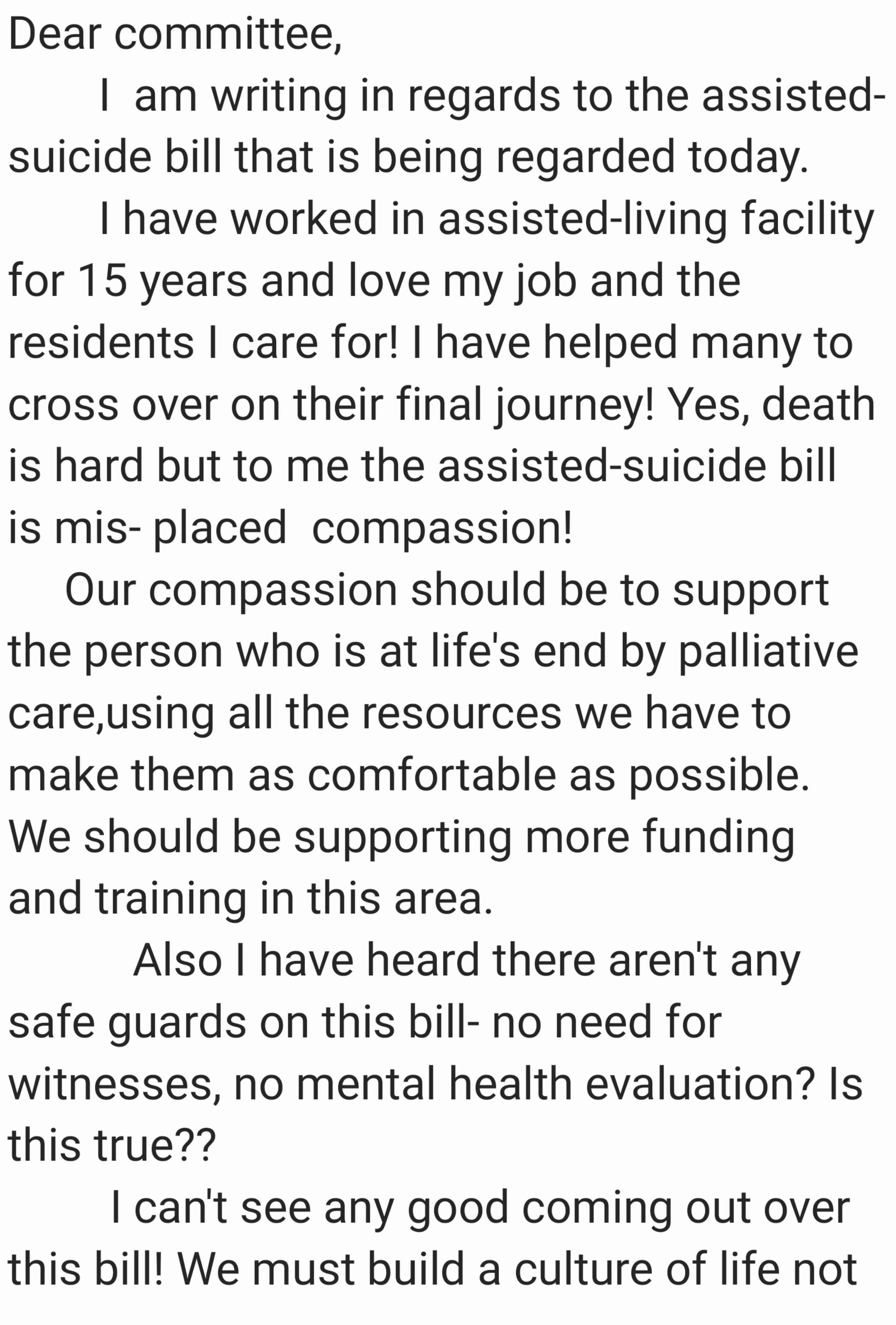
We appreciate the authors defining in the bill language that end-of-life options and compounding and dispensing aid in dying medications for patients who choose to act on their option is not suicide and this section would further define that protection for pharmacists, qualified individuals, and healthcare providers.

Thank you for your attention to our comments and suggestions related to your End-of-Life Options legislation. We look forward to continuing our dialogue and are happy to meet with the authors and stakeholders about this issue. If you have any questions or think we can provide further assistance, please do not hesitate to contact Buck Humphrey: hubert4@gmail.com; 612-889-6515

Sincerely,

Jason Miller, Pharm D
MPhA PA Co-Chair
Jason.Miller@Cobornsinc.com

Tamara Bezdicek, PharmD, BCPS, FMSHP
Co-Chair: MN Pharmacy Alliance/MSHP
tbezdicek@gmail.com



Dear committee,

I am writing in regards to the assisted-suicide bill that is being regarded today.

I have worked in assisted-living facility for 15 years and love my job and the residents I care for! I have helped many to cross over on their final journey! Yes, death is hard but to me the assisted-suicide bill is mis- placed compassion!

Our compassion should be to support the person who is at life's end by palliative care,using all the resources we have to make them as comfortable as possible. We should be supporting more funding and training in this area.

Also I have heard there aren't any safe guards on this bill- no need for witnesses, no mental health evaluation? Is this true??

I can't see any good coming out over this bill! We must build a culture of life not death!

Sincerely,

Julie Hogan

Ramifications on Care and Culture with HF 1930, The End-of-Life Option Act

I would like to offer another perspective on the bill HF 1930, the End-of-Life Option Act before the Minnesota state legislature. It is born out of my 40 plus years of experience as an ICU nurse, my experience as a mother in caring for my youngest son who is medically fragile with significant disabilities, and a belief system that values the dignity of human life at every stage. These views are my own.

First, the passage of this bill will change the provider/patient relationship. This is a working relationship grounded in trust and safety knowing that the provider has the patient's best interest in mind to "do no harm" which is in alignment with the Hippocratic Oath. The passage of this bill creates irreconcilable conflict with healthcare professionals as it creates ethical dilemmas within these relationships. Advocates of this bill tout patient autonomy and the right to die on their own terms. Do patients have the right to involve health care providers and institutions in their own demise to hasten their deaths if providers do not agree? Consider the ramifications on our healthcare system in Minnesota should there be an exodus of providers and pharmacists from the state if they are required to participate in what they believe is morally wrong. This would result in increased strain on the existing system.

Second, I am deeply concerned about the implications that such a law could have on the weakest members of our society and all of us. I am the mother and care giver of an adult son who has severe disabilities. Michael has a catastrophic form of epilepsy. At 23 months of age, the posterior aspect of the left hemisphere of his brain was surgically removed in attempt to gain control of seizures. He still has seizures almost every day. He requires full care in all areas of his life. Despite his disabilities, he has a twinkle in his eye, a broad smile on his face, and a distinct happy personality filled with gratitude. If the state can approve a "less offensive" option of allowing terminally ill people to commit suicide with provider prescribed medication, what is to prevent the state from arbitrarily moving the line of protection, putting high-risk groups, people like Michael, in jeopardy, particularly if the state has a financial interest in their care? It is conceivable that people could be evaluated on their worthiness to receive resources and care. Once the state's protection of the weak has been eroded, no one is safe.

Third, when truth is rejected and is exchanged for a lie, it influences how people can perceive and deal with reality. The truths of a moral code to not kill and not lie are written on every person’s conscience. The bill would legally allow for self-murder with the overdose of medications. Instead, it is disguised as compassion. The truth is this bill requires documentation on the death record to be attributed to the underlying terminal disease and not be designated as a suicide. This is deception because it does not represent the true cause of death. The language used is important. It influences how people perceive the realities of the dying process and death. Whoever controls the language, controls the culture.

In my 40 plus years as an ICU nurse, I have had the privilege to provide compassionate care for patients and their families in the dying process. I have received the Daisy Award after being nominated by a family for care given to their loved one in the final days. Compassionate care is rooted in acknowledging the uniqueness and value of a person given by God. It involves alleviating pain and suffering, suffering that is not only physical, but also mental, emotional, and spiritual in nature. Suffering is frequently underpinned by grief, anguish, and the need for hope, even in the dying process. To enter the sphere of another person’s pain is a profound experience. It allows for compassion and kindness to be given to another person in their greatest need. This bill diminishes the value of a person under a false premise that it is compassionate.

Janet M. Lacher

Shoreview, MN

March 11, 2024

As a medical professional, daughter, mother, family member, friend and concerned constituent, I implore everyone in our great state of Minnesota to oppose physician-assisted suicide.

As a medical professional, I took an oath to do no harm, and it is my job to care for patients and help to improve their quality of *life*-not to be obligated to suggest, or free to encourage them, to end their lives. The mounting pressures of fear and uncertainty that often come with diagnoses prohibit anyone from making a legitimate choice. Furthermore, H.F. 1930 disregards a provider's conscience objection and initiates an inadequate and easily abused process for requesting lethal drugs.

As a daughter, it is my privilege to suffer alongside my father as I accompany him and help to bear the burdens terminal cancer has inflicted upon him. When my father was first diagnosed with a rare form of incurable metastatic cancer, he made end of life arrangements while simultaneously enduring grueling treatment. Laden with fear, he experienced true suffering and despair. It is not compassionate to suggest that he should choose death during this vulnerable time; *it would delegitimize his choice* as pressures surmounted. True compassion does not lie in trying to do the impossible of eliminating suffering; but rather, compassion literally means "to suffer with". H.F. 1930 fails to protect vulnerable patients from coercion, intimidation, and undue influence. With this legislation, if caught up in a moment of despair and weakness, my father could opt for death and there would be nothing his doctor, family, friends or even his power of attorney could do to stop it.

As a mother, I have supported my youngest child through dismal prognoses and countless travails: respiratory failure requiring ventilator support and oxygen, renal failure requiring daily dialysis and transplant, dual cancer diagnoses requiring intense chemotherapy and difficult surgical interventions, quadriplegic cerebral palsy...the list goes on. When my son was given only a 2-5% survival rate, and a physician said, "S*omeone has to be in that 2-5%, why can't it be him?".* Instead of assisting my son in ending his life prematurely, our providers offered us hope and remedies that could cure or improve my son's conditions. *Hope is a powerful medicine.* Today, we utilize the palliative care model, an interdisciplinary medical caregiving approach that gives my son an extra layer of support to optimize his comfort and quality of life as he lives with disabilities and chronic illnesses. H.F. 1930 dangerously defines assisting a patient's suicide as satisfying the medical standard of care. It is a shame that society has such a distorted concept of care that it glorifies health and ability more than it honors life itself. My son may never live a normal, healthy or productive life by the world's standard, but his life has dignity. H.F. 1930 will take that away and will make him vulnerable and at risk to becoming a victim of physician-assisted suicide.

As a relative of a loved one who died by suicide, I live daily with the tragic repercussions. Ten years ago, a beloved family member took his own life after battling depression. The aftermath is far from the picture of peace and relief that he hoped he and everyone else would experience when he was gone. This action was not freely chosen for he was bound by despair and the mounting pressures that come with mental health disorders. He left behind a wake of sadness, anger, fear, anxiety, and depression that family and friends still grapple with today as they struggle to cope with his actions. H.F. 1930 does not require mental health evaluations for people who request assisted suicide. Dying by suicide, whether by one's own hand or by the assistance of a physician, perpetuates mental health disorders and disregards the dignity and worth of every human life. We should prevent suicide, not prescribe it.

Physican-assisted suicide would open wide the doors to expanding regulations to include longer-term prognoses, non-terminal illnesses, and mental health conditions. It makes individuals with disabilities, chronic illnesses and mental health conditions vulnerable and at risk. Legalizing physician-assisted suicide is more than just a slippery slope; It is a dangerous cliff. Minnesota should not set this precedent.

Sincerely,
Tricia Borg, AGNP, RN

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. It's 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 for their own good, 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

Dear Legislators,

Thank you for taking time to consider the ethical aspects of physician assisted suicide. I again write to oppose physician assisted suicide. As a neurologist, particularly dealing with older individuals with progressive disabling neurological disease like Alzheimer's disease or amyotrophic lateral sclerosis, i have serious concerns about physician assisted suicide creating a slippery slope and devaluing human life at its end. Patients who are afflicted with serious neurological conditions, may be subject to involuntary physician assisted suicide because it is deemed by those responsible, that their “life is not worth living”. There are many examples now of such behavior in places where physician assisted suicide has taken hold, in Canada and Holland.

Physician assisted suicide is a direct violation on the Hippocratic oath, as it was originally conceived. In Hippocrates’ time, physicians held the power to try to heal the patient or decide to end the patient’s life because it was not worth continuing to live. Hippocrates changed that to a morality of “do no harm”, that has been whittled away in modern times.

I view the path of physician assisted suicide as a failure of the medical care system. Specifically, palliative care and hospice care, are designed to eliminate suffering at the end of life and obviate the need for physician assisted suicide. These alleviate suffering tailoring the end-of-life scenario to comfort until death. Palliative approaches are applied without a rapid suicidal or murderous intent. These approaches do not require physicians to be death administrators. Most commonly, physician assisted suicide is chosen by patients because of **fear and anxiety** about facing death, not because of intractable suffering.

Please vote against proposals in Minnesota for physician assisted suicide. I provide this opinion as a private and concerned citizen, and it does not reflect policies or directives from Mayo Clinic. I would be happy to amplify on my comments in a more detailed way if useful. Thank you for listening.

Sincerely,

Allen J Aksamit M.D.

Neurology, Mayo Clinic, Rochester MN

I am a retired obstetrician writing in opposition to the proposed legislation advancing approval of physician assisted suicide.

Over a career of more than 40 years and after delivering approximately 6000 babies, the perverted idea of requiring me, or any physician to suggest or assist in providing a method of suicide is abhorrent. It seems to mandate a schizophrenic mind change to move from a vocation dedicated to life-affirmation and healing to the suggestion or provision of a means of death.

My career spans the golden age of medicine in so many ways. I saw the first organ transplants, the great advances in cancer treatment, and the explosion of technology to improve diagnosis and treatment of so many disorders previously considered hopeless. In my field of women's health, the understanding of the ovulation cycle and the development of assisted reproduction techniques have offered hope to many childless couples. (I was present at the conference when the first successful IVF pregnancy was presented). Advances in understanding and care of newborn babies has allowed younger and smaller babies to survive and flourish. These massive break throughs in both knowledge and practice have been the objects of universal praise and pride.

During my years there has also been a not so subtle shift in expectations. Medicine, for decades a field marked by a desire for professionalism, (tho not without the too frequent interloper), has maintained the ancient goal of a compassionate healing vision. This has focused on providing relief for pain and suffering as well as offering healing of disorder and disease. That focus was always on preservation of life and function, recognizing that there were times when all we could offer was compassion and hope. The shift has come as decisions regarding how that care could or should be given has been removed from the physician-patient relationship and lifted onto a system dictated by protocol or patient demand. From a physician's perspective, this shift has removed the relationship from one of a professional offering stand-alongside assistance to one of a professional providing a consumer-demanded service.The result has been an erosion of trust and confidence in what has traditionally been a trust based relationship.

The present proposal for legalization of physician assisted death is but another illustration of this trend. It bypasses or ignores the availability of advances in pain control, comfort care, and end of life hospice care that has allowed autonomy in decision making and facility in compassionate care-giving. The implementation of end of life directives already legally mandates implementation of a dying patient's end of life decisions regarding therapeutic efforts and comfort care.

The bill under consideration appears to demand offering participation in a suicide demand from anyone who might request it without any concern for the physicians conscience. Altho consistent with the current care philosophy mandating treatment on patient demand, it undermines the centuries old position of the healer, a professional committed to healing and life preservation.

As a physician who has lived thru so many wonderful advances in medicine, I speak with some context when I say that this bill, advocating and mandating the suggested option of physician assisted suicide, is in direct opposition to my, and all physicians, vocation. I urge you to reject this call to further undermine the already fragile relationship between a hurting, dying patient and their physician.

David W Johnson MD

Retired obstetrician / gynecologist

St Paul, Minnesota

Testimony in Opposition to HF 1930

My name is Katherine Szepieniec and I submit this testimony on behalf of my daughter, Rosemary.

As a now almost two-year old with Down Syndrome, she has already had to overcome her share of health challenges. She has benefitted greatly from the hard fight of the disability community for decades to get to a point where society has begun to recognize the innate human dignity that she and her peers possess. Without this basic recognition by medical providers of the dignity and right to life that every person has regardless of disability, she and her peers would not be afforded the care needed to live. Assisted suicide is an attack on this foundational societal agreement that life should be cared for not hastened to its end.

The level of care or assistance someone may need when given a 6-month prognosis is often similar to the care that many people with disabilities need every day. What does this bill then say to people with disabilities or those who cannot afford to be cared for at the end of life?

Upon receiving Rosemary's Down Syndrome diagnosis at birth, I recall my sister's extremely excited reaction that her niece was not "neuro typical." She saw the reality that Down Syndrome is not a death sentence and the joy that comes in caring for another. If we can continue to advocate for real care throughout life's journey instead of focusing on ways to end life prematurely, Rosemary could easily out live any of her "nuero-typical" peers. Maybe she will even be running a legislative committee deciding matters of life and death.

Endless possibilities and a long-life expectancy were not always the case for people with Down Syndrome. It was not until as recently as the 1970's that their median life expectancy began to rise beyond toddlerhood.

The reality is that advancements in how we care for and treat people with disabilities do not happen when society views life as disposable, especially when life becomes challenging for the people who are providing the care. **Assisted suicide only promotes this mentality by insinuating, if not explicitly stated, to patients that death is preferable when care is difficult or expensive.** No one, especially someone in their final days of life or someone with a lifelong disability wants to feel like a burden. So, for the sake of my daughter and peers like her, who may not have a mama bear around to protect them as they grow old, I pray that you will vote no to devaluing life so that medicine will continue to make great strides forward in the care and treatment of all people.

Sincerely,

Katherine Szepieniec
Hastings, MN

WRITTEN TESTIMONY IN SUPPORT OF H.F. 1930 BEFORE THE MINNESOTA HOUSE OF REPRESENTATIVES JUDICIARY FINANCE AND CIVIL LAW COMMITTEE

MARCH 12, 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 bill in my personal capacity.

I submit this testimony for three purposes. First, I address the immunities and penalties sections of the bill. Second, I address a 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. This concern is misplaced and ungrounded. Third, I address the overall bill.

2. Sections on Immunities, Penalties, and Effect on Wills and Contracts

Sections 8, 10, and 13 of H.F. 1930 address immunities, penalties, and the effect of the MAID on wills and contracts. These sections are common in the MAID statutes of other states (California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington, and Washington, DC). These sections are also common in the more than 20 bills now being considered by other state legislatures in early 2024.

Furthermore, these three sections parallel those in the decades-old Minn. Stat. 145C. That statute addresses healthcare decisions and advance directives. So, like H.F. 1930, 145C addresses actions taken by healthcare professionals that end patients' lives at their request. It may be useful to compare the bill text to this existing statutory text side-by-side.

Sec. 8. IMMUNITIES FOR ACTIONS IN GOOD FAITH; PROHIBITION AGAINST REPRISALS.	**145C.11 IMMUNITIES.**
(a) No individual, including no provider, pharmacist, licensed mental health consultant, or hospice provider employee, shall be subject to civil or criminal liability or professional disciplinary action, including censure, suspension, loss of license, loss of privileges, or any other penalty for engaging in good faith compliance with this chapter. (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: (1) providing medical aid in dying in accordance with the standard of care and in good faith under this chapter while engaged in the outside practice of the individual's profession and off the facility premises; (2) providing scientific and accurate information about medical aid in dying to an individual when discussing end-of-life care options; or (3) choosing not to practice or participate in medical aid in dying. (c) No individual shall be subject to civil or criminal liability or professional disciplinary action if, at the request of the qualified individual, the individual is present outside the scope of their employment contract and off the facility premises when the qualified individual self-administers medical aid in dying medication or at the time of death. An individual who is present may, without civil or criminal liability, assist the qualified individual by preparing the medical aid in dying medication, including opening medication containers, measuring the medication, or preparing an enteral dispenser containing the medication. The assisting individual is not permitted to assist the qualified individual by administering a prepared enteral dispenser to the qualified individual. (d) The following acts do not constitute neglect or elder abuse and are not a basis for appointment of a guardian or conservator: (1) a request by an individual for medical aid in dying medication; or (2) the provision of medical aid in dying medication. (e) A failure by a provider or a licensed mental health consultant to confirm that an individual requesting medical aid in dying medication is mentally capable is not a basis for appointment of a guardian or conservator. (f) This section does not limit civil liability for intentional or negligent misconduct.	Subdivision 1. Health care agent. A health care agent is not subject to criminal prosecution or civil liability if the health care agent acts in good faith. Subd. 2.Health care provider. (a) With respect to health care provided to a patient with a health care directive, a health care provider is not subject to criminal prosecution, civil liability, or professional disciplinary action if the health care provider acts in good faith and in accordance with applicable standards of care. (b) A health care provider is not subject to criminal prosecution, civil liability, or professional disciplinary action if the health care provider relies on a health care decision made by the health care agent and the following requirements are satisfied: (1) the health care provider believes in good faith that the decision was made by a health care agent appointed to make the decision and has no actual knowledge that the health care directive has been revoked; and (2) the health care provider believes in good faith that the health care agent is acting in good faith. (c) A health care provider who administers health care necessary to keep the principal alive, despite a health care decision of the health care agent to withhold or withdraw that treatment, is not subject to criminal prosecution, civil liability, or professional disciplinary action if that health care provider promptly took all reasonable steps to: (1) notify the health care agent of the health care provider's unwillingness to comply; (2) document the notification in the principal's medical record; and (3) permit the health care agent to arrange to transfer care of the principal to another health care provider willing to comply with the decision of the health care agent.

Sec. 10. EFFECT ON CONSTRUCTION OF WILLS AND CONTRACTS. (a) No provision in a contract, will, or other agreement, whether written or oral, that would determine whether an individual may make or rescind a request for medical aid in dying medication is valid. (b) No obligation owing under any currently existing contract shall be conditioned on or affected by an individual's act of making or rescinding a request for medical aid in dying medication.	**145C.12 PROHIBITED PRACTICES.** Subdivision 1.Health care provider. 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. §Subd. 2.Insurance. 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.
Sec. 13. OFFENSES, PENALTIES, AND CLAIMS FOR COSTS INCURRED. Subdivision 1. Offenses. Whoever does any of the following is guilty of a felony and may be sentenced as provided in subdivision 2: (1) intentionally alters or falsifies a request for medical aid in dying medication for another individual; (2) without authority of law, intentionally destroys, mutilates, or conceals another individual's rescission of a request for medical aid in dying medication; (3) compels another individual to request medical aid in dying medication through the use of coercion, undue influence, harassment, duress, compulsion, or other enticement; or (4) compels another individual to self-administer medical aid in dying medication through the use of coercion, undue influence, harassment, duress, compulsion, or other enticement and murder in the first or second degree was not committed thereby. Subd. 2. Penalties. (a) An individual who violates subdivision 1, clause (1) or (2), may be sentenced to imprisonment for not more than five years or to payment of a fine of not more than $10,000, or both. (b) An individual who violates subdivision 1, clause (3), may be sentenced to imprisonment for not more than ten years or to payment of a fine of not more than $20,000, or both. (c) An individual who violates subdivision 1, clause (4), may be sentenced to: (1) imprisonment for not more than 20 years or to payment of a fine of not more than $40,000, or both; or	**145C.13 PENALTIES.** Subdivision 1.Gross misdemeanor offenses. Whoever commits any of the following acts is guilty of a gross misdemeanor: (1) willfully conceals, cancels, defaces, or obliterates a health care directive of a principal without the consent of the principal; (2) willfully conceals or withholds personal knowledge of a revocation of a health care directive; (3) falsifies or forges a health care directive or a revocation of the instrument; (4) coerces or fraudulently induces another to execute a health care directive; or (5) requires or prohibits the execution of a health care directive as a condition for being insured for or receiving all or some health care services. Subd. 2.Felony offenses. Whoever commits an act prohibited under subdivision 1 is guilty of a felony if the act results in bodily harm to the principal or to the person who would have been a principal but for the unlawful act.

(2) if the person accomplished the violation through the use of force, imprisonment for not more than 25 years or to payment of a fine of not more than $50,000, or both. Subd. 3. Venue. Notwithstanding anything to the contrary in section 627.01, an offense committed under this section may be prosecuted in: (1) the county where any part of the offense occurred; or (2) the county of residence of the victim or one of the victims. Subd. 4. Civil liability; other criminal penalties. (a) Nothing in this section limits civil liability nor damages arising from negligent conduct or intentional misconduct related to the provision of medical aid in dying, including failure to obtain informed consent by any person, provider, or health care facility. (b) The penalties in this section do not preclude criminal penalties applicable under other laws for conduct that violates this chapter. Subd. 5. Claims by governmental entity for costs incurred. A governmental entity that incurs costs resulting from a qualified individual's self-administration, in a public place, of medical aid in dying medication prescribed under section 145E.15 shall have a claim against the estate of the qualified individual to recover such costs and reasonable attorney fees related to enforcing the claim.	

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 the legislature itself can amend the eligibility conditions and safeguards it specifies. Notably, no

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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.

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.

Testimony Against H.F. 1930

Dear Chair and members of the Committee,

I am writing as a doctor of African descent, resident in Minnesota for almost 10 years to strongly urge you to vote NO on this bill. Legalization of physician assisted suicide is only likely to further erode the trust medical professionals are trying to (re)build with communities of color in our state and country. The first experience of mistrust of my intention to work for the highest good of my patient's health was from a fellow Black person here in Miinnesota. The only way I was able to process this attack was understanding the harms that Black people have experienced intentionally[1] and unintentionally from healthcare interactions. Passing this law opens up yet another avenue to cause harm, rather than promote health. A patient is best served by a doctor who would not consider their lives dispensable or diminished because it's duration or quality has been negatively impacted by disease or illness. I have vowed to do no harm as a doctor, and to promote the health of my patients. This bill does not support the health of patients, rather it forces healthcare providers to offer (and/or provide) patients a way to end their own lives. This is the exact opposite of the reason I decided to study medicine and provide healthcare to patients and families that I am privileged to serve. Palliative care is available and legal, physician assisted suicide should NOT be legalized under any circumstances in Minnesota.

I would be happy to further discuss my testimony and my opinion on reasons that have been shared by others on this bill.

Thank you,

Ifelayo P. Ojo, MBBS, MPH

Shoreview, Minnesota

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[1] For example, Public Health Service Study of Untreated Syphilis at Tuskegee and Macon County, AL - Timeline - CDC - OS

March 10, 2024

Dear Minnesota House Judiciary Finance and Civil Law Committee,

My name is Maria Kaefer, and I have been, and continue to be, a practicing family medicine physician in Minnesota for the last 20 years. I support, wholeheartedly and passionately the Minnesota End-of-Life Options Act (FH1930). I wish I could be there to speak to you today in person, but am seeing patients during your committee meeting.

I have read and understand the entire proposed law, but want to take some time today to speak to you about Section 8, which addresses immunities for actions in good faith, and prohibition against reprisals under this proposed law. First I would like to speak to you from three different life experiences: as a clinician, as a patient, and as a friend.

First, as a clinician, I have worked my entire career to increase the collaborative nature of my relationship with my patients, emphasizing their autonomy and choices. I have had several patients die in great pain and suffering, because their choices were limited to available therapies. It is a fact that the medications and other measures we can offer cannot always take away pain, or help a person have autonomy over their bodies and lives. I work with every single patient I have to help them fill out advanced directives and speak about what gives their lives meaning and how they would like to be cared for when they find themselves in a life threatening situation. Currently, I find these very necessary, because without one's stated wishes, every possible action will be taken to revive a person or prolong their life as a default. Many people do not share this value of prolonged life at any cost and under any circumstance. I do not hold this value for my own person. So let me speak about myself a bit:

I became a cancer survivor the first time at age 26 when I had non-hodgkins lymphoma. This has affected my entire life since (I am now 57), and I have lived with an anxiety about death and lack of control around suffering since that time. I have since had, and survived, two other separate cancers, sarcoma and breast cancer, felt to be a long term consequence of my treatments in my 20's. I also witnessed my father's death at age 53 from stomach cancer, when his last words (in the hospital where he died and where he had plenty of access to pain medication and hospice) were "I feel like I have swallowed glass and I am in so much pain." I am not afraid of dying, but I am afraid of suffering and having no choice in how I face my own death. I may not ever use the choices provided in this Act, should it become law, but just its presence would decrease my anxiety so significantly, that It would increase my quality of LIFE. And isn't that what we all desire?

Thirdly, as a friend, I support this bill. Last year, a dear friend of mine called me up. Her sister had end stage ALS and had asked her to support her wish to die when she felt ready to die. The time had come. My friend had no idea how to help her sister, both of whom live here in Minnesota where her only option was hospice and waiting until her body completely shut down due to the illness, with all of the attendant mental and physical suffering that this would entail.

I felt helpless to help my friend and her sister. They turned to me as a friend and as a physician, hoping that I would be able to provide some guidance. We all were looking to the internet to help us find an answer. *The internet*. I think you can all agree that in something as important as how we live and die, we should not have the internet as our primary source. We did find some answers there, but in the end my friend had saved enough medications to help her sister die with dignity. However, that was a huge responsibility for her to shoulder, and was accompanied by the uncertainty of whether it would work or not. They spent several agonizing hours not sure if her death would come or not, not sure if they could offer to their sister how she wanted to die, which they saw, and I see, as a profound act of love for the person who is clear about their situation, has considered all of their options, and would like to end their suffering. They deserve good and sound and compassionate guidance in this life decision. As it stood, if I had in any way provided them with any information (if I had it), I would have been liable to prosecution. One of the beautiful parts of this proposed law is that it would provide protection to providers who render this service to patients, and would also protect providers who opt out. This would take away the fear from providers who want to accompany their patients in this last and beautiful time of our lives here on earth.

Honorable Legislators:

Once again the issue of so-called medical aid in dying, otherwise known as physician assisted suicide (PAS) comes up before the Minnesota legislature. Much has already been written year-by-year as this topic continues to surface. I would recommend op-eds in the Minneapolis Star Tribune most recently by Minnesota Senator John Hoffman and more remotely an excellent piece done by esteemed Mayo Clinic physician Dr. Edward Creagan speaking against the practice as being inimical to what it means to be a practitioner of healthcare and the healing arts, and wrong for Minnesota. It remains wrong for Minnesota.

I am a board-certified family physician in the state of Minnesota practicing for the last 13 years in the area of facility care geriatrics with our most frail seniors. Anecdotally over that time I have seen amazing things happen with residents of long-term care and their family when the focus of their late life care has not been truncating their life but in fact seeking to relieve suffering and provide comfort - and provide time in many cases for reconciliation, relationship building, remembrance, and personal and family healing that would not have been possible had the mere shortening of life been the primary approach to the individual's situation. Where there is life there is hope and much care can be provided to foster dignity and comfort even in situations where – as yet – cure is not a possibility. And this care is provided without blurring the distinction between physician as care provider and physician as direct agent of death. I have been providing true “medical aid in dying” for 40 years without once having the focus of that aid be death itself. This remains possible and I would argue remains best for the citizens of Minnesota. The time honored Hippocratic tradition remains upheld and trust remains fostered in healthcare as actual care.

The legislation itself is problematic from the standpoint of obfuscating the true proximate cause of death, i.e. physician assisted suicide, in registering the death. This poses ethical problems on the most basic of levels. I have always taken the death certificate very seriously and tried to provide the best picture of what was truly the final and most proximate cause of death and our ability going forward to trust this important public health document will be compromised if death prescription is kept out of the record. The ability to track the provision of this action will be significantly truncated.

The business of death prediction as is well known from hospice statistics in terms of judging a six month prognosis is problematic in and of itself as well, and in as many as 15 to 20% of cases results in a situation where a person's status stabilizes and they receive a revised and extended prognosis —often contributed to by the provision of an adequate level of care and symptom management.

Care is expensive and can often be difficult, providing a death prescription by contrast simple and cheap. I have real fear this will begin to move along a continuum on the part of the especially medically vulnerable and complex — and the disabled population, as well as the socioeconomically disadvantaged — from an opportunity to receive life-ending prescription to a gradually expanding sense of expectation to die to prevent becoming a burden to those they love and to the society who may increasingly feel it is in fact their duty to die. So-called personal choice never occurs in a vacuum devoid of the perceived needs and expectations of those surrounding the one who is choosing. I too am concerned that the already substantial control that the medical insurance industry has over prescribing will be further expanded as care options become more limited for complex conditions, with a clear —even if implicit and not explicit —understanding that "you know there is another option …"

The American Medial Association remains in opposition to PAS.

It is my opinion that this Legislation will weaken and even make a mockery of suicide prevention efforts as mental health conditions will fall under coverage considerations for assisted suicide. Healthcare providers will truly be able to be accused of talking out of both sides of their mouth - Are we in fact death duelers or death dealers? Eventually patients will be right to question the thoughts and motives of the provider they are in front of with their difficult conditions. As less resource, both economic and cognitive, are devoted to the difficult business of providing care, the risk certainly is present that difficult conditions and symptoms will be increasingly less well-managed resulting in a self-fulfilling prophecy of desiring death in the face of poorly managed symptoms. What we should in fact be doubling down on in this time is emphasis on increasingly more skillful symptom management and good hospice care which values life and leaves no ambiguity in the mind of those cared for in particular and the public in general that the lives of those needing and seeking care are indeed of value.

Few topics to once again be considered this session are as seminal as the caring for and honoring of life while life is present. Thank you for your thoughtful consideration.

Respectfully,
Barry J. Larson MD, CAQ Geriatrics\s
Blaine, MN

Tom Albin Testimony for HF1930

Thank you for the opportunity to speak today. My name is Tom Albin, Minneapolis has been my home for 35 years, where my wife and I raised our two daughters. I'm testifying in favor of HF1930.

In late 2021, I started having trouble speaking and swallowing. I'm an avid hockey player & started having choking fits while drinking water during games, and I totally lost the ability to yell to my teammates.

I went through a series of tests with 5 different doctors & almost a year later I received a diagnosis of Bulbar ALS at the Mayo Clinic. The bulbar variant of ALS means that my speech, swallowing, and lungs are affected first, then my limbs. As you can hear, my voice is strained and hoarse. Eating is painful and difficult. In September I had a feeding tube inserted which has been great - I'm no longer losing weight.

For now, I'm able to take care of myself, but it's a matter of time before ALS robs me of my autonomy. It's coming and there's nothing I or anyone can do to stop it. One day I'll no longer be able to even scratch my nose. Talk about not being in control..

But I'm not here to talk about how I want to die. I'm here to talk about how I want to live. I LOVE my life! I'm a BIG believer in the idiom "Every day is a gift." I won't bore you with a long list of the things I enjoy. Suffice it to say that I cherish Quality of Life over Quantity of life! Anyone that sees this bill as "assisted suicide" or a step towards euthanasia probably hasn't read it!

ALS is long-term torture; you're a hostage and are just along for the ride. Having ALS is like dying in slow motion. I want to be in control of my life. To decide, "Enough is enough. I'm taking over," means a lot to me. That's why I want the option of medical aid in dying here in Minnesota. We built our lives here in Minnesota and it's where my support structure & medical team is. I shouldn't have to leave our state to maintain some say in the last stretch of my life.

I don't want my family to be filled with traumatizing memories of my prolonged death – doped up on pain meds, no longer myself. It would be more humane for my family and I to be allowed to spend quality time together in my last moments. HF1930 can change months of actual torture into a beautiful moment with my family. That's what I'm asking for.

My story is at: https://www.compassionandchoices.org/stories/tom-albin

Thank you.

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

March 11, 2024

Dear Members of the Judiciary Finance and Civil Law Committee,

I thank you for your dedicated service to your constituents and to the State of Minnesota. With your help, all of us Minnesotans can make a difference in providing better for the common good of everyone in our communities. As a lifelong resident of Minnesota, currently living in Roseville (MN House District 66A), and a licensed mental health provider in the State of Minnesota, I wish to share testimony pertaining to HF 1930 in the hopes of contributing to the common good of all Minnesotans.

As I contemplate what contributes to the common good of fellow Minnesotans, the first condition of providing anything rests on recognizing the value of human life. Indeed, the authors of the Declaration of Independence established a foundational principle for this country that everyone is created equal and possesses an unalienable right to life. Given this natural starting point of human rights and our own nation, I and no small number of Minnesotans have serious objections to HF 1930. This bill is expressly purposed for legalizing the intentional and direct termination of human life. Because of this objective, this bill undermines the very foundation of this state and nation, the idea of health care as a service to promote healing of Minnesotans who are suffering, and human dignity everywhere.

One of the reasons I object so strongly to this bill is that in my work as a licensed mental health provider in the State of Minnesota, perhaps the most important component of my job is to assess individuals for the risk of suicide. The public naturally and rightly anticipates that mental health providers will be well positioned to detect whether someone is at such risk, and intervene to prevent it. Preventing suicide entails alleviating a person's suffering by assisting them to gain or regain a sense of meaning/purpose in their life. So-called "medical aid in dying," a euphemism for physician-assisted suicide, does just the opposite. It is a false assertion that death is now the purpose for one's life. This assertion is an ominous contradiction that undermines the whole notion of mental health care as mental health professionals have been trained and are expected to deliver it.

When a mental health provider assesses that an individual is at risk of suicide, it is not only ethically necessary for us to take steps that will hopefully ensure that person's safety, but we could be held liable under the law for not providing care that might have preserved a person's life. This is the expectation despite the fact that an individual might be stating that they want to end their life. It is known to us that many people attempt suicide not because they want to die, but that they don't know how to ease the pain they feel. Mental health care seeks to ease suffering and preserve life. Suicide is intuitively, for all of us, understood and felt as a tragic loss. No one reasonably opposes the expectation of mental health providers to intervene when someone is thinking about suicide. However, physician-assisted suicide will either stand in the way of the work of mental health professionals, or have them work counter to the purpose of mental health care.

Physician-assisted suicide is the direct and intentional termination of human life. Even though it may happen with the involvement of health care professionals, it still is not health care. It may more properly be described as anti-health care. Even where the motivation for it is to end suffering as a person's life is naturally and imminently coming to its end, intentionally ending life is a failure to provide health care. Health care is the promotion of healing, or at least providing comfort for someone until death naturally overtakes them. Physician-assisted suicide does not embrace health. Rather, it embraces death by causing it. This is bound to disrupt the trust between Minnesotans and health care providers if intentionally ending one's life is presented as an option and disguised as an appropriate remedy. By celebrating physician-assisted suicide as somehow humane and legitimate health care, it actually promotes suicide and thereby speaks in opposition to human life as having inherent value.

Accepting physician-assisted suicide would also set Minnesota on a path that is likely only to expand the situations in which physician-assisted suicide is performed. We need just look at how abortion laws have developed in recent years. In 2023, Minnesota gave broad protections to abortion after already having removed limits such as 3rd trimester abortions and parental notification in 2022. Minnesota now hails itself as an "abortion sanctuary," enticing not just Minnesotans, but people from around the country to procure an abortion in Minnesota. The latest data from the Minnesota Department of Health's annual report to the Minnesota Legislature shows that induced abortions are trending upward. The direct and intentional termination of pre-born human life is expanding. The precedent for greater permissiveness to intentionally end human life is set. Thus, it is not a stretch to think that if Minnesota legalizes physician-assisted suicide now, a trend toward expanding it in coming years will also have been put in motion. The sense of human life as inherently valuable and endowed with meaning at every stage is tragically eroding in Minnesota. The value of life at its beginning and end stages is being diminished, which leaves the middle stages of life as the next frontier to consider how life may be legally terminated in situations that arise there.

All the grief we experience as we see a rise in suicide in our communities in recent years, and the resources we've dedicated to identify those at risk in order to prevent suicide and provide lifesaving care, or just to provide comfort care for those who are near the natural end of their life, will be undermined by any bill like HF 1930. As a mental health care provider, the work that I and many thousands of others do in the State of Minnesota will be diminished. We will find the law standing directly opposed to our efforts to do what the State has every interest in promoting: compassionate care that honors the value of life by reflecting that life has meaning at every moment. For those who are experiencing terrible suffering, mental health providers, and frankly all of us, are called to come to the side of those persons and help them to know the value of their lives. In their hours of need, we can and ought to give them comfort by affirming the value of their lives. We are not called to contribute to a sense that there is no hope for meaning in their lives, and leave them for dead. This is counter to human nature and health care itself.

Legalizing physician-assisted suicide also effectively shifts a significant amount of our focus away from compassionate palliative care and efforts that can improve it. When the simpler and cheaper possibility of terminating one's life gets more emphasis than alleviating suffering *and* restoring a sufficient sense of meaning that provides a person comfort and a compelling reason to live as long as nature allows, Minnesotans cannot grow in compassion for one another as we increasingly treat life as disposable. Providing for the common good of all Minnesotans requires that we value their lives at every moment.

I respectfully ask that Minnesota legislators reject HF 1930 and all manner of physician-assisted suicide.

Sincerely,

Joseph W. Pribyl MA, LMFT

Joseph W. Pribyl, MA, LMFT
Roseville, Minnesota