

In Opposition to H.F. 1930, “End-Of-Life Option Act.”
MN Health Finance and Policy Committee
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Rep. Tina Liebling, Chair

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Good morning, Madame Chair, Members of the Committee, and other distinguished guests. I am pleased to have been given the opportunity to submit written testimony in opposition to the “End-Of-Life Option Act.”, H.F. 1930.

My testimony represents my professional knowledge and opinion as both a practicing lawyer and law professor at the University of St. Thomas School of Law, where I direct the school's ProLife Center. I regularly teach Property Law, Constitutional Litigation, and bioethics. I am an elected member of the American Law Institute and have testified before committees of the U.S. Senate and House of Representatives, as well as before legislative committees in several states. My testimony today represents my own views and is not intended to represent the views of my employer, the University of St. Thomas School of Law, or any other organization or person.

The debate over the role of medical professionals in the dying process goes by many names: “euthanasia”, “mercy killing”, “assisted suicide”, “compassionate choices”, or as in H.F. 1930 “medical aid in dying.” This variety of vague terminology reflects attempts to favorably summarize the issue being debated; an issue that includes respect for autonomy of both the patient and medical professional, the purpose of medicine and its current role in society, as well as our obligations to care for the most vulnerable in society. A wide variety of medical professionals across the political spectrum oppose this alleged care and the wide majority of state legislatures have not legalized the process.

Let me be clear: This debate does not pertain to the withholding or withdrawal of life-sustaining care, such as ventilators, CPR, and artificially administered nutrition and hydration. These medical decisions are primarily governed by tort law and have been widely recognized as within the patient's right to decline unwanted treatment.¹ Rejecting H.F. 1930 would not

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¹ *CRUZAN V. MO. DEPT. OF HEALTH*, 497 U.S. 261 (1990). The Supreme Court held that: (1) a competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment; (2) the United States Constitution did not forbid Missouri from requiring that clear and convincing evidence of an incompetent's wishes to the withdrawal of life-sustaining treatment; (3) state Supreme Court did not commit constitutional error in concluding that evidence adduced at trial did not amount to clear and convincing evidence of patient's desire to cease hydration and nutrition; and (4) due process did not require state to accept substituted

undermine the right of Minnesota citizens to refuse medical interventions in accordance with their personal convictions.

In the guise of “compassionate choices” HF 1930 encourages Minnesota healthcare providers to abandon their role as healers and serve as accomplices to the deaths of some of the most vulnerable among us – those suffering from terminal illnesses.

1. Pain Management as a Trojan Horse

The most common argument in favor of allowing physician assisted suicide (“PAS”) or medical aid in dying (“MAD”) as phrased in HF 1930 is to facilitate pain management for patients who are facing terminal illness. The average citizen may see physician assisted suicide as a reasonable means to alleviate pain. At least one study, however, has found that after legalization of , success in pain management decreases. After four years of MAD in Oregon (from June 2000 to March 2002), there were almost twice as many dying patients in moderate or severe pain or distress, as there had been prior to Oregon's assisted suicide law being used.²

Perhaps even more compelling is the fact that fear of pain is rarely the reason that terminally ill patients give for their decision to request drugs in lethal doses. In its 2022 report of the implementation of its Death with Dignity Act, Oregon, the first state to legalize PAS, reported that the 90.3 percent of all patients seeking lethal drugs **in the years 1998 through 2022** made the request due to fear of losing their autonomy, followed closely (90 percent) by a sense of being less able to engage in activities making life enjoyable. Inadequate or fear of inadequate pain control came in a distant sixth among reasons given.³

Data reported by the Washington State Department of Health in the years from 2009 to 2022 mirrors this same hierarchy of concerns with the vast majority of patients seeking physician-assisted suicide motivated by fears of losing their autonomy and/or an inability to participate in activities making life enjoyable.⁴ Like in Oregon, many fewer patients expressed concerns about uncontrolled pain.

judgment of close family members absent substantial proof that their views reflected those of patient.

² Fromme et al. Increased family reports of pain or distress in dying Oregonians: 1996 to 2002, 7 J. Palliative Medicine 431 (2004).

³ Or. Pub. Health Div., Oregon Death with Dignity Act, 2022 Data Summary at <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.pdf> at p. 14.

⁴ Reports are available at Wash. Dept. Pub. Health, Death with Dignity at <https://doh.wa.gov/data-and-statistical-reports/health-statistics/death-dignity-act/death-dignity-data>.

2. MAD is the wrong response to loneliness and depression.

In 2023 the Surgeon General of the United States declared there is a national epidemic of loneliness and isolation. This is particularly acute among nursing home and other long-term care facility residents, cancer patients, older adults, and adolescents. Among these groups systematic reviews of studies on loneliness, social isolation, and low social support are associated with suicidal ideation.⁵

”While the desire to kill oneself is not synonymous with a mental illness, 80%–90% of completed suicides are associated with a mental disorder, most commonly depression.”⁶ This is particularly true among patients seeking PAS or MAD. “A high proportion of patients who request physician-assisted suicide are suffering from depression or present depressive symptoms.”⁷ Given this reality, at a minimum patients seeking lethal doses of drugs should be required to undergo evaluation for depression and anxiety, and treatment provided when those conditions are found to exist. Yet no such requirement appears in this proposed legislation.

In fact, even in states requiring referral in limited circumstances, it appears that few patients are referred for mental health evaluation by their prescribing physicians. Oregon’s 2023 Death with Dignity Data Report notes that between the years of 1998 and 2022, about 3 referrals a year were made. During the 25 years the law had been in effect, only 76 patients were referred for psychiatric evaluation of the 2,454 patients who died by ingesting lethal doses of medication.⁸ No comparable data from Washington is available since the data collected is not made available publicly.⁹

Even when referrals occur, a study published after Oregon enacted its assisted suicide law found only 6% of Oregon psychiatrists were very confident that in a single evaluation, they could

⁵ U.S. Surgeon General, Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General’s Advisory on the Healing Effects of Social Connection and Community at <https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf> at p. 30.

⁶ Working with Decisionally Capable Patients Who are Determined to End Their Own Lives, J. Clin Psychiatry. 2018 May 22;79(4). pii: 17r11767. doi: 10.4088/JCP.17r11767.

⁷ Jonathan Y. Tsou, Depression and Suicide Are Natural Kinds: Implications for Physician-Assisted Suicide, 36 Int’l J. L. & Psychiatry 461, 461 (2013).

⁸ Or. Pub. Health Div., Oregon Death with Dignity Act, 2022 Data Summary at <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.pdf> at p. 13.

⁹ Wash. Dept. Pub. Health, 2023 Death with Dignity Data Report at <https://doh.wa.gov/sites/default/files/2023-10/422-109-DeathWithDignityAct2022.pdf> at 10.

adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide.¹⁰

Given the prevalence of loneliness and isolation, the concerns expressed in a report by the National Institute of Medicine are compelling.

While an overtreated dying is feared, the opposite medical response—abandonment—is likewise frightening. Patients and those close to them may suffer physically and emotionally when physicians and nurses conclude that a patient is dying and then withdraw—passing by the hospital room on rounds, failing to follow up on the patient at home, and disregarding pain and other symptoms. Abandonment is also a societal problem when friends, neighbors, co-workers, and even family avoid people who are dying. . . . It is a dual perversity that interest in assisted suicide sometimes reflects anxiety about overly aggressive medical treatment, sometimes dread about abandonment, and sometimes fear that dying people may suffer simultaneously or sequentially from both misfortunes.¹¹

Legislation like HF 1930 is premised on the false assumption that MAD is a reasonable therapeutic option for those suffering from terminal illness. It is not.

Society's goal should be to make dying less, not more, medical. Physician-assisted suicide is neither a therapy nor a solution to difficult questions raised at the end of life. . . . Control over the manner and timing of a person's death has not been and should not be a goal of medicine. However, through high-quality care, effective communication, compassionate support, and the right resources, physicians can help patients control many aspects of how they live out life's last chapter.¹²

Minnesota is known for its world-class medical care. Patients from around the world come to our state to be diagnosed, treated, and cured. In those rare cases where cure is not possible, the Minnesota medical community provides care and support. This legislation would undermine that reality.

3. MAD will be shrouded in secrecy under HF 1930.

While there are many points of concern with this legislation, one of the most grave is denial of public reporting relating to the practice of MAD. Unlike in Oregon and Washington where at

¹⁰ Attitudes of Oregon psychiatrists toward physician-assisted suicide. Ganzini L, Fenn DS, Lee MA, Heintz RT, Bloom JD. *Am J Psychiatry*. 1996 Nov;153(11):1469-75.

¹¹ Institute of Medicine, *Approaching Death: Improving Care at the End of Life* (2014).

¹² American College of Physicians, “Ethics and the Legalization of Physician-Assisted Suicide” (2017) at https://www.acpjournals.org/doi/10.7326/M17-0938?_ga=2.219193049.1759306232.1706105025-1073435638.1706105025.

least some important public health data is made available annually, HF 1930 does not require full and accurate public reporting on key factors affecting the practice of MAD.

Section 4(d) of the Reporting Requirements merely requires the Minnesota Department of Health to “annually review a sample of records” to ensure compliance with all statutory requirements. Given the number of deaths reported in states permitting PAS or MAD, it is customary to require review of all records to assure that there are not particular populations where denial of necessary medical care is being unethically replaced with exclusive offers of medical aid in dying.

In addition to failing to provide for full review of all reports, section 4 directs that only the most barebones summary of the reports be available to the public. HF 1930 would only allow the public to learn the number of prescriptions written, the number of providers writing those prescriptions, and the number of people dying after taking the prescribed drugs. No other information would be available to the public.

This is in stark contrast to Oregon where annual reports include critical public health information regarding the patient characteristics (sex, age, race, medical status), end of life care (hospice enrollment and method of payment), nature of the underlying illness, and important details on the process of requesting, receiving, and administering the lethal drugs. These details include how many patients outlived the 6-month prognosis given rise to the prescription, how many were referred for psychiatric evaluation, the location of patient’s death, and the type of lethal medication prescribed. The reasons patients sought lethal medications are reported as end-of-life concerns, as are details about who was present at the patient’s death, and any complications that arose during the time the medication was ingested. Finally, the reports provide important information about the length of the physician-patient relationship, and the timing between the first request for the drugs and the patient’s death. Washington state also provides much of this information.

All of the Oregon information is statistical in nature, and each piece of data provides invaluable insights into the delivery of health care in that state. The reports provide no information that could lead to the identification of any individual patient, and there are no news accounts of any such identification occurring. Fears that such reports could endanger individual patient’s medical privacy are unfounded.

What these reports do provide is information that allows the public and officials to guard against any patterns of abuse based on age, sex, or race. They also provide insight into the adequacy of care patients have received prior to resorting to suicide by lethal drugs.

HF 1930 prohibits almost all of this important information from being reported to the public. The bill leaves all Minnesotans in the dark about critical public health aspects and denies both patients and medical professions important insights that could lead to the improvements of care for terminally ill patients.

This lack of transparency and deprivation of important public health information alone should lead members of this community to vote no on HF 1930.

Conclusion

Medical assistance in dying abandon patients to despair and disease, corrupts the medical providers involved, and can be used as excuses to deny curative and palliative care. I urge you to vote no on HF 1930 and thank you for allowing me to present my opposition to this proposed legislation through this written testimony.