

Dear Mr. Sande:

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 Medical 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.