

Alexander Larson
North Oaks, MN

Hi all, I'm Alex Larson, an Eighth Grader from North Oaks, and this bill hits close to home for me, as I have had a family member who died from type 1 diabetes and I would like to voice my opposition to the bill for multiple, important reasons. First, I don't think that it is acceptable to allow physician assisted suicide, because it devalues the lives of people with terminal illnesses, people with terminal illnesses should know that they are valued, and assisted suicide sends just the opposite message. According to the Washington Department of Health, 52% of people who did assisted suicide feared being a burden on their families. People with terminal illnesses should not feel this way, and an assisted suicide bill would, unfortunately, reinforce this kind of thinking.

People with chronic illnesses should hear a life affirming support of them, and this bill would betray that. We also know from the Washington Department of Health that 13% of people seeking assisted suicide said that treatment was a financial burden. This is a huge problem, no one should ever be coerced into prematurely ending their lives due to their financial state. These statistics present a bleak picture. Assisted suicide will, unfortunately put pressure on those who can't afford treatment, and those who don't have sufficient care, to end their lives instead of living as long as they can. We should instead focus our efforts as a State on improving access to hospice and palliative care.

This bill raises some important medical ethics concerns. Innocent human lives should never be deliberately ended prematurely, and there are many measures taken to protect lives at other places. As a student, I walk by 988 suicide lifeline posters all the time. The enormous efforts to protect life should not be changed just because of an ailment someone has, and instead, lives should be protected by increased investment in palliative care programs. No one has the right to take an innocent human life. Doctors take the Hippocratic oath, and one of the components of that oath, as pointed out by multiple websites, is the resolution to do no harm. Doctors should not be compelled to prescribe these drugs or refer to someone who will.

Another point that has been raised by many organizations and people is how these bills can quickly expand in scope. The Mn Alliance for Ethical Healthcare pointed out that in Canada, a law similar to this was passed, and now it includes people with disabilities and incurable illnesses. People should not be defined by their illness or disability. They should be defined by who they are, and assisted suicide does the former. Assisted suicide is not a good policy, it targets the less fortunate and those without caregivers, it deliberately ends a life. State efforts should be directed towards preventing suicide and promoting life, not promoting suicide.

Respectfully,
Alex Larson

Hello,

My name is Amity Foster; and I am writing this is as an individual, not representing any organization.

I am writing in support of HF1930—the End of Life Option bill. More than 20 years ago, I was diagnosed with acute promyelocytic leukemia. It was bad; I was hospitalized for three months, and for a few of those weeks, in very bad pain—couldn't eat, breathing was hard, couldn't stand to be touched by anything or anyone. There is nothing I can share to explain to you how bad it was. When I finally left the hospital, I found out from my parents that they thought I was going to die. I was not terminal. But that doesn't mean I didn't think about death— and I had family and a hospital counselor to talk to about it. The thought of ending my life wasn't part of those conversations then.

However. As I get older, I think about this—what's the quality I want my life to be at the end? If I am mentally competent, I want to be able to choose how my life ends—in pain and suffering, or on my own accord. What's the quality of life I want for my friends and family? I want them to be able to know that I made my choice, that I decided for myself.

People who are of sound mind, who have talked to their family & friends, who are making an informed decision should be able to make the decision to end their life with dignity. This bill allows for all of that, and also requires people to be intentional—so that **THEY** are making the decision. No one else is doing it for them.

Please support this legislation.

Thank you
Amity Foster
HD60A

Angela F. Sovak PsyD LP LLC

9531 West 78th Street Suite 340
Eden Prairie, MN 55344

Ph. 612.314.6241
Fax. 612.230.1235

March 6th, 2024

To the House Public Safety Finance and Policy Committee,

My name is Angela Sovak and I am a psychologist, licensed in the state of Minnesota. I am writing in support of the MN End of Life Options Act. As you consider this bill, I feel it is important to distinguish medical aid in dying (MAID) from suicide, and to address any concerns about a 'contagion effect' between MAID and suicide.

Medical aid in dying involves an individual with a terminal illness, (a prognosis of six months, or less, to live). They have been determined to have the mental capacity to make the decision. They do not want to die, but they are going to die. What they want is a *peaceful* death. The decision is often made with the support of friends and family. The individual and their loved ones often use the time before death to celebrate the life that has been lived and to live fully in the time that remains. A time of preserving the self. The death itself is peaceful, often in a room filled with the love of friends and family that are present or have been near to say goodbye.

Suicide involves an individual with a treatable mental illness, as defined by the Diagnostic and Statistical Manual of Mental Disorders. These are diagnoses that are *not terminal*. Individuals with mental illness who are actively suicidal are deemed not to have the capacity to make the decision to end their lives precisely because the feelings of hopelessness and despair that are leading to the suicidality are symptoms of the mental illness itself - the mental illness that is *not terminal*. The decision is often impulsive, secretive, isolated, a way to escape their life that they view as poor in quality, meaningless, or worthless. It is a destruction of the self. This is a stark contrast to the experience of medical aid in dying.

Some have expressed concern that when MAID is legalized, there would be a sort of 'contagion' effect and that suicide rates increase in states after MAID is legalized. This is not true. The one study that made such a suggestion [Jones DA, Paton D. How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide? South Med J. 2015 Oct;108(10):599-604. doi: 10.14423/SMJ.0000000000000349. PMID: 26437189.] was flawed in that the authors included medical aid in dying deaths in the definition of suicide deaths, so of course the overall rate went up after the law passed. When you remove the deaths by MAID, there was no statistically significant change in the number of suicides that occurred after legalization of MAID. Jones and Paton even acknowledge that fact, albeit in one part of one sentence, in their published article. Across the 10 states (and Washington DC) where MAID is legal, there is no evidence that legalization of medical aid in dying produces this 'contagion' effect of increased rates of suicide.

I appreciate the Committee taking this information into account as you consider this incredibly important bill.

Sincerely,

Angela F Sovak PsyD LP

Angela F Sovak PsyD LP

March 6, 2024

Dear Rep. Ellen McDaniel and the House Public Safety 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 determine 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.

Dear Ms McDaniel,

I am a strong supporter of HF1930. My personal experience with end-of-life options for my elderly parents and mother-in-law guides my strong support. Prolonged pain and suffering could have been avoided for my family members and, instead, they would have had the opportunity to plan their final days and enjoy time with loved ones. Costly end-of-life medical needs, much of which was paid for by the state or federal government, would have been reduced dramatically.

I know there are plenty of positive case studies about other states that have enacted this legislation and I would hope our legislature would make a prudent decision based on factual knowledge and not religious zealotry.

--

Thanks,

Anita Gille
4117 W 8th St
Duluth Mn 55807
anitagille@gmail.com

TESTIMONY OF ANNETTE HANSON, MD

443-885-0964

hanson1072@gmail.com

To: *House Public Safety Finance and Policy Committee*
Representative Kelly Moller, Chair
Representative Sandra Feist, Vice Chair

From: Annette Hanson, MD
Date: March 5, 2024
Re: HF 1930
Position: **OPPOSE**

Dear Chair Moller, Vice Chair Feist, 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

TESTIMONY OF ANNETTE HANSON, MD


443-885-0964

hanson1072@gmail.com

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

References:

1. Munson K, Clayworth J. Suicide with a helping hand worries Iowans on both sides of the “right to die.” Des Moines Register. 2016. Available at: <http://www.desmoinesregister.com/story/news/investigations/2016/11/25/too-weak-kill-herself-assistance-legal/92407392/>. Accessed February 27, 2022
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.

My father passed away in 2022 after a long battle with cancer. For his entire life, his greatest fear was losing his mental faculties at the end of his life. He voiced this concern frequently. He wanted to die as he lived in life: strong, smart, and with a sense of agency.

He fought the cancer as long as he could and had many treatments along the way, but the cancer was incurable and we knew there was no hope of recovery. He actively wanted to die at the end, but we all had to simply wait until his body and mind withered away slowly and excruciatingly. Losing a terrific father was painful enough, but watching his greatest fear become a reality right before my eyes as his body and mind shut down was in many ways worse.

I plead with you to allow people like my father to die with dignity and humanity. Losing a loved one is heartbreaking enough, please don't allow the terminally ill to suffer unnecessarily. My hope is that other families in this horrible situation won't have to experience this same anguish of a needlessly slow and painful death that my father and my family experienced.



AutisticAdvocacy.org

Testimony Against H.F. 1930

Health Finance and Policy Committee– Public Hearing January 25, 2024

Dear Chairwoman Liebling and Members of the Committee:

As a self-advocacy network, The Autistic Self Advocacy Network lives and works by the motto “Nothing About Us Without Us”?

“Nothing About Us Without Us” means that autistic people need to be involved whenever autism is discussed. When non-autistic people make decisions about autism without Autistic input, those decisions are usually bad. This makes it harder for us to get by in the world. Decisions about autism need to be made with autistic people. That way, we can make policies that help us live our lives and teach people how to be understanding and supportive of the autistic community.

ASAN opposes H.F. 1930 and any actions that advance physician assisted suicide.

As leading advocates for the autonomy of people with autism, opposing physician assisted suicide might, at first glance, seem inconsistent with our goal of bodily autonomy. The choice of physician assisted suicide requires full autonomy, but many people with disabilities do not have bodily autonomy. In light of a high rate of poverty in the disability community, underfunded and fragmented service systems, high rates of institutionalization, and poor pain management for many people, have fewer choices and less autonomy than many who will advocate for physician assisted suicide.

We don't believe there is a way to implement PAS in this society that will not put pressure on disabled people to die instead of using services, supports, and medical care that cost more money than the one-time application of lethal drugs. These issues are hard and fraught, but that is the position we must take because of how this has played out in jurisdictions that legalize it and what a slippery slope it has become.

Thank you for your time and attention to the concerns of people with autism. Please vote “No” on H.F. 1930 and any efforts to expand access to physician assisted suicide.

March 4, 2024

Representative Ellen McDaniel
Mn House of Representatives
St. Paul, MN

RE: HF 1930 Written Testimony

Dear Ms. McDaniel,

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

My dear friend's father passed away from cancer. His greatest fear was losing his mental faculties at the end of his life. He voiced this concern frequently to my friend and others. He wanted to die as he lived in life: strong, smart, and with a sense of agency; he was a badass.

The cancer was incurable and we knew there was no hope of recovery. He actively and seriously wanted to die at the end, but everyone had to simply wait until his body and mind just withered away slowly and excruciatingly-- including him.

Losing a terrific father was painful enough for my friend, but watching his greatest fear become a reality right before her eyes as his body and mind shut down was in many ways worse for her, and certainly was worse for him. I plead with you to allow people in painful, incurable situations to die with dignity and humanity.

Losing a loved one is heartbreaking enough, please don't allow the terminally ill to suffer unnecessarily. My hope is that other families in this horrible situation won't have to experience this same anguish of a needlessly slow and painful death that my friend's father and her family experienced.

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.

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 decide 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. 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
1289 Lafond Avenue
Saint Paul, MN 55104
conrad@brothersofpeace.org
651-315-3570

Dear Ellen McDaniel,

I am writing to you as a registered public health nurse in the state of Minnesota, to urge you to oppose the proposed bill on assisted suicide. The number of patients with mental health concerns has increased significantly in the last few years. The number of suicides has also increased. This is such a tragedy. The effect suicide has on the friends and family members of those who are left behind is more mental health concerns. Death without suicide is difficult enough for people to process.

How can we as health care providers discuss suicide awareness and encourage people to seek mental health support on the one hand and give fatal doses of medication to patients on the other? It does not make sense. Non-maleficence is a core principle of medical ethics. Healthcare providers are supposed to uphold this principle to do no harm.

There are so many wonderful programs with hospice care that aid our community through dying with dignity. Assisted suicide is not the solution. It will bring about more mental health problems for those who participate in it as well as those who are left behind. Supporting assisted suicide will be to the detriment of our society.

I urge you to oppose this horrific bill of assisted suicide - HF 1930.

Sincerely,
Cassandra Bruski RN, BSN, PHN

3404 Barbara Ln
Burnsville MN 55337

Dear Ellen McDaniel,

I am against HF 193 (Physician assisted suicide), first and foremost because all life is sacred.

I also believe it makes things easier for family members to look to this option as an out. Either from having to care for their loved ones or financing nursing care, either at home or a facility.

I also think it puts our physician in a position of having to offer assisted suicide as an option, not because it's the best thing but because they have to. That also may put them into a position to go against everything they believe in.

Charles G Honzay
~~Charles G Honzay~~
Bird. Island MN

Testimony to the House Public Safety Finance and Policy Committee March 6, 2024

I'm writing to ask that the Committee please support the End-of-Life Options Act (HF1930.)

As a licensed clinical medical social worker for over forty years, I've had the honor to work with many patients and their families during their final days or weeks, of having to endure a terminal illness. The variety of complex medical diagnoses and complications are too vast to state here, since each patient situation is individual and unique. Some of those patients had the "luxury" to stop or resist an invasive treatment or procedure so they could choose to die by foregoing a treatment. Most did not have that option, and when developing untreatable conditions that prolonged their suffering and pain, had to refuse to eat as a means of starving themselves to death. If they were fortunate, someone may have been with them when they died, but that was unpredictable. Families were devastated when they weren't present.

Patients with complex medical problems, particularly certain cancers, don't always have treatment options that will extend, or improve their quality of life and they must continue their intolerable pain and suffering while waiting (or, hoping) to die. Not all types of pain can be adequately treated to make a patient comfortable. What multiple studies have demonstrated, is that patients find comfort by even knowing they have the option to end their suffering while being surrounded by their loved ones in a familiar environment. Currently, Minnesotans who have a terminal condition wanting to die peacefully in their own home, may tragically take their own life, or travel to other states, or countries (if they have the financial resources) as an only means to end their pain and suffering.

Patients who do not want to consider this option don't have to use it, but we should not penalize those who might. Allowing individuals the choice to maintain their autonomy throughout life (and death), with the support of their physicians, demonstrates compassionate care when patients need it most.

Thank you for your consideration and support of the Minnesotans you serve.

Most Sincerely,

Cheryl Jacobs, LICSW, MSW

612-325-0324

March 4, 2024

TO: House Public Safety and Finance Policy 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 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, he and could only speak in a whisper. He was so hunched over he could only see the ground. He lived in a tremendous amount of 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.

As a family doctor, I have significant public safety concerns related to this bill.

In states where physician assisted suicide is currently legal, it is a cheaper option for care than treating the underlying disease. In our low-income patients, it is easy to see how the financial burden would pressure them to end their life prematurely. Rather than the state of Minnesota working towards optimizing our palliative and hospice care systems, it would be a clear sign where we prioritize our resources. Even more abominable is that those who elect for physician assisted suicide are able to claim life insurance benefits after their passing. In locations where PAS is legal, patients do not primarily opt for it to avoid pain. **They opt for it due to the fear of becoming a physical or financial burden on their families.** It is obvious how coercive this seems that the state of MN would support a 'healthcare' where not only can your doctor help you die faster, but you can also make money for your family when you do it. **These patients would be worth more dead than alive.**

An additional safety concern is the fate of unused medication. 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, **once the medication is prescribed, there is no true way to control what is done with it.**

Further, there is a significant rift in trust between doctors and their patients, only exacerbated in the last few years. I'm concerned that as a physician, I cannot "engage in false, misleading, or deceptive practices" related to offering physician assisted suicide. Who will define these terms? When a myriad of primary providers decline to refer for or discuss this option with patients, knowing it will undercut trust in the provider/patient relationship, we could be charged with a gross misdemeanor and disciplinary action through the medical board. In an age of a shrinking primary care workforce, having legal ramifications of not participating in this horrifying 'medical care' will assuredly **drive high quality, caring healthcare providers away from primary care in the state of Minnesota.** I wouldn't stop at physicians- this will impact quality nurses and pharmacists alike who will not want to even have a hand in this assisting suicide in the patients they strive to care for.

Finally, public safety and trust will be eroded when we start to have state supported suicide. Considering the amount of money that the state of Minnesota pays to suicide prevention programs, if this were to pass, it would completely undercut the intention of those programs. **To say that we want to prevent suicide in certain populations, but we will actively facilitate it for others, is a horrifying double standard.**

I deeply urge you to stand against this bill due to these, and so many other unintended consequences that it will have for **my family and yours alike.**

Christine Broszko, MD, Blaine, Minnesota

Dear Ellen McDaniel,

I am against HF 193 (Physician assisted suicide), first and foremost because all life is sacred.

I also believe it makes things easier for family members to look to this option as an out. Either from having to care for their loved ones or financing nursing care, either at home or a facility.

I also think it puts our physician in a position of having to offer assisted suicide as an option, not because its the best thing but because they have to. That also may put them into a position to go against everything they believe in.

Christine Honzay
Christine Honzay
Bird. Island MN

I am writing to ask that the committee please support the End-of -Life Options Act (HF1930).

After seeing my father suffer with ALS and die from near asphyxiation, I support patient choices for ending pain and suffering at the end of life.

Currently, Minnesotans who have a terminal condition or an extremely poor quality of life may take tragic measures to take their own life which may include suicide in different forms. No one wants to take this option but many are desperate and it becomes their only option.

I believe everyone should have a more peaceful, safe and supportive way to end of life.

Thank you for considering this Act!

Sincerely,
Christine Kunewa Walker
612.867.6628



To: House Public Safety Finance and Policy Committee
 Testimony in Support of HF 1930, Section 14
 March 7, 2024

Chair Moller and members of the committee:

The End-of-Life Options Act (HF1930) authorizes the practice of medical aid in dying. It is modeled after similar statutes found in 10 jurisdictions in which the practice is narrowly defined and differentiated from the illegal act of assisting a suicide. See Table.

Section 14 of HF 1930 appropriately distinguishes medical aid in dying from assisted suicide, euthanasia, elder abuse and homicide. Please support passage of HF 1930.

Respectfully submitted,
 Rebecca Thoman, M.D.
 Compassion & Choices Action Network

TABLE: Medical Aid in Dying and Suicide Are Fundamentally Different

Suicide	Medical Aid in Dying
With effective treatment, a person may find relief from feeling like they want to take their own life.	Death is inevitable due to the expected outcome of a person’s terminal illness.
A person typically struggles with mental health in silence or alone.	A person is able to talk with their healthcare team and typically with their loved ones and community.
A preventable yet often traumatic outcome.	A compassionate and respectful option at the end of life.
No involvement with healthcare providers. Typically no family involvement. Often carried out alone and in secrecy	An accepted medical practice in which at least two medical providers confirm terminal diagnosis and prognosis. The terminally ill person can make an informed healthcare decision.
Death is often sudden, unexpected and violent, traumatizing loved ones and communities.	Allows for a peaceful death, often at home where loved ones can be present and have greater closure.
Many factors can lead to suicide including mental health conditions.	Only patients who have an incurable, irreversible, terminal illness have the option to go through the qualification process.
Proper medical intervention may prevent death by suicide.	Medical intervention will not prevent death, but the availability of the option allows patients to get the appropriate help they need, including, when appropriate, medical aid in dying to avoid prolonged end-of-life suffering.

Dear Ms McDaniel:

Please add my written testimony in opposition to HF 1930 which is scheduled for committee hearing this week.

I have been in practice in Duluth since 1988 employed by Essentia Health, one of the largest medical systems in the state. I have never had a patient request for this service. I have discussed this bill and the multiple versions preceding it with literally hundreds of colleagues. The vast majority of my medical associates are strongly opposed to bills promoting medically assisted suicide. In fact I can only name a single physician that I know who is in favor of this legislation.

This legislation puts a burden on all health care workers to consider and/or act on medical decisions that are not part of our healing vocation. In addition this legislation puts some of our most vulnerable citizens at terrible risk.

Many opponents have focused on the many moral, medical, and legal aspects of this bill and the presumptions associated with the need for this legislation. I agree with all of these well-known concerns. I will raise another issue that I'm certain has not been addressed:

This bill is blatantly racist. Is this too strong a term? I certainly don't think so. Please consider the statistics and demographics of those who utilize assisted suicide. The states with the longest history of physician assisted suicide such as Oregon have documented that the people who are in favor of these bills and who have availed themselves of this procedure are typically educated Caucasians with financial security. If any other type of bill was proposed that primarily addressed the needs of rich white folk, there would ensue a justified public outcry. Why has not this been considered in any of the discussions of the bill? Why have the supporters of this bill not addressed this serious issue? Do we really need a bill that basically serves the need and concerns of a small, wealthy, influential group of Minnesotans?

Along with my colleagues in the medical field, I stand in opposition to HF 1930.

Respectfully submitted,

Daniel N Skorich MD
8321 Congdon Blvd
Duluth MN 55804

To Ellen McDaniel,

I am writing to you because of our concern over physician assisted suicide. Please do not pass this legislation!

Respectfully,

Darald and Leitha Bothun

**Testimony to the House Public Safety Finance and Policy Committee
March 6, 2024**

I'm writing to ask that the Committee please support the End-of-Life Options Act (HF1930.)

As a practicing physician for over 4 decades, I've had the honor to work with many patients and their families during their final days or weeks of having to endure a terminal illness. Although cancer is a common terminal disease, other neurologic and musculoskeletal processes can be untreatable and intolerable. Some of these patients had the "luxury" to stop or resist an invasive treatment or procedure so they could choose to die rather than continuing their dying process. Most do not have that option, and their only choice to end their suffering is to refuse to eat as a means of starving themselves to death. This seems cruel and has its own side effects.

Patients with complex terminal medical problems often don't always have treatment options that will extend, or improve their quality of life. Also, pain is not the only cause of suffering and indignity for patients and caregivers and palliation in those circumstances can be unattainable. Many patients and families understand that when the quality of their lives will not improve, prolonging the inevitable is in itself a source of suffering. What multiple studies have demonstrated is that patients find comfort by even knowing they have the option to end their suffering while being surrounded by their loved ones in a familiar environment.

Patients who do not want to consider this option don't have to use it, but we should not penalize those who might. Invoking the "slippery slope" of what MIGHT happen, ignores the current real suffering of patients. Allowing individuals the choice to maintain their autonomy throughout life (and death), with the support of their physicians and family demonstrates compassionate care when patients need it most.

Thank you for your consideration and support of the Minnesotans you serve.

Sincerely,

David A. Plut, MD
612-860-8416

To: The House Public Safety, Finance, and Policy Committee

Subj. HF1930 Minnesota End of Life Options Act – Hearing March 7, 2024

Regarding sections 13 and 14 of the Act dealing with offenses, penalties and claims for costs, in almost 30 years of experience in other authorized states with similar bill language, there has not been one adjudicated case involving misuse of these statutes. The life ending medication is ALWAYS administered by the authorized individual. To my knowledge, this requirement has never been violated in the long history of Medical Aid in Dying in this country. These laws work as written.

The following are my reasons for supporting the passage of HR 1930:

My end of life journey, my end of life process, is MINE. If I am of sound mind, no one but me should have any say in this. That is what autonomy is: my ability to make my 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 you 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 carcinoma lesions, unable to stand, bedsores, medications, morphine, on and on. What he did have was his sound mind. Two days before he passed he offered this 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,

Hospice at his side trying desperately with morphine to quiet his choking and obvious pain.

Exactly the death my dad didn't want.

Now, in Dec. 2022 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 and heavily medicated. He learned of California's Death with Dignity law 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 humorous anecdote, went to sleep, and in 20 minutes had passed with family and friends at his side. Highly emotional as you might expect, incredibly peaceful but this is what he wanted. This was his option.

No of us are getting out of here alive. When my time comes, do I want my dad's experience or my friend Tom's experience. I WANT THE OPTION that the Minnesota End of Life Options Act will provide.

To Rep. Moller and members of the House Public Safety Finance and Policy Committee:

Please support HF 1930, the Minnesota End-of-Life Options Act.

As you read this, I trust that you will remember that you sit in a seat that you and your supporters worked hard to earn. It is a seat that you occupy in health and strength. It is a seat from which you work to serve and support actions that honor your community and the people who elected you.

You are fortunate. You look forward to a path of advocacy, of impact, and of action. A path of life.

Others are not so fortunate. They face pain and suffering and hard choices at the end of their lives. Their choices are limited – but you can widen those choices. You cannot shoulder their burdens, but you can help to clear the way.

Section 13 and Section 14 very clearly lay out the offenses and penalties and liability for abuse of the process. Strict guidelines are set so that the process protects anyone in the difficult and painful position to need the End-of-Life Options process. Abuse of these procedures in other states and countries where similar laws exist is vanishingly low. Minnesota can and will make it so here as well and this law facilitates that.

Please give Minnesotans in the last months of their lives the power to make the choices that they and their families need and desire. I would want this choice and I believe that you would want this choice for yourself, for those whom you love, and for those whom you honor but will never know.

I dread the day when I must make these hard choices, but I hope for the freedom to make them.

Please support HF 1930 and urge your fellow committee members and members of our Minnesota House and Senate to do the same.

Many thanks for your time, consideration, and service.

Sincerely,

Deborah Zvosec




Testimony Opposing “End-of-Life Option Act” HF 1930

Public Safety, Finance and Policy Committee

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

March 7, 2024

	<p>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.</p>
---	--

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, Gaird 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

March 5, 2024

Via email
ellen.mcdaniel@house.mn.gov

WRITTEN TESTIMONY ON HF 1930

Dear Members of the Minnesota Public Safety Finance and Policy Committee:

Thank you for the opportunity to provide testimony on HF 1930: “End of Life Options Established for Terminally Ill Adults.”

Disability Rights Education & Defense Fund (DREDF) is a national, nonprofit law and policy center led by people with disabilities and dedicated to advancing and protecting the civil and human rights of disabled people. We oppose HF 1930 for the following reasons.

ASSISTED SUICIDE ADDS TO THE NATION’S HISTORY OF STATE-SANCTIONED DISCRIMINATION. Assisted suicide must be considered against the backdrop of the United States’ tragic history of state-sanctioned discrimination and bias against people with disabilities and chronic illnesses in health care settings. This sordid history includes nonconsensual experimentation, forced sterilization, the denial of essential medical care based on biased and/or inaccurate quality of their life assessments, and most recently, employing COVID crisis standards of care and health care rationing systems that explicitly, openly devalue disabled lives. This history is the result of common, largely unspoken biases in society and in the medical profession that assume (without evidence) that the quality of life and inherent worth of people with disabilities is beneath that of their non-disabled peers. Studies have consistently revealed that health care providers hold negative views of people with disabilities that too frequently result in failures to equitably protect, serve, or support disabled people.

Legalizing assisted suicide would add to the above-described history of discrimination and bias against people with disabilities.

ASSISTED SUICIDE LAWS DEVALUE DISABLED LIVES. Assisted suicide statutes also violate anti-discrimination laws by treating disabled people who

want to end their lives differently, conveying the message that disabled lives are less worthy. Under such laws, the presence or absence of disability alone determines whether an individual's expressions of suicidal intent are responded to with intervention, preventative measures and the provision of adequate and accessible health care services (including consumer-directed personal care services and competent palliative and hospice care), or aid in implementing lethal measures. Where states have nonetheless authorized this practice, key protections have consistently been eliminated and rolled back, without any concurrent improvements in access to life-preserving supports and services.

REQUESTS FOR ASSISTED SUICIDE ARE INTRINSICALLY INTERTWINED WITH LACK OF ACCESS TO SERVICES AND ARE BEST ADDRESSED BY INCREASING ACCESS TO SUPPORTIVE CARE AND TREATMENT. There are misconceptions about the role pain plays in individuals choosing assisted suicide. Although the desire to avoid pain and fear of pain are often raised as the primary reason for enacting assisted suicide laws, the top five reasons for requesting assisted suicide are disability-related: loss of autonomy; decreasing ability to participate in activities that make life enjoyable; loss of dignity; burden on family, friends/caregivers; and losing control of bodily functions. When people choose to end their lives because of social stigma, isolation, or lack of access to disability-related services, we should not accept this "choice" as voluntary and actively facilitate suicide. Rather, we should be responding with supportive care and treatment, such as counseling, peer support, pain medication, or in-home consumer-directed personal assistance. We urge the State of Minnesota to refocus its efforts on improving access to, and the availability of, such services.

THE DIAGNOSIS AND PROGNOSIS OF A "TERMINAL CONDITION" IS INHERENTLY UNCERTAIN. Clinicians are frequently wrong in their predictions of the capabilities and life spans of people with disabilities. For example, one study found 15 percent of critical care patients thought to be dying survived unexpectedly, even when predicted to die by all medical caretakers.¹

¹ Shapiro, Terminal Uncertainty, SEATTLE WEEKLY, January 14, 2009, <https://www.seattleweekly.com/news/terminal-uncertainty/> (exploring both the clinical and statistical uncertainty in terminal prognoses). See also Quill et al., Sounding Board:

Because terminal conditions are so often misdiagnosed, establishing a right to assisted suicide will open the door to death imprecisely and unjustifiably to many people with disabilities who are not terminally ill. The risks to recently disabled people, such as those with significant spinal cord injuries and strokes, are particularly great.² These individuals may be misdiagnosed as terminal but end up outliving these prognoses by years. Moreover, research overwhelmingly shows that people with new disabilities frequently go through initial despondency and suicidal feelings, but later adapt well and find great satisfaction in their lives.³

ASSISTED SUICIDE CAN EASILY EXPAND BEYOND THE TERMINALLY ILL.

Supporters of assisted suicide claim that the practice will be narrowly limited to people who are terminally ill. However, if enacted, assisted suicide can easily expand beyond those with a terminal label, as illustrated by the experiences in the few countries outside the U.S. that permit assisted suicide and other forms of hastened death, including Canada and the Netherlands.⁴

In Canada, people with disabilities who are not terminally ill can already be given a lethal injection to end their lives, and the protections and limitations on the law keep deteriorating. In 2021, the Canadian Government passed a bill that relaxed a number of significant safeguards for getting an assisted

Care of the Hopelessly Ill, 327 *New Eng. J. Med.* 1380, 1381 (1992) (“[W]e acknowledge the inexactness of such prognosis [of imminent death]”).

² See, e.g., Ruder, *Refusing to Die: The Chris Dunn Story*, (United Spinal Ass’n., Kew Gardens, NY), <https://unitedspinal.org/refusing-to-die-the-chris-dunn-story/> (last visited Feb. 10, 2022).

³ Harris, Louis & Associates, *The ICD Survey of Disabled Americans: Bringing Disabled Americans into the Mainstream* (1986); Gerhart et al., *supra* note 20; Cameron et al., *The Life Satisfaction of Nonnormal Persons*, 41 *J. CONSULTING AND CLINICAL PSYCHOLOGY* 207-14 (1973); Ray & West, *Social, Sexual and Personal Implications of Paraplegia*, 22 *PARAPLEGIA*, 75–86 (1984); Stensman, *Severely Mobility-Disabled People Assess the Quality of Their Lives*, 17 *SCANDINAVIAN J. REHAB. MED.* 87-99 (1985); Whiteneck et al., *Rocky Mountain Spinal Cord Injury System Report*, *NAT’L INST. HANDICAPPED RESEARCH* 29-33 (1985); Eisenberg & Saltz, *Quality of Life Among Aging Spinal Cord Injured Persons: Long Term Rehabilitation Outcomes*, *PARAPLEGIA* 29 (1991).

⁴ See generally Patients’ Rights Council, Canada, <https://www.patientsrightscouncil.org/site/canada/>

death.⁵ Under the new law: (1) it is no longer required that death be reasonably foreseeable; (2) the waiting period has been reduced; (3) the number of witnesses required has been reduced; and (4) the requirement that the individual seeking to die give final consent has been eliminated.⁶ The law also expands availability of assisted dying to people with solely mental health disabilities.⁷

Based on the foregoing, we urge the Public Safety Finance and Policy Committee to vote No on HF 1930.

Authorizing assisted suicide in Minnesota would increase existing threats to the civil rights and lives of profoundly oppressed and already marginalized communities. It would establish a discriminatory and deadly double standard for how health care providers, government authorities, and others treat disabled individuals versus others.

Thank you for your consideration,



Michelle Uzeta
Deputy Legal Director
Disability Rights Education and Defense Fund

⁵ Bill C-7 (An Act to amend the Criminal Code (medical assistance in dying)) 2nd Session, 43rd Parliament, 2020-2021. See also, Council of Canadians with Disabilities, CCD Disappointed by House of Commons Yes Vote on Bill C-7 (Medical Aid in Dying), March 12, 2021, <http://www.ccdonline.ca/en/humanrights/endoflife/Media-Release-Bill-C7-12March2021>

⁶ *Id.*

⁷ *Id.*



DISABILITY RIGHTS OREGON

February 10, 2016

FEB 16 2016

Roland L. Halpern, MNM
Cultivation Manager
Compassion & Choices
4155 E Jewell Avenue
Denver, CO 80222

Dear Roland:

Thank you for your letter of January 22 asking if anything has occurred that would change my former position on the matter.

The answer is no. DRO has still not received a complaint of exploitation or coercion of an individual with disabilities in the use of Oregon's Death with Dignity Act.

Thanks for you inquiry.

Sincerely,

Bob Joondeph
Executive Director

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

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

WRITTEN TESTIMONY HF 1930 (End Of Life Options Bill)

To Chair Rep Kelly Moller and members of the Public Safety and Policy Committee:

I submit the following written testimony in support of HF 1930 (End of Life Options Bill/Sec 13-14) to the public record for the 3/7/24 Public Safety and Policy Committee.

I have taken care of many elderly friends and family members and have watched them bravely face their final hours without this law. I am not sure that they would have exercised their right to choose their time and place if this law was enacted, as they did not linger in the dying process – with comfort.

My mother and I had long discussions back in the early 2000s about the Terri Schiavo case: a heartbreaking story of a woman in an irreversible "persistent vegetative state". These discussions prompted my mother (a devout Catholic) to expediate her health care directive, wishing not to be resuscitated if her condition at advanced age of illness was imminent, painful, and terminal. We both came to terms with the belief that the right for a peaceful and atraumatic ending of a person's life with an agonizing terminal dying process should be available. We hoped that if we could alleviate suffering at our end of life, it would be a blessing.

It is a very personal decision that rests in the hands of the individual, with communication between loved ones and their healthcare team.

Now we have this opportunity to pass the End of Life Options bill. This bill is thoughtfully conceived and written to protect the vulnerable in our society. Please support this right for those who clearly need it for a peaceful exit.

Thank you for very much for your consideration and your service.

Respectfully,
Dr. Ann Jennen
St. Paul, MN

Dear Ms. McDaniel:

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
Blaine, MN

Testimony to the House Public Safety Finance and Policy Committee
March 6, 2024

I'm writing to ask that the Committee please support the End-of-Life Options Act (HF1930.)

As a caregiver to three parents

As a physician for over forty years, I've treated many patients during their final days or weeks, of having to endure a terminal illness. In my specialty, I am often requested to relieve pain, but no amount of medicine is adequate in providing relief for some of the worst conditions. Watching these patients suffer unfathomable pain is inhumane and I've often wondered to myself if I'm honoring my oath to "do no harm".

I respectfully request the committee's support of the End-of-Life Options Act (HF1930) that in my professional opinion enables me to best serve my patients and their wishes

Most Sincerely,
Bryan J. Walker, M.D.
612-867.6628

To the House Public Safety and Finance Committee:

I am a practicing physician and mental health advocate writing in support of H1930, 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 H1930.

Kaci McCleary, MD

Maria K. Poirier, M.D.

Testimony on H.F. 1930

End-of-Life Option Act

March 7, 2024

Madame Chairwoman and members of the Public Safety Finance and Policy Committee,

Thank you for allowing me to submit written testimony in opposition to the End-of-Life Option Act. My name is Maria Poirier, and I am an internal medicine physician from Rochester.

HF 1930 is ethically and legally challenging in several ways.

Example: Sec. 5 Concerning responsibilities of attending provider

Subd. 5. No duty to provide medical aid in dying. (a) A provider must provide sufficient information to an individual with a terminal disease regarding available options, the alternatives, and the foreseeable risks and benefits of each so that the individual is able to make informed decisions regarding the individual's end-of-life health care.

Medical aid in dying is not health care because the intent and purpose of prescribing and self-administering a lethal drug is for the patient to commit suicide, not to receive health care. Therefore, the state of Minnesota should not compel providers to speak about medical aid in dying as an end-of-life healthcare option.

I frequently see seriously ill patients who tell me they would be better off dying. Requiring a provider to counsel a patient having an existential crisis about medical aid in dying would be cruel and unethical.

I take care of many patients who live outside of Minnesota where medical aid in dying is illegal. If I diagnose one of these out-of-state patients with a terminal illness, would this bill require me to provide information about the option of medical aid in dying?

Example: Sec. 8. [145E.30] IMMUNITIES FOR ACTIONS IN GOOD FAITH; PROHIBITION AGAINST REPRISALS.

(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:

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

How is “choosing not to practice or participate” being defined? Does this clause provide immunity for providers who refuse to counsel terminally ill patients about medical aid in dying as an option?

I urge you to vote NO.

3/6/24

RE: HF 1930

Dear Committee Chair Moller and Members of the House Public Safety Finance and Policy Committee:

I write in support of HF 1930.

I fully support the entirety of the bill and specifically the provisions in section 13.

As a physician with nearly 40 years accompanying my patients with head and neck cancers from diagnosis to cure or through every step leading to death, I also fully support the distinctions and exclusions outlined in section 14 as well. Suicide is the desperate act of those who have lost all hope, feel helpless in the face of life's worst challenges, and seek that one last means to alleviate the pain of deep depression. Patients who elect medical aid in dying do NOT want to die. Would we consider those who jumped from burning World Trade Center towers to be committing suicide? My patients want to live, yet they are dying and face many kinds of suffering beyond simply pain that cannot be controlled without the dire effects of medically induced coma. The stipulations of section 14 shine legal clarity into the psycho-emotional cloud of confusion that cannot be resolved without your help for our patients, their friends and families, and our communities.

The bill stipulation requiring two independent assessments further safeguards against abuse. As you know, summing the years of experience with this law in ten states and the District of Columbia, one hundred and four years of authorized medical aid in dying practice demonstrates that the laws work as intended with absolutely no substantiated case of abuse.

Reliable surveys of Minnesotans indicate more than 70% of Democrats and the majority of Republicans want this law passed and that 70% of American Catholics support the medical practice. Of those that responded to the 2023 Minnesota State Fair House of Representatives poll, 70% support the bill.

Please pass HF 1930.

Thank you for your good work.

Sincerely,
Michael Tedford, MD
3932 Abbott Avenue South
Minneapolis

Submitted by
Neal C. Buddensiek, MD, CMD, HMDC, WCC
Chief Medical Officer, Benedictine
Testimony to the Minnesota Public Safety, Finance & Policy Committee
In **OPPOSITION** to HF 1930 – “End of Life Option”
Thursday, March 7, 2024

My name is Neal Christopher Buddensiek. I’m a Board Certified Internal Medicine, a certified nursing home medical director and a certified hospice medical director with over 17-years experience practicing in Minnesota’s long-term care nursing homes, assisted living facilities and residential homes. I am also passionate about relieving human suffering.

Steven Levenson, a fellow long-term care physician, certified medical director, teacher, writer, leader and colleague recently and posthumously had a column entitled, “Medical Aid in Dying Laws: The Hidden Conflicts and Controversies” published in *Caring for the Ages* (An Official Publication of The Society For Post-Acute and Long-Term Care Medicine). My testimony today echoes and honors Dr. Levenson’s 43-years working as a LTC physician and medical director who also testified four times before the Maryland legislature against MAID.

Compassion and Choices asserts that “in more than 20 years of experience since the first law was enacted in Oregon, and an additional 40+ years of combined evidence and cumulative data from the laws passed in other jurisdictions there has not been a single substantiated case of abuse or coercion nor any civil or criminal charges filed related to the practice” (Compassion and Choices, “The Facts About Medical Aid in Dying,” Jan. 4, 2022). However, this seems highly unlikely due to known challenges related to prognostication, assessment of decision-making capacity, and other aspects.

Consider for a moment the five key things that must be done by a physician in order to safeguard patients as they go through the MAID process:

- Complete diagnosis to enable accurate prognosis determination;
- Determination of prognosis;
- Relevant and understandable discussion with the patient;
- Determination of decision-making capacity;
- Determination of absence of undue influence or coercion.

There is significant evidence of inconsistent performance of these key tasks on which these laws are based. For example, medical practitioners vary in determining decision-making capacity. As per a 2011 article, incapacity is common and often not recognized (*JAMA* 2011;306:420– 427). Psychiatrists in Oregon had low confidence in “their ability to determine whether a psychiatric disorder such as depression was impairing the judgment of a patient requesting assisted suicide” (*Am J Psychiatry* 1996;153:1469–1475). Predicting prognosis is also very challenging and often inaccurate. Almost one in five hospice patients are discharged alive from hospice (*Gerontol Geriatr Med* 2022; 8:23337214221109984). These laws typically ask physicians to certify that patients are not being coerced and are acting freely, just like MN HF 1930, but in reality it is hard to conceive of how most physicians have the training, time, or means to be certain of this. Thus, even assuming that each of these five key steps is done right 95% of the time, we would only have about a 77% (0.955) chance of consistently correct performance.

Taking all of these factors into account, the chances of everything going right consistently are nowhere near 100%. They also tell us that we must dig deeper and read between the lines about everything we have been told about MAID legislation. Furthermore, the safeguards are primarily on paper and are largely unenforceable. In order to protect patient privacy, the laws preclude adequate investigation, disclosure, and discovery, so there are significant challenges in confirming whether required procedures were done correctly and whether the patient met the criteria and was not coerced.

Physicians and legislators need to pursue viable alternatives to MAID, including “aggressively responding to the needs of patients at the end of life,” respecting patient autonomy, providing good communication and emotional support, and providing adequate comfort care and pain control. In other words, as with so many things, these issues of compassionate and effective care at the end of life can — and should — be addressed by incentivizing more widespread and effective use of currently available palliative care tools and well-established processes (*J Am Med Dir Assoc* 2000;1:77–85).

I adamantly believe every Minnesotan can experience the potential of palliative care in the years to come IF we say an emphatic NO to medical aid in dying and an emphatic Yes to even better palliative care supports and systems. Death comes for us all and no one will ultimately be safer or more comforted in MN from HF 1930. Thank you for your time and attention to this testimony.



Neal C. Buddensiek, MD, CMD, HMDC, WCC
Mahtomedi, Minnesota

To Representative Moller and Members of the House Public Safety Finance and Policy Committee,

Please support HF 1930, The Minnesota End of Life Options Act

I am an Emergency Physician (MD) at Hennepin County Medical Center.

Every day, I see patients who are suffering greatly from a terminal illness and want to have more control over the end of their life.

They do not necessarily even want to end it by themselves, before nature does, but they want to know that they have the option. Just having the option gives them great comfort.

I, too, want this option for myself.

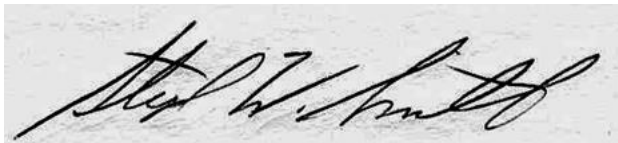
It is inconceivable to me that some people want to deny this option to others.

It is a well written and well-conceived bill.

In particular, sections 13 and 14 very clearly proscribe any person's attempts to falsify a request for medical aid or a request to rescind any such request.

I urge you to pass HF 1930 and give all Minnesotans control over their final days/weeks/hours.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen W. Smith", written in a cursive style.

Stephen W. Smith

Faculty Emergency Physician, Hennepin Healthcare (HCMC, downtown campus)
Professor of Emergency Medicine, University of Minnesota School of Medicine
4741 Humboldt Ave. S
Minneapolis, MN 55419
612-875-4226

I am Steven C Bergeson, M.D. and live in Shoreview, Minnesota, Senate District 40, and House District 40A. I have been a licensed physician for 42 years and have practiced the entire time in Minnesota. I am retired and currently volunteer at a clinic for underserved individuals.

I am providing written testimony in opposition to HF 1930: End-of-life option established for terminally ill adults.

The bill threatens the safety of our most vulnerable and the safeguards outlined in section 13 are inadequate and not enforceable.

The language of the bill says describes that it is a felony to: "15.30 (3) compels another individual to request medical aid in dying medication through the use of coercion, undue influence, harassment, duress, compulsion, or other enticement;"

In the Documentary, "How to Die in Oregon" a person who has received a lethal dose of medication under Oregon's DWD Statute is drinking a large glass of a lethal mix of medications. Halfway through the person stops... the viewer doesn't know if it is due to nausea or second thoughts? Their friend exhorts him to proceed, 'you can do it!'

When the person starts drinking again, the friend offers continued encouragement: 'Come on! Go Go Go! You can do it!'

Have we just witnessed a crime? At what point was there "undue influence, compulsion, or other enticement"? Who reports this?

Fast forward to me sitting in the privacy of my office with a frail elderly man, who has just requested my help as his attending physician to end his life. I ask as I always do, "can you tell me more what led you to this decision?" When the reply is, 'well my son suggested it, he thought I had suffered long enough'. Is that a crime? Probably not. How can Minnesotans tell when would it be one?

What if I next hear, 'My son has been so great to take care of me, my other kids haven't even visited me'. 'My son also made an appointment for me with my lawyer and I changed my will so he gets everything - and it's going to be soon.'

Now has a crime been committed?

The bill threatens the safety of our most vulnerable. The safeguards outlined in section 13 are inadequate and not enforceable.

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

My name is Françoise Willems-Shirley and I would, first of all, like to thank you for your service to the state of Minnesota.

My mom's name was Tonny Willems and she passed away from cancer in March of 2022. I 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.

My mom was kindness personified, she was the rare person who took the time to really see and hear everyone who crossed her path. Yet, sadly, when it came to her own life, she often felt unheard, unseen and felt like she had very little choice in many aspects of her life.

She advocated all of her adult life for the ability to die peacefully, when that time came. I recall numerous times being at a doctor's appointment with her and she would bring up medical aid in dying with her doctor again and again. "You know what I would want", she would say to her doctor, "I want to die on my own terms, I don't want to suffer in pain when we know death is inevitable" to which her doctor replied, "yes, Tonny, I know that is what you would want but you know we can't do that here". My mom felt so strongly about this that she even hand wrote it into her health directive even though she knew it was likely not going to be a choice for her, but she held out hope that it would be.

My mom had been struggling for over 20 years, widowed unexpectedly at age 63, heart problems and procedures, a debilitating autoimmune disease and, ultimately, cancer.

In February of 2022, we found our mom on the floor of her apartment. Within a day we found out she had cancer and it had spread everywhere, with no chance of survival. Hospice care was advised for her and we were told that she had days to weeks to live. At that point, had it been available, my mom would have chosen medical aid in dying. The end was near and all that was left was more pain and suffering.

My mom chose to go to a hospice facility to live out her final days. Many of us, who have not been through this, 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.

Within a couple of days she struggled to talk, move, eat or drink and her pain continued to increase. A few days into hospice, we were told that the signs were there that she was nearing the end. We thought, "Thank God, her suffering is over." From there, it was another **FOUR** weeks before she actually passed away. Four weeks without food or water, four weeks of begging and pleading with medical staff to address my mom's suffering, four weeks of a living hell for her and for us all. We had been told by her doctors that a body can't survive without water for longer than 3-5 days. That may be true for some or even many, but I am here to tell you it was not true for my mom!

What we lived those weeks can only be described as inhumane. Situations such as eating your lunch while your mom is literally decomposing in front of you, her body convulsing while you take notes on the timing of those convulsions so you have proof that she is suffering in order to advocate for more medication, became our normal. If only we could have been convinced that she was not aware, but sadly, we would see signs that she was still, at times, aware and suffering.

Witnessing and experiencing what we did left lifelong scars. We were not able to truly grieve, mourn, honor and remember my mom after she passed because the trauma of what we had lived haunted us and was all consuming.

Having a voice and a choice in how you wish to die should be the standard of care and available for all terminally ill Minnesotans. This is not about politics. It is about humanity, dignity, and compassion.

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

March 6, 2024

RE: HF 1930 – request for your support

Dear Committee Chair Moller and Members of the House Public Safety Finance and Policy Committee:

I ask you to pass the bill HF 1930.

My support wasn't always 100% certain. This bill's strong safeguards, and reading about other states' experiences, have changed that.

Thank you for serving and protecting Minnesotans.

Sincerely,

Gail Helland
2700 W 44th St . #205
Minneapolis, MN 55410

Ellen McDaniel
Committee Administrator
Minnesota House of Representatives
Public Safety Finance and Policy Committee
Ellen.McDaniel@house.mn.gov

Re HF1930 written testimony

Dear sirs

Please deny the assisted suicide legislation, and vote against the assisted suicide bill.
It is not needed and unjust. It is a government overreach , and the government is not needed in this regard .

Greg Sebald
1298 jeffersoin st
Shakopee,Mn
55379

Theresa Finished Well

A little over 12 years ago, my wife Theresa died peacefully after a 5-year journey with Ovarian Cancer. During this time, she had participated in six different chemo treatment protocols, including a clinical trial in Chicago. After hospitalization for bowel obstruction, her Palliative Care physician suggested she focus on quality-of-life care, and she entered hospice.

With her bowel obstruction, she relied on nutrition and hydration through an IV connected to a backpack that she carried and replaced each day. This approach allowed for good mobility and time with others. Unfortunately, over the next 3 months, the cancer began consuming all this nutrition, along with progressively more body mass to a point where she was just skin and bones.

After a conversation with her minister, Theresa decided her life was complete, so she stopped her nutrition/hydration IV. Four days later she was dead, but she avoided an agonizing uncertain dying process. During these 4 days, family and friends, some from other states, were able to visit and say goodbye to her.

Not all of us, at the end of our lives, can shut off an IV, but we all need an option. Theresa's family and friends are grateful that she was able to "Finish Well".

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@hbc.com

March 7, 2024

Madam Chair and members of the Committee:

I write today in support of HF 1930, the End-of-Life Option Act. I do so as a man with a terminal diagnosis of small-cell lung cancer. I do not take this diagnosis lightly. I am, in fact, currently receiving what I hope to be life-extending treatment. The disease ultimately will be fatal.

15 years ago, I witnessed my younger brother die of the same disease. In the months left to him, he spent many weeks in physical, mental, and emotional agony. I sat by his side as he struggled to breathe, swallow, and speak. Often his suffering was so intense that he could not even listen as I read to him from his Bible.

My father died of emphysema, a disease that rendered him all but unable to breathe in his final weeks. As I would do with my brother, I spent long nights by his side, administering morphine as needed in an effort to quell his struggles. His body, however, refused to ignore the fact that he was slowly suffocating.

I cannot say whether either of them would have opted to exercise their rights under this act, had it been law at the time. I, however, am very likely to do so if HF 1930 is enacted, as it should be. Frankly, the manner of their deaths has scarred me. I look upon the prospect of a similar death with nothing less than terror, for myself, my wife, my son, and the friends who will care for me in my final days.

This is a matter of my personal autonomy. It is not and has not been proven to be a threat to any person, of whatever age or level of ability in any state in which similar laws exist. The principal section committed to your care, Section 13, ensures that only those specifically authorized by the Act will make use of the right the Act recognizes. Do not be diverted from your task by a parade of horrors. There is no slippery slope to be feared, there is no real threat to anyone who does not choose medical aid in dying of their own free will.

Please vote YES on HF 1930.

James M. Hamilton

1310 Osceola Ave.

Saint Paul, MN 55105

(651) 698-5887

Subject: HF 1930 Written Testimony

Where have our Midwestern-senses gone? Our state use to be one that showed common sense and values for our people, but that has really changed over these last years, and I am ashamed at the bills that have been passed, be it abortion, legalizing cannabis (beyond medicinal usage) and others, but the Physician-Assisted Suicide bill that is on the doorstep to be legalized is another absolute mistake in so many ways.

Are elected people (who are supposed to represent the people who elected them, and not go off on their own agendas just to make a name for themselves) suddenly feel empowered and god-like to even think that this Physician-Assisted Suicide bill is a good idea?

I am Catholic, but I don't think that religion is even an issue for this to be yet another decision that just doesn't make sense to me. There are other avenues for people that are suffering can take. It may seem like the humane way of approaching death, but we are not the ones in control. Humans are not like pets that can be euthanized when the time is deemed appropriate.

Our moral obligation is to treat all life, from conception until natural death, with respect and dignity, and use means to keep the dying comfortable and hopefully without pain. This should NOT include giving the green light to anyone to seek death via a physician.

This goes beyond the inequities, disparities and marginalization that face certain disabled, ethnic, elderly and limited income people in our state – it affects us ALL!! If this passes, it will open the door to many other ways to do away with people who are no longer considered productive or worthy of having around.

Please oppose this bill!!

Thank you!

**Janelle Richter
Comfrey, MN**

MN House Public Safety Policy Committee
Written Testimony HF1930
State Office Building, Room 200
March 7, 2024

I have serious concerns about how HF1930 would affect the safety and well-being of vulnerable persons, such as the elderly and those with disabilities.

Although this law currently applies only to people with a terminal illness, guidelines in other places have expanded from terminal illness to include people with disabilities.

In 1980, I became paralyzed in a car accident. I spent the next year and a half in various hospitals, learning to live as a quadriplegic. During that time, I fell into a deep depression, and I just wanted to die. But I'm so grateful that assisted suicide was not available, and that those around me gave me what I really needed – good medical care, counseling, access to disability services, and lots of prayer and loving support.

As a person with a disability, I see at least two troubling consequences of HF1930 that would affect the safety and well-being of persons like me, should this legislation eventually expand.

First, people may be denied access to disability services, such as sufficient PCA care and certain needed medical equipment. In Minnesota, PCA care is already underfunded and many people with disabilities are having difficulty getting adequate PCA services. In Canada, Christine Gauthier, a paralyzed veteran, requested a wheelchair ramp. She was told that they could not provide a ramp, but they could offer her medical aid in dying.

Second, and perhaps more serious, they may be denied life-saving medical care. Decisions about medical procedures seem to be shifting from doctors and patients to bureaucrats whose job it is to save money. It will become more and more tempting to deny expensive—but needed—medical care in favor of much more economical physician assisted suicide.

If people are not able to get the medical care and services they need to survive, and instead are offered physician assisted suicide, some will likely choose suicide out of desperation. Or worse, they may be pressured by others to choose such a course.

You on this committee are called to be guardians of public safety. Once we open the door to this type of legislation, there is no way to guarantee the safety and well-being of our most vulnerable citizens. I respectfully ask you to please vote no on HF1930.

Jean Swenson 64B
MA Counseling Psychology
2353 Youngman Avenue #106
Saint Paul, Minnesota 55116
jswenson@usfamily.net

To Ellen McDaniel:

Please **Vote "NO"** on the Physician Assisted Suicide bill! Our country was founded as a Christian based country and choosing suicide is murder. I have to live with the memory of my husband choosing suicide and living with the memory of a loved one choosing death is extremely difficult. God gave us life and will end our life in ***His*** time!

PLEASE VOTE NO!!

Remember, you also will live with the result of allowing others to choose suicide and face our Lord when you die.

**Jeaneen Nelson
2917 Norwood Ave.
Slayton, MN 56172**

Greetings Committee Members,

My name is Jennifer Williams, I live in St Paul in district 67B. I oppose the HF1930 bill for numerous reasons.

I am a nurse of 27 years with 25 of those in inpatient and outpatient care of medical and oncology patients, and I have witnessed many deaths. The "Request for Medication to End My Life in a Peaceful Manner" is misleading and assumes that death will be peaceful. Death is not always peaceful. Even with the proposed method of terminating one's own life, unanticipated things can occur as death draws close. A person approaching death is going to the unknown and oftentimes this brings many unexpected physiological and psychological changes, including but not limited to some level of anxiety, and most distressing very high anxiety and agitation. The person who is ending their life intentionally will be left without the care and support of health care providers who can assist with the unexpected that often happens as death approaches.

The bill refers to the importance of having another person present when the individual self-administers the medical aid in dying medication. This other person will very likely suffer trauma, initially and long term from witnessing this kind of death, which is in all truth and honesty, a suicide. Please note the definition of suicide is according to Merriam Webster "the act or an instance of taking one's own life voluntarily and intentionally".

It is also a hypocritical bill in our current times of "opioid overdose crisis". Thousands of family & friends in MN have suffered loss & trauma from death of loved ones to opioid overdose and this bill is legalizing overdose causing death and perpetuating the crisis & suffering.

It is an unnecessary bill as people with terminal diagnosis have a plethora of options for care to manage & alleviate suffering caused by the disease, such as traditional pain medications, palliative care and hospice.

It is unfortunate to have a person end their life prematurely when their last days could be full of meaning. I have witnessed many times personally and as a nurse, friends & families reflecting and sharing, laughing and crying and loving deeply in the last months & days of life.

It must be noted that prognosis is not a certainty, it is an educated guess. I have known many people I cared for as a nurse die much quicker than their prognosis and I have had the joy of many more months to years with people I love who were given a prognosis of less than 6 months.

Death is always a tragedy and intentionally ending life increases the trauma, tragedy, suffering, anguish and pain.

Please do not pass this bill for the good and well-being of the people of the state of MN.

Thank you for your time and serious consideration.

Dear Minnesota State House of Representatives:

To those who will be voting on **HF1930** regarding assisted suicide;

This is an outrageous attack on human life.

We cannot fathom what you people are thinking.

We as citizens and Christians of Minnesota are outraged by this proposed bill.

Please vote **NO** on this egregious attack on human life.

Regards;

Jim and Jayne Boersma

Olivia, Minnesota

To whom it may concern,

I'm writing to inform you my opposition to the physician assisted suicide bill. This bill will only cheapen life in general. But worse will make some elderly or infirmed folks think that they are a burden on society and/or family. And sadly, think they are better off killing themselves.

Sincerely,

Joe and Tina Scherer (Waverly, MN.)

Written Testimony for Public Safety Hearing on HF 1930
March 7, 2024

Dear Members of the Committee.

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 am 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 several reasons that undergird the AMA position 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 could 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

March 6, 2024

Dear Minnesota Legislators,

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, myself and no small number of other 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 "aid in dying," which we must acknowledge is a sanitized 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.

It is routine for mental health providers to do some level of suicide risk assessment with all of the people to whom we provide professional care. When our assessment might demonstrate 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 someone feels that they want to end their life. No one reasonably opposes the expectation of mental health providers to intervene because suicide is intuitively, for all of us, understood and felt as a tragic loss. It is known to us that many people attempt suicide not because they want to die, but they don't know how to ease the pain they feel. Mental health care seeks to ease suffering and preserve life.

The direct and intentional termination of human life, even though it may happen with the involvement of health care professionals, 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 a healing remedy. By celebrating physician-assisted suicide as somehow humane and appropriate health care, it actually promotes suicide and thereby speaks in

opposition to human life as having inherent value, and it works directly against a major purpose of the mental health profession.

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 stage.

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

Sincerely,

A handwritten signature in black ink that reads "Joseph W. Pribyl MA, LMFT". The signature is written in a cursive, flowing style.

Joseph W. Pribyl, MA, LMFT
Roseville, Minnesota

Dear Ms. McDaniel,

I am writing to request you oppose the Physician Assisted Suicide proposed legislation.

I am a nurse who has worked for 39 years in healthcare. I have a variety of experience ranging from Neonatal Intensive Care to Pediatric and Adult Oncology.

Physician-assisted suicide is not compassionate care. The word “compassion” is a word that has been part of the English language for centuries. It comes from Latin com- and pati- which means “to bear, suffer.” It does not say, “remove suffering by killing or allowing someone to kill themselves.”

Human life is not ours to take.

- Our physicians take a **Hippocratic Oath** when they become doctors. One of the promises within that oath is "first, do no harm." Suicide harms, physician-assisted or otherwise.
- An evil action (legalized murder/Physician-assisted suicide) cannot be justified by reference to a good intention (ending or diminishing suffering). (CCC 1759) This is legalized murder. It does not benefit society, and it does not contribute to overall well-being.
- The Preamble of the Constitution of the United States, which is yours to uphold, states:
 - **We the People** of the United States, in Order to form a more perfect Union, establish Justice, ensure domestic Tranquility, provide for the common defense, **promote the general Welfare**, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America. (<https://www.archives.gov/founding-docs/constitution>) Physician assisted suicide is detrimental and in no way promotes the general welfare. It “removes” valuable human life from society.

It is not compassionate care to allow someone a way out as opposed to a way through. The way out is to just get rid of the pain and suffering by literally killing a patient; the problem with this, outside of the obvious legalization of killing, is that it could lead to an expansion of this legislation to include the elderly, the disabled, the poor, and/or the marginalized for any other reason that the government deems “a problem.” Regardless of whether the legislation is proposed to be between a provider and the patient, these are potential scenarios, this should not be an option, and **this legislation MUST be stopped**. In addition, not everything a person *wants* to do during a stressful period in their life is what they would choose if they considered the same situation at a time when they are free from stress, pain, and fear. To allow this as an available option is wrong on many, many levels.

While I agree that suffering is sometimes brutal and unimaginable, and that the journey through any illness can be extremely painful, difficult, and stressful, I believe that the role of Health Care Providers is to provide “compassionate care” that does not end a life but compassionate care that allows others to enter into the suffering with the patient to offer measures that assist the patient in managing his/her suffering through human contact: Palliative Care, Hospice, comfort

measures, and medications. This allows families, communities, and patients to engage with each other in the end-of-life stage, not take it all away.

When a patient enters hospice care, there is no guarantee that the patient “will die” within 6 months, even if the patient is deemed terminal. There are patients on hospice for 2+ years or more. A diagnosis of “terminally ill” may be incorrect, and no human person, doctor or otherwise can predict when a life will end. Why would we allow someone to prescribe medication that would kill them instead of allowing them to spend time with loved ones before they die?

The Physician-assisted suicide legislation has very few safeguards. It does not require any witnesses to be present when the patient takes the lethal dose of medication prescribed, and it does not even require the patient to ever take the medication once it is dispensed. **This is dangerous.**

- It opens the door to someone mistakenly taking the medication and killing themselves accidentally, or someone selling medication that may impact society and harm others. Who is going to be held accountable when this happens? ...because it will happen. Will it be the doctors, the person selling the drug, or you who voted it in, Governor Walz included?
- It could allow a guardian to decide on suicide for a comatose patient, disabled patient, or a patient who has suffered cognitive injuries and can't communicate. And in this scenario, who will “give” the medication?

Please, as representatives of myself and many others in the great state of Minnesota, **oppose** this legislation. It is what your constituents want.

Sincerely,
Julie Persoon

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 outlive any of her "neuro-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

Respectfully submitted to the House Public Safety Finance and Policy Committee for the meeting to discuss HF1930: End-of-life option established for terminally ill adults.

Dear Committee Members,

I am writing to you to ask for your support of the Minnesota End of Life Option Act. This law would provide relief or peace of mind to those who meet the qualifications established by the law, and who choose to take advantage of it, if suffering becomes unendurable in their end days. I don't know that I would take advantage of the benefits this law would provide, if I qualified for its implementation, but just knowing it is available would give me a level of reassurance that I might limit the length of suffering I need endure at the end of my life.

I never thought much about the subject before my sister, Rochelle, died several years ago. She died after two weeks in hospice care. This followed more than two debilitatingly painful years suffering the ravages of metastatic melanoma. Her disease slowly drained the life from her, but what must have been the most agonizing part of the process was waiting for death once she gave in to the realization that the end was near and she entered hospice.

Rochelle started walking and talking before she was one year old, and once she started, she never stopped getting out and talking to anyone and everyone who would listen. She loved and lived for conversation. Up to the time she entered hospice, she was able to maintain some ability to connect and talk to friends and family, but once active medical intervention in hospice entered the picture, physical comfort and pain management became the objective, and conversation—what made my sister who she was and gave my sister life—became all but impossible. She couldn't express herself, and the frustration of not being able to do what she had loved for a lifetime, inflicted an anguish her medical team could not ease.

Whether we like it or not, whether we admit it or not, when terminally ill people enter hospice care, they are beginning the process of medically assisted dying. The only thing I am asking for with this legislation is more control over how long the process of dying is allowed to go on; just a little more control over how much anguish one must endure—IF one decides to exercise the option provided by this legislation.

I don't know if Rochelle would have chosen to accelerate her process of medically assisted dying, but I do know the look in her eyes as she struggled to do what she loved so much and could no longer do. Having witnessed the end of my sister's life; it would give me comfort to know this legislation was in place if I was given a similar prognosis.

Please support this legislation. I would hope not to have to take advantage of it, but I would appreciate knowing the option is available if I truly believed it was necessary.

If you choose not to support this legislation, I await your response with an explanation as to why you have made this decision.

Respectfully,

Kennon Moen
24612 Labrador Beach Road
Pelican Rapids, MN 56572-7188
HP: 218-863-1828
CP: 301-908-7245



My sister Patty, has always been an active and energetic person. We road bike most every Saturday during the summer, at times up to 30 miles or so.

In August of 2022, she began to have symptoms related to ALS. This diagnose was confirmed by Mayo Clinic. Her disease progressed rapidly. By Christmas she needed to use a walker. She had to move out of her beautiful home and into an assisted living facility. Over time, ALS took her mobility, her independence and her dignity.

The final stage of ALS leaves only the ability to breathe and swallow. At this point all treatment stopped and she was moved to hospice care. During her last several weeks of life, she slowly suffocated, starved and was painfully dehydrated.

She writhed in pain, she howled in agony and sobbed unconsolably. Hospice people were unable to provide anything to ease her suffering. This went on for weeks. Her daughters were helpless and there was much confusion about what could be done. There are some that suggest Voluntarily Stopping Eating and Drinking (VSED) is a peaceful and painless option. My sister's experience (which was not voluntary) was a horrific and cruel way to die. Families need options to care for their loved ones. Health care directives can only withhold life-saving care but cannot prescribe the conditions and process for providing a compassionate and dignified end of life.

My wife passed way in August of last year from an aggressive form of Lymphoma. She never left the hospital. The nursing staff had concerns that my directions to them to provide comfort their actions could have unintended consequences. I had to assure them I would not put them at risk of violating hospital policy and Minnesota state law. They did what they could. Thankfully her suffering did not last.

In looking at the Vermont legislation I was struck by the power given to physicians to take action on their own at the same time to provide absolute impunity to their actions.

Instead, I feel the top priority is to honor a person's request for a dignified and compassionate way to die. This should be included in a person's health directive along with instructions preventing resuscitation or other extraordinary means when a person's quality of life is significantly diminished.

In either case, there should be input from an appointed family member as defined by Power of Attorney. A third-party should also be able to provide input such as a social or Palliative medical professional.

The intent of this is to prevent coercion or other nefarious actions but not intended to override a patient's or appointee's desire to provide a dignified and compassionate way to die.

Years ago, I had a dog whose lungs were collapsing. The vet confirmed nothing could be done and the humane thing to do was to "put him to sleep".

We need to allow this to be an option for our loved ones and ourselves. It would be the humane thing to do.

Kevin Murphy
583 Lois Lane
Lino Lakes MN 55014
612-368-7717

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

Dear Ms. McDaniel,

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.

Sincerely,
Kim Braegelmann
Litchfield, MN 55355

March 6, 2024

Dear House, Public Safety 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.

This language should be removed because it creates confusion. If it is not suicide, then what would one call it?

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



March 4, 2024

House Public Safety Finance and Policy
Room 200, State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd
Saint Paul, MN 55155

Re: Testimony in Support of HF1930

Dear Rep. Moller and members of the House Public Safety Finance and Policy 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 $\frac{2}{3}$ 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,

A handwritten signature in black ink that reads "Sam Streukens". The signature is written in a cursive, flowing style.

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

Hello,

I'm writing to voice opposition to a draft bill HF 1930 to legalize physician assisted suicide that will be considered by the House Public Safety Committee on Thursday.

Thank you for your service!

Mark Klema
(16B western Kandiyohi County)

M. Perry Testimony in Support of HF 1930 End of Life Options Act

It has been my privilege and responsibility to be with two of my sisters at the time of their final illnesses and their deaths. Both women died too young—one at age 41 from complications of type 1 diabetes and multiple sclerosis, and the other at age 66 from glioblastoma. Sadly, neither of them had the comfort of the choices that the End of Life Options Act (HF 1930) would have afforded them.

There is nothing like this experience to make the theoretical thoughts, ideas, and philosophies we hold become real. Although we three shared an upbringing and were similar in many ways, my sisters made choices that were different from each other and different from the choices I would have made in their places. This drives the point home that all terminally ill people need the freedom to choose how to spend their last days and the right to die with dignity. Please do all you can to see that HF 1930 passes.

HF 1930 Written Testimony

March 6, 2024

The Minnesota House of Representatives Public Safety Committee

Regarding HF 1930

Laws are made to protect people, to protect others and to protect each of us from ourselves. I cannot understand how this Bill is even being considered. What happened to the oath that doctors take? How would you trust a doctor that is willing to euthanize their patients?

I am against this Bill and I urge you to not pass HF 1930.

Mary Davis
Mound Minnesota

I am writing to ask that the committee please support the End-of -Life Options Act (HF1930).

After seeing my father suffer with cancer, dementia and health problems and then my mother-in-law suffer for years after a stroke I am very supportive of choices for ending pain and suffering at the end of life.

Currently, Minnesotans who have a terminal condition or an extremely poor quality of life may take tragic measures to take their own life which may include suicide in different forms. No one wants to take this option but many are desperate and it becomes their only option.

I believe everyone should have a more peaceful, safe and supportive way to end of life.

Thank you for considering this Act!

Sincerely,
Mary Werbalowsky
612.860.9632

Tuesday, March 5, 2024
 Matthew Kent, Ph.D.
 215 Locust Street
 Monticello, MN 55362
 Phone: 763-295-3212
 mateossoccer@gmail.com

Ms. Ellen McDaniel
 Committee Administrator - DFL Caucus
 520 State Office Building
 100 Rev. Dr. Martin Luther King Jr. Blvd.
 Saint Paul Minnesota 55155

Dear Ms. McDaniel:

Please communicate to the appropriate legislators in the House my strong objection to H.F. 1930, the bill to legalize assisted suicide in our state.

As a Ph.D. in philosophy, I would like to point out to you that assisted suicide violates in a fundamental and serious way the crucial notions of virtue and Natural Law.

Socrates, for example, actually looked forward to death, since he provided philosophical arguments for the immortality of the human soul. But when his friends asked him why he did not simply commit suicide, he replied by defending the thesis “that a man should wait, and not take his own life until God summons him.”

Thus, in philosophy at least, the idea that human life is sacred, and must be treated as something that we are mere stewards of, goes back to the ancient Greeks – along with medical ethics, specifically as found in the great physician Hippocrates, whose oath is of course taken to this day in the medical profession.

The famous philosophical notion of Natural Law points out that a thing is good when it fulfills its purpose. A good pen is one that writes. A good ear is one that hears. Likewise, then a good human is one who fulfills the human purpose. What, then, is the human purpose? Well, as Aristotle and myriad others have pointed out, we are not mere plants or animals; we humans have reason. Thus, we are called upon to live according to reason, **not as if mere bodily pleasures and pains were the ultimate goals of our nature.**

So what does it mean to be reasonable? It includes respecting the fact that human life is a gift that all of us have **received** and none of us has **made**.

Thus, virtue (a word that means “excellence” – that is, excellence at fulfilling our human function of living toward ideals and thus as more than animals) requires that we should indeed strive to alleviate suffering for the dying. This is in accord with important ideals – apprehended by reason – like mercy, compassion, generosity, and courage. But virtue also requires that we

must alleviate suffering in a way that respects **another fact that reason can apprehend**: the nature of human life as not a **piece of self-made property** but rather a **gift** (since this is what reason rather easily proves it to be – *did you make yourself?!?*). This is why the most fundamental job of a doctor is to *heal* – to support life, not to take it.

The end does not justify the means. If I have the end goal of donating money to the poor, that is a laudable goal, but I may not do it by means of beating up my next-door neighbor and stealing her purse. The choice of end goal is praiseworthy but the choice of means is morally wrong. Likewise, the end goal of alleviating suffering must be accomplished by means of an ethical method – namely, a choice that respects the value of every human life, including the life of one who is terminally ill. Otherwise, I have made one ethical choice but one unethical choice, and indeed in a very major way.

We should not play God. (Of course, there have been atheist philosophers, but they above all have no right to play God, since they think there isn't one!) Our human condition requires us to admit that human life contains mysterious elements, and our job is to face them with virtues such as love and compassion and respect for life – not to violate any one of these ideals. The state should exist to serve human life, not to encourage the taking of it. Assisted suicide is not merely “letting nature take its course,” which can be justified in some circumstances – it means actively trying to attack human life!

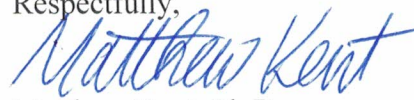
One final remark: Assisted suicide sends **an extremely negative message to others, especially the handicapped.** It is a slippery slope by which a society irrationally declares for the philosophy of Hedonism – as if this life before death is all we have, and as if this life before death lacks rational purpose for ourselves and others once it can no longer be enjoyed. (And if any members of the House would like to debate me about whether we should adopt Hedonism as the official State Philosophy of Minnesota, which in effect this law implicitly does, then I accept the challenge. It is easy to show that human nature, whether one likes it or not, is made for virtue, not mere pleasure, and thus that all human lives have dignity and meaning, and must be respected by both themselves and others!)

We can do better than this. Let's heed the message of Socrates, Hippocrates, Aristotle, and others who have championed the cause of virtue and the Natural Law. All lives have meaning, and thus medical service to all lives (including the reduction of suffering by means that respect human life) has meaning.

Let's respect the inviolable dignity of every life, all the way to natural death.

Let's respect the fact that **the elderly and the handicapped and the mentally ill have lives worth living**, and that those who care for them, even up to their final moments, are not wasting their time!

Respectfully,



Matthew Kent, Ph.D.



March 7, 2024

Public Safety Finance and Policy
Minnesota State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

Dear Chair Moller 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

¹HF 1930 1st Engrossment.

²See, 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).

³CMS 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
Acting Director of Public Policy
Minnesota Family Council

Renee K. Carlson
General Counsel
True North Legal

⁴Honderich, H. (2023, January 14). *Who can die? Canada wrestles with euthanasia for the mentally ill*. BBC News.

⁵Hopper, T. (2023, May 16). *One third of Canadians fine with assisted suicide for homelessness ...* National Post.

Michael Blissenbach Testimony Against H.F. 1930
Public Safety Finance and Policy Committee– Public Hearing March 7, 2024

Dear Chairwoman Moller 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.

March 5, 2024

To: The Minnesota House of Representatives Public Safety Committee

From: Michael Border, Minnesota Citizen, Veteran, and Roman Catholic

Public Safety Committee- I am shocked that this state would even consider enacting an assisted suicide law! As a Vietnam veteran I'm alarmed that human life has become so downgraded as to invite the state into the decision process. It's estimated that some 22 veterans commit suicide daily. What does this mean to each of us about our society's priorities?

Do anyone truly consider public governance to be so accurate in its assessments and superior in its judgements as to place the rubber stamp of life or death under its purview? Does any patient feel comfortable being treated by a physician who might agree, or even suggest, a choice to end their life?

Minnesota has adopted a barbaric stance regarding human life. Life originates far from government's domain. Life is a gift from God, from birth to natural death. Truncating the natural course of a life, either at the beginning, or later, should not be presumed as a power of government or physicians. This is an example of unhealthy tampering with the natural order.

Michael Border

Hello, my name is Mindy Smith and I am here today in support of The Minnesota End-of-Life Options Act. (HF1930). I fully support the law's intention to provide choices for those that have a terminal diagnosis. I was actively involved in my father's care as he struggled with ALS and was unable to make the choices that he wanted based on current state laws. My father, an active, avid outdoorsman of 62 years young, full of life and hope was given the blow of a devastating diagnosis full of dread and death in his near future. As I am sure everyone here is aware, ALS is a terminal diagnosis and one that is certainly horrific to hear for a 6'6", former college athlete, who enjoyed life outdoors in the beauty of northern Minnesota with his wife, children, and grandchildren. His care was managed by a compassionate group of providers who could offer only physical and emotional "support" ...no treatment, no medication, no care that could eliminate the pain, suffering and emotional trauma this diagnosis brought to my father and our family. He wanted choices, so he researched how to end his life without resorting to suicide which he knew would devastate our family. He investigated moving to another state that had passed a right to die law, but realized time would likely run out. And then, very quickly he was unable to move and eventually to speak...the heart wrenching statement he made to me and my sister was "I waited too long to end this" ... And then for months he begged us to take his life for him. At first with words, then motions and finally with groans of "roll me over" ...pleading with us to help him smother. My father's death on Christmas morning that year was a gift for him and for us, because his suffering was finally over... however, he died alone, in the middle of the night in a nursing home.

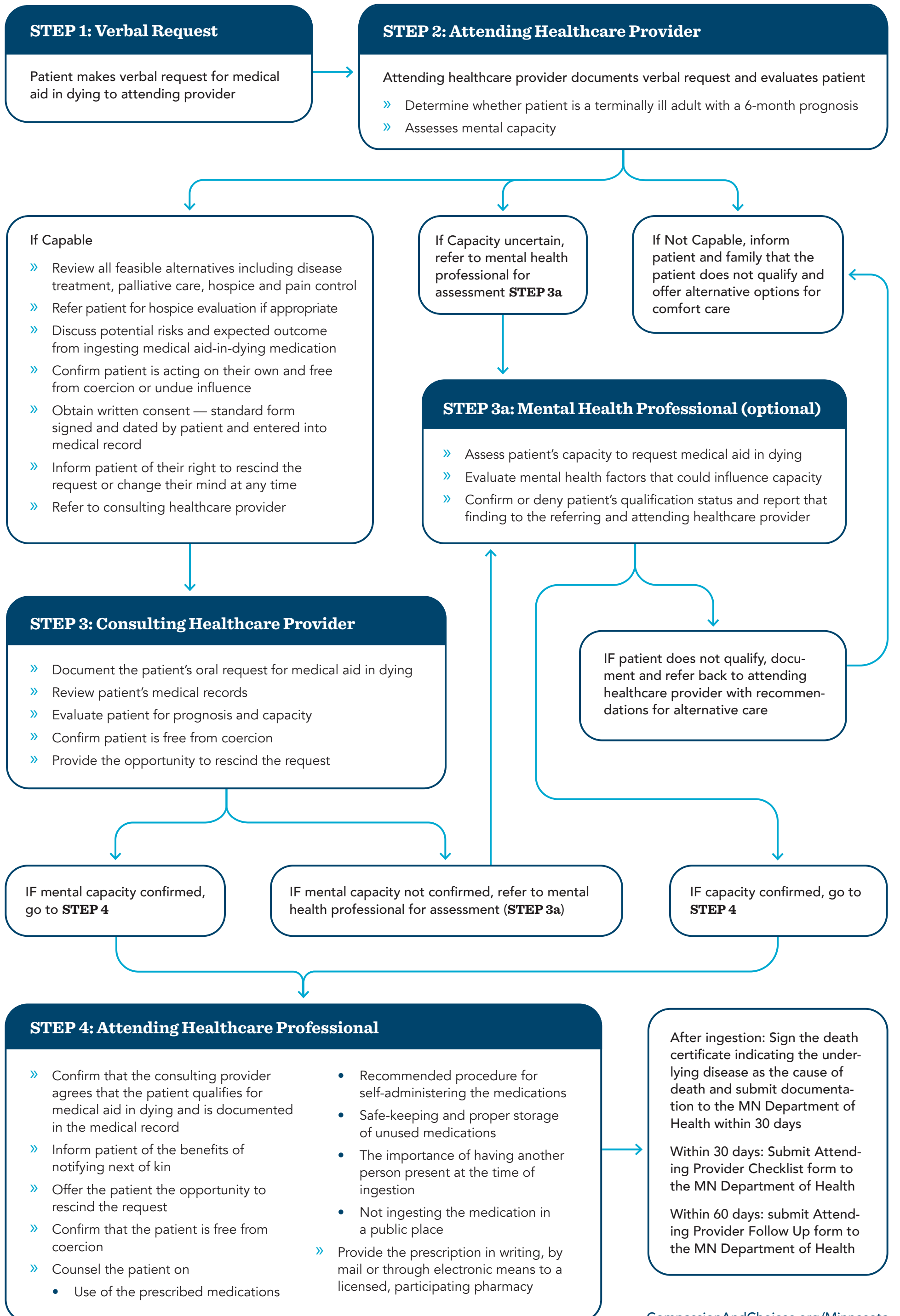
His dream was to gather those that loved him, celebrate his life and when the time was right for him, administer a medication to help him leave this earth on his terms, wrapped in loved one's arms. The Minnesota End-of-Life Options Act would provide that choice of love and compassion for someone like my father.

Thank you.

Mindy Smith

mindysmith05@gmail.com

Medical Aid-in-Dying Steps



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

Paul Deeming
3635-C St. Francis Way
Eagan, MN 55123
March 4, 2024

To: the House Public Safety Finance and Policy Committee

Re: The Minnesota End-of-Life Options Act (HF1930)

I am writing to strongly support HF 1930, the Minnesota End-of-Life Options Act. I can sum up my reason in one word: autonomy. Every adult should have the right to their own health decisions, their own autonomy as an adult. I and many others should have the right to determine our care in dying, especially in face of a terminal illness, just as much as we do in our healthcare during our lives.

This is even more poignant to me right now as I sit vigil with my younger brother in a New York state hospice who is slowly and – despite all best attempts at pain control – painfully dying from Pancreatic cancer which has spread throughout his body in less than six months. Unfortunately, New York also does not have end-of-life options laws, so he never had the chance to make such a decision for himself.

I never hope I nor another other of my family or friends have to go through this hell!! EoLOA would give us the options we need. Please do all you can to pass this legislation! IT IS TIME!

Sincerely,

Paul Deeming
Eagan, MN

IN SUPPORT:

The Minnesota End-of-Life Option bill / HF1930

I support the bill for several reasons.

My father had Parkinson's Disease, and now my husband is afflicted with it. My father, toward the end of his life, was losing his ability to swallow. It was very frightening. He ended up dying of prostate cancer, and the cancer was actually a blessing, because it was *decisive*. (my father chose to forgo treatment.)

My husband could develop the swallowing problem, too. He rejects tube feeding, as do I. At that point, he will be dying. Not committing suicide--dying. And, he can make the choice to end his own life, *slowly and uncomfortably*. Why is this necessary? Both outcomes are the same.

I have heard people who oppose this bill state terminally ill people deserve respect. Isn't it more "dignified" to give people agency, in how they die?

On a different matter:

I have worked extensively with disabled people. I helped a quadriplegic for 30 years with his morning cares. To suggest people like Jimmie can be easily manipulated makes me laugh. It's condescending to suggest people with disabilities are pliable and unable to make end of life decisions for themselves.

Thank you for your attention,
Paula Keller
Minneapolis

**WRITTEN TESTIMONY IN SUPPORT OF H.F. 1930
BEFORE THE MINNESOTA HOUSE OF REPRESENTATIVES
COMMITTEE ON PUBLIC SAFETY FINANCE AND POLICY**

MARCH 7, 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 to address one specific objection to H.F. 1930. Some commentators have expressed 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. But this concern is misplaced and ungrounded.

2. 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

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.

3. 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

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.

4. 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 either 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.

Attachments. In case it might aid the committee, I attach two of articles reviewing the legal history of medical aid in dying.

March 4, 2024

MN House Of Representatives Public Safety Finance & Policy Committee
Representative Kelly Moller, Chair
509 State Office Building
St. Paul, MN 55155

re.: HF 1930

Dear Rep. Moller & Committee Members:

I am writing to you to express my opposition to this bill and the practice of assisted suicide in general. The last several years have seen an increase in suicide in our state and nation. While this is tragic, it has also helped bring attention to the topic, which has in turn lead to an increase in resources available to help those who are struggling and hurting and increased awareness of those resources.

I believe this bill, by making suicide a more available and easier option, flies the face of all of those efforts to help hurting individuals. It will only hurt them further, by adding official weight to the narrative that “your life is worth less, there’s no hope for you, you’d be better off dead.” That is the last thing that people in these situations need to hear.

My own father suffers from advanced dementia and is in a skilled nursing facility. He recently developed a urinary tract infection (UTI). While discussing treatment options, one option that was presented to us was that if left untreated, the UTI would develop into sepsis, he would be given medication to make him comfortable, and eventually he would “just go to sleep.” I think this option was presented as a way to “end his suffering” and make us feel like it was okay to do so. I felt like we were even being encouraged to see this as the “best” way to care for him. The alternative was to treat the infection with a common, inexpensive, easily-available antibiotic. We chose the latter option. As the UTI cleared, my father showed dramatic improvement, becoming more lively and talkative. He was clearly happy, comfortable, and able to find joy in his life.

I appreciate the thought that was given toward making my father comfortable and easing his suffering. I believe that there should be strong emphasis on palliative care options and those options should be available to all people, especially those suffering with terminal illnesses. This experience, however, made it clear to me how easy it is for the distinction between supportive care and direct action to end a life to become blurred. If passed, I believe this bill would significantly increase the pressure placed on those suffering with terminal illness, as well as their caregivers, to end their lives, rather than seek palliative care. Such action devalues the individual and contributes to a utilitarian approach to healthcare, rather than one based on caring for health.

My father’s condition is terminal. He will never recover and in fact, he will continue to decline. Thanks to receiving assisted care, however, he has had more time to be alert and interacting with others—staff, visitors, and family members. Does he always remember who those people are, including family members? No, but he still enjoys talking with and spending time with them. That is precious and worthy life time that could very easily never have taken place if a decision had been made that it would be better to end his life.

Minnesota has a strong reputation as a destination for quality healthcare and medical innovation. I feel we should focus our attention on continuing to develop those resources to help care for and support those in difficult life and medical situations. Assisted suicide is not that kind of care. It is a short cut strategy that preys upon the weak and vulnerable, rather than supporting them. Please do not create a legal justification for that kind of mistreatment by passing this bill.

Thank you for your time and consideration.

Sincerely,

A handwritten signature in cursive script that reads "Reed Heidelberg".

Reed Heidelberg
17000 Co Rd 28
Villard, MN 56385

We Support the End-of-Life Options Act!

As a minister and a co-founder and leader of *Minnesota Interfaith Clergy for End-of-Life Options*, I wholeheartedly support passage of End-of-Life Options Act.

We have sat with people in the last weeks, days and hours of their life and can assure you that medical aid-in-dying is *not* suicide. The term "suicide" describes an act by those who *want* to die and who often do so impulsively, alone, sometimes violently and almost always due to mental illness or addiction.

People who wish to end their lives through medical aid-in-dying want to live! Their disease is killing them and they simply seek a peaceful death. Their terminal illness and the often unpreventable pain they feel makes their life miserable. They seek what most everyone wants: relief from intolerable pain.

Please pass this legislation. 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

My name is R. Paul Post, MD and I am a retired board-certified family physician, having practiced medicine in Minnesota for 37 years. I am currently consulting for several health care organizations. I am testifying in opposition to HF 1930. Since this is the Public Safety, Finance and Policy Committee, I will be focusing my comments on my serious concerns about the public safety implications of this bill. Section 13 of the bill indicates that it will be a crime to use coercion, undue influence, harassment, etc. to compel someone to choose this option. However, this bill sets the standard of care as requiring all physicians to offer medical assistance in dying as an option. If practitioners are continually reminding patients that physician assisted suicide is a treatment option, this is incredibly coercive. People view doctors with a tremendous amount of respect and trust them. In my practice, I know I was able to convince my patients to take the course of action that I felt was best for them on many occasions, yet I felt I was not harassing or coercing them.

Making this the standard of care and requiring doctors to offer it as an option will feel like a suggestion, intended or not. And when each new provider a patient encounters offers this, imagine the effect this will have. Many will begin to think they have a duty to die, rather than a right to die. They will feel it is their duty to relieve the burden on their family and society.

The bottom line is that making this the standard of care threatens public safety, especially for the vulnerable and disabled in our state. I urge you to vote no on HF 1930.

R. Paul Post, MD, FAAFP
State Director, American Academy of Medical Ethics.

Testimony in Support of the End-of-Life Option Act HF 1930

March 6, 2024

Dear members of the House Public Safety Finance and Policy Committee,

My name is Rosie Gaston and I am a hospice clinical social worker here in the Twin Cities. I am also a researcher, writer, educator, and advocate for medical aid in dying. I am writing on behalf of my support for the End-of-Life Option Act. I could name numerous reasons why while today I would like to focus this written testimony on differentiating medical aid in dying and dying by suicide through the lens of a hospice social worker.

It is not uncommon for hospice social workers to be sent to a patient's place of residence to complete a suicide risk assessment after a comment has been made by the patient suggesting suicidal ideation. The most common assessment tool I have used across numerous hospice agencies is the Columbia Suicide Severity Rating Scale as research suggests it is a good tool not just for hospice settings, but also for patients with dementia. I have not only performed many of these assessments in my career, I have also been a leader in developing a suicide assessment protocol for a national hospice agency. I take the mental health needs of my patients very seriously and want to ensure they have the support they need.

I remember one of these bedside assessments very well, the nurse had asked me to go out and visit a patient who resided in a nursing home after she made a statement that sounded something like, "I am just done with this life and don't understand why I can't just hurry this along. May be its time to just throw myself out my window." As we visited, I directly asked her about the statements and if "you have thoughts of killing yourself." She openly shared that sometimes she does. She was an adventurous, spicy, brave, and independent woman. She used to spend her time at her cabin in the country where she would read, spend time in nature, and befriend and name the wild animals. She had pictures to prove it. She now lived in a nursing home where she became short of breath with any exertion. One of the few joys she had left was smoking and she had to rely on staff to bring her outside, which happened less and less. Many of her friends and family had died. Like many patients that request MAID in Oregon, she had lost the ability to engage in activities that make her life enjoyable, she was losing more and more autonomy and dignity as her illness progressed. This quality of life was unacceptable to her. And unlike individuals who struggle with suicidal ideation due to mental illness or substance abuse, her concerns were not going to go away, this is not something I could create a treatment plan to improve. Her body was slowly dying and mentally, emotionally, and spiritually she was ready.

We often speak to this as death ideation. Which is different than suicidal ideation. These patients know the end of their life is impending and they want to process it and talk about it.

There have been some in my career who I did rate high on the assessment scale where a plan had to be established. Most of these patients had previous suicide attempts and had a significant history of struggling with mental illness. I have coordinated for outside mental health support to come in, I have called 911 and had my patient brought to the ER, I have sat with a patient as he shared the details of his failed attempt from the night before. I have fought for these patients and always will.

Some patients I have served have been ready to die long before I even met them. While some still have some fear and anxiety of the unknown, who doesn't, their values surrounding quality of life have been severely compromised and that is not what they want for themselves. Most of the patients I have completed suicide assessments with are not suicidal, they are just ready. And I want to fight to give them that option. I have an on going petition listing 54 other MN clinicians who stand with me. From medical doctors, to nurse practitioners, to PhD's, to LICSW's, to RN's. All front-line worker who see what I do every day. To learn more visit, <https://www.change.org/p/minnesota-clinicians-support-the-mn-end-of-life-option-act>

Thank you for taking the time to learn about my experiences and for allowing this bill to be heard.

All my best,

Rosie Gaston, MSW, LICSW, APHSW-C

2/18/2024

There is a scene in a movie where doctors and nurses wearing white coats are sitting at desks with charts. Patients appear in front of them. The medical staff appear to be taking notes about the patients. This scene isn't in a doctor's office. It is at Auschwitz concentration camp. The movie is *Schindler's List*. The medical providers are not treating the patients, providing compassionate care. Rather, they are deciding which individuals are allowed to continue to live for another day or week or month, and which ones will go to their deaths in a gas chamber. Over 50% of German medical professionals joined the Nazi Party by 1933. They thought it would help their careers.

Germany required a medical professional at all individual executions and at exterminations at the gas chamber at Auschwitz. The medical providers originally sterilized those that were deemed to be "unfit." "The atrocities justified and performed by the health practitioners serving the Nazi eugenics and "euthanasia" programs exemplify how small steps along a slippery slope can lead to crimes against humanity. The Nazi doctors gradually progressed from eugenic sterilization to child and adult "euthanasia" and ultimately to murder and genocide. Framed in such medical terms as "healing work" and "death assistance," German health practitioners carried out the murder of thousands of the "unfit."

The Nazi Physicians as Leaders in Eugenics and "Euthanasia": Lessons for Today - PMC (nih.gov)

The scene from *Schindler's List* came to my mind as our state legislators consider whether medical professionals will have the legal right to end the lives of their patients. Euthanasia, mercy killing, medical assisted dying or physician assisted suicide, it really means the same thing. Doctors who went through years of medical training to care for, treat, and heal patients will now help them die.

The ability for medical providers to predict death is ultimately an estimate, a guess. They may be right some of the times, but they are often wrong. My mother was diagnosed with stage 4 colon cancer at the age of 65. She was given 3-5 years to live. She lived for 14 years. Even as she was dying, the hospice nurses attempted to anticipate her death, from a week to a couple of weeks, yet she lived for six weeks. Two months after her death, my dad was diagnosed with bladder cancer. Although my dad, at 84, was reluctant, his doctor convinced him that surgery would improve his quality of life. There were complications. His colon was nicked during surgery and his body filled with bacteria. He became septic. There really was nothing to be done. The medical team predicted that he would die within three days. He lived for ten. His doctor felt horrible as this clearly was not the outcome he planned. My family accepted it. Doctors aren't perfect after all. Mistakes happen.

We want the "body autonomy" to decide when and how we die. There of course are many ways to kill yourself. Sadly, it is happening daily in the United States at rates higher than ever. The ethical issue is whether medical professionals should be in the business of helping people "die with dignity." Perhaps we want to legitimize suicide, make it less horrific by recruiting a medical professional to assist us. However, a doctor who gives a gun to a mentally ill person to kill themselves is really no different than giving a lethal amount of drugs to a person who has cancer. Both are suffering, which may cloud their judgment. Both are in a vulnerable state where death might seem like a welcomed end to their

suffering. Who would volunteer for a death that involves suffering? But who would prefer a life that involves suffering?

Our need to control our deaths, to choose when and how we die, doesn't just affect us. It affects those around us. I know this very well. When my husband died of suicide in 2011, the youngest of my 7 children were 6, 7, and 9. Because of their young ages, I originally told them he died of depression. As each turned 13, I told them their father died by suicide. They are now young adults and struggle more now than when he first died. They don't remember how sick he was, how he became preoccupied with death on and off for the last 3 years of his life. I have tried my best throughout the years to help them understand that he was suffering greatly and likely not rational at the time of his death. It gives them some consolation but not much. But what if his death was carried out by a medical provider, who was rational, and not under the burden of years of serious mental illness? That would be much harder to accept, I think. Now they would experience strong emotions about their father but also the person who helped to end his life. Will we tell our children and grandchildren that a doctor trained to care and heal, killed our loved one? If euthanasia is moral and ethical, we should be comfortable sharing this with our families and friends. What happens to a doctor, trained to heal, but also kills?

People have strong feelings about doctor assisted suicide based on their own experiences. I watched both of my parents slowly die and my husband suffer with mental illness for years. I would rather suffer myself than watch someone else suffer. But what happens when a society shifts from caring for those suffering, to killing them? What message do we give our young people when we give the authority to some of the most intelligent, well-educated professionals the right to objectively kill the most vulnerable and weakest individuals? Will we send a message to those not as intelligent or educated or emotionally stable, that in certain circumstances, we have the right to kill? Are we really promoting peace and love? Are we really any better than Nazi Germany?

Murder is defined as: "the unlawful premeditated killing of one human being by another" The only change with euthanasia is the removal of "un." Whether you believe in God or not, I think we can all agree that doctors are not gods. Perhaps we should stop treating them like they are. I implore you to vote "**NO**" on any legislation related to giving medical providers the legal right to commit an act of violence, to kill those who are suffering.

Thank you for your serious consideration,

Ruth Boubin

I am a healthy active married 71 year old male living in Minnetonka. I have 3 married children and 9 grandchildren.

I am most definitely in favor of passing the “end of life option act”.

Scott Bader

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

March 6, 2024

Dear Committee Chair Moller and Members of the House Public Safety Finance and Policy Committee:

I am a woman in my 60s who has two daughters—one with a physical disability. I am a firm believer in bodily autonomy and have always been in favor of laws ensuring end of life options for myself. However, several disability justice groups that I respect have come out against laws such as these, so I have been doing more research into this issue and giving it greater consideration.

After talking with my disabled daughter and other members of the disability community, I have come to realize that I do, in fact, continue to believe that Minnesota needs to pass a law ensuring end of life options, if it includes safeguards that prevent the most vulnerable, including people with disabilities, from being coerced into this decision.

I believe that HF1930 is a good bill, one that includes these safeguards. As a currently able-bodied woman in decent health, I want that option for myself and for all my loved ones, including my disabled daughter. Just as the government should not force her into making any medical decisions against her will, neither should it prevent her from having the right to end her own life, provided she meets the criteria of the law. She is a smart, competent young woman who deserves to make her own decisions about her own body, both now and in the future.

Matthew Sanford is a disabled teacher and writer that I admire. He published his opinion supporting this bill on January 11, 2024. He makes a compelling argument in favor of legalizing end of life options for all Minnesotans. I urge you and your colleagues to support HF1930.

Thank you.

Sherry Kempf
2304 28th Ave South
Minneapolis, MN 55406

March 4, 2024

I feel compelled to submit a testimonial on why I vehemently oppose HF 1930 regarding assisted suicide. I have been working in senior care/long term care for 15 years, and during that time have witnessed and experienced countless deaths. While death is never easy, and the dying process can take many months and may be painful to witness, I have found it can also be a beautiful and moving experience to be a part of. I have witnessed laughs, tears, smiling, prayers, reconnecting, and countless other emotions from both the dying person and their loved ones and caregivers. I believe that it is an important part of life, to be able to die naturally as your body and God intended! I recently had a resident's family member tell me that although it was difficult to witness their mother in her journey with dementia, they wouldn't have changed a thing, because she was able to tell them she loved them until her dying day, even if it was just through non-verbal actions at times. What an incredible testimony - I would never want to take away that beautiful experience from a person just because the dying process is difficult.

I have also been blessed to work with wonderful hospice agencies, who partner with a person/their families/caregivers to care for a person in their remaining days/months, who listen to and respect their end of life wishes, who assist with pain management, and can educate on and anticipate the upcoming needs of the dying person. Their support, care and services are immensely helpful and may be overlooked by those who wish to take the easy route by choosing assisted suicide.

Simply put, it is immoral and unjust to pass legislation supporting assisted suicide. We need to value human life, from conception to natural death. We cannot allow assisted suicide to become a reality in Minnesota – instead we should utilize our many healthcare options and supports in our state until the final breath is taken.

Sincerely,

A handwritten signature in black ink that reads "Stephanie Capelle". The signature is written in a cursive, flowing style.

Stephanie Capelle
Resident of Jordan, MN

March 6, 2024

Dear Committee Chair Moller and Members of the House Public Safety Finance and Policy Committee:

I write in support of HF 1930

I took care of my mother through seven years of dementia and her death was a slow downward slide where she was anxious and agitated much of the time. Scared, in fact. If I should received that diagnosis, I would want another option that allows me to die peacefully, with my family around me, at a time that I remember and love them. Please hear my genuine concerns.

Please pass HF 1930.

Thank you for your good work.

Sincerely,

Susan Herridge
3534 Harriet Ave #2
Minneapolis, MN 55408

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 work 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

Tara Flaherty Guy

2809 Virginia Avenue

Roseville, MN 55113

651-343-1603

taraguy058@gmail.com

March 5, 2024

TO: House Public Safety and Finance Policy Committee Members

RE: House File 1930 (MN End of Life Options Act)

Honorable Chair and Committee Members:

I am writing to you to express support for HF1930 which you will be considering in pertinent part at public hearing on Thursday, March 7, 2024. I strongly support this legislation after witnessing a number of bad deaths - accompanied by unrelieved suffering - among terminally ill family and friends who would have been greatly helped by the End of Life Options Act.

I am thankful that the House Public Safety Committee is considering the draft legislation, because there are aspects of public safety and well-being that extend beyond that of the dying person in question. I'm talking about the families of the sick and suffering people who take their own lives – or attempt to – to end their own suffering. Their loved ones are not only left with the loss of the one they loved, but also the trauma of the suicide.

I am a volunteer with Compassion & Choices, in honor of my best friend Doris, who died after a lengthy illness, agonizing suffering, and a botched suicide attempt. The hospital disregarded her advanced directive, instead listening to the demands of her boyfriend, who had no legal standing to make decisions for her, and put Doris on life support for four agonizing days. The staff was finally persuaded through legal action to eliminate the unwanted life support from my friend, who had explicitly prohibited it in her advanced directive. She died “naturally” three days later. After coming to work with Compassion & Choices, I was shocked at how many volunteers had lost terminally ill loved ones in similar tragic ways – suicide, or botched attempts. So much heartache.

There is much collateral damage associated with actual suicide. Medical aid in dying is NOT suicide, it is the voluntary choice of a peaceful end, made by a suffering, terminally ill person. Please understand the critical difference. Having lost all control over their lives on the day of their diagnosis, these people at least deserve to have some choice about how they will die. *People will find a way to end their suffering.* Please help them to end their lives with the grace and peace of family around them in their final moments.

Sincerely,

Tara Flaherty Guy

Passing MAID would mean we have failed; we have thrown up our hands and said “just die already, I don’t care”!

Minnesota, a State that is a leader in healthcare, can do better! Let’s improve healthcare and let people know they are loved and their life matters.

I’m a Nurse Practitioner who has been working in Geriatrics in a variety of settings in the Twin cities for the past 30yrs. I can tell you that passing this bill will further destroy families. So much grace occurs during the period of time when people are facing a terminal condition. It is a time when defenses are allowed to be relaxed and individuals often have conversations in a depth that could not have happened without the faced challenges. There is a profound trust and bond that forms and character development in all parties participating in the relationship and terminal “adventure” (or journey). Our dignified humanity blooms during this time!

In my experience, most people are not afraid of pain once they are working with a caring healthcare team. We have great understanding of the science and providing pain relief today, so this really isn’t a rational concern requiring escalating death.

In assisted suicide the individual is trying to hang on to what they believe is autonomy and they are disregarding what happens after they achieve this end (and we don’t study it). It is really a lonely exit because they have discarded the compassion (suffering with) of loved ones as having any value. Assisted suicide gives into despair, which we are constantly trying to fight against in healthcare.

It is not civil to kill yourself. It is worse to make someone an accomplice and it ends a safe and supportive healthcare system and ultimately society.

Sincerely,
United in service,
TeresaTawil APRN, CNP
Plymouth, 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.

January 24, 2024

I am here in support of HF1930, the Minnesota End-of-Life Options Act.

As a daughter of a woman who chose to use VSED, Voluntary Stopping Eating and Drinking, to hasten her death, I understand the importance of bodily autonomy. My mother, Cheryl Hauser, was locally and nationally recognized for her decision to not live the final stages of Alzheimer's which would steal her dignity but instead brought hope and inspiration to our community as her story was one of the most popular aired in 2023 on MPR with Cathy Wurzer and local news stations. It was clear, people are interested in options around their end of life. These are options.

As an end-of-life doula, I have witnessed numerous loved ones ready, and sometimes pleading, for their life to end because of a painful, incurable disease which has taken away their grace, comfort and joy, leaving families feeling helpless. They would like options.

As a teenager I lost a dear friend to suicide on my first day of our senior year. Kevin, a bright and athletic young man took a gun to his head and killed himself. He had depression, he told no one and was alone that night he died. Kevin was not terminally ill and did not have a prognosis of six months or less to live. Thus, my friend would have never qualified to receive Medical Aid in Dying in any state where this bill has been legalized. Kevin is not who this bill is created for – He was not in the dying process.

And as an English major, I understand how words matter. When we name something, this determines how we think about it. As cultural anthropologist, Anita Hannig, points out "until just recently, the primary term in the English language for a purposeful death of oneself was suicide. We simply had no other ways of referring to this idea of an intentional self death."

But times have simply changed. And over the past 25 years since Oregon enacted the country's first Medical Aid in Dying law, along with 9 other states plus Washington D.C. joining the movement, a Medical Aid in Dying death has occupied a new legal and moral category.

Because, please hear my words, a Medical Aid in Dying death today is a new medical response to the shattering and overwhelming reality of a terminal illness. Please, allow this to be an option for Minnesotans.

Thank you,

Wendy Brown

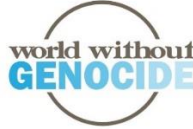
Wendy Longacre Brown
End-of-Life Doula
wendy@mychemin.com
mychemin.com
612-282-8644



Dear Legislators,

It is interesting that HF 1930 regarding physician assisted suicide is being discussed in the public safety committee. The only reason I could see this being a cause for safety concern is if the bill is actually passed, which would lead to those who are susceptible to the temptation of suicide to be in danger of pressure from the very people who are supposed to be looking out for their wellbeing encouraging them to choose death. Right now, the bill is limited in its scope, but if we look to other places that have implemented this kind of legislation, we can see that it broadens over time. As someone with a disability, this is a cause for concern. This is a foot in the door for suggesting suicide to people rather than providing them with the loving care they need and deserve. Imagine a person with a physical or mental disability being given the option to end their life rather than getting some help alleviating their pain. If we start down this road by passing this bill, it could easily lead to a situation where people are even denied treatment or care due to the push for suicide. It seems like that would never happen, but history is full of examples where things that began with good intentions spiraled out of control soon after. This is the very thing that led to the Holocaust. Many people don't know that this horrendous event actually began with the legalization and acceptance of euthanasia. It was deemed more humane to just euthanize all the people with disabilities rather than force them to suffer their miserable lives. As someone with a disability, that is incredibly insulting. I love my life. Yes, I deal with chronic pain, but I would never want someone to suggest that the solution is to end my life. Imagine going to your family members, telling them you are in pain, and hearing them suggest for you to kill yourself. Would you feel loved by that suggestion? People are not disposable objects. Life is not something that is ours to give and take. That belongs to God alone. Please do not fall for this wicked temptation. Please vote against HF 1930.

William Scheremet
Northfield, MN



AT MITCHELL HAMLINE SCHOOL OF LAW

March 7, 2024

To Members of the House Public Safety and Finance 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 medical 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 combined evidence and cumulative data from the laws passed in 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.

This option is currently available to more than 28 million people around the world and to people in ten U.S. states and Washington, D.C.

We urge passage of the End-of-Life Options Act for people in Minnesota.

Thank you,

A handwritten signature in black ink that reads "Ellen J. Kennedy". The signature is written in a cursive, flowing style.

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