Written Testimony of Bradley N. Kehr, J.D.
Government Affairs Director, Americans United for Life
In Opposition of HF1930 and Amendment DE1-1
Submitted to the House Health, Finance, and Policy Committee
January 24, 2024

Dear Chair Liebling, Vice Chair Bierman, and Members of the Committee:

My name is Bradley N. Kehr, and I serve as Government Affairs Director at Americans United for Life ("AUL"). Established in 1971, AUL is a national law and policy nonprofit organization with a specialization in abortion, end-of-life issues, and bioethics law. AUL publishes pro-life model legislation and policy guides on end-of-life issues,[1] tracks state bioethics legislation,[2] and regularly testifies on pro-life legislation in Congress and the states. Our vision at AUL is to strive for a world where everyone is welcomed in life and protected in law. As Government Affairs Director, I specialize in life-related legislation, constitutional law, and end-of-life public policy.

Thank you for the opportunity to provide written testimony against HF1930, "End-of-Life Option Act" and amendment DE1-1 (together, "bill"). I have thoroughly examined this bill, and it is in my opinion that the bill goes against the prevailing consensus that states have a duty to protect life, places already-vulnerable persons at greater risk, and fails to protect the integrity and ethics of the medical profession.

I. *Suicide by Physician Targets Already-Vulnerable Persons and Puts Them at Greater Risk of Abuse and Coercion*

Minnesota has a responsibility to protect its most vulnerable persons—including people living in poverty, the elderly, and those living with disabilities—from abuse, neglect, and coercion. These individuals are already exposed to greater risks, thus, legalizing suicide by physician is neither "compassionate" nor an appropriate solution for those who may suffer depression or loss of hope at the end of their lives.

Contrary to the prevailing cultural narrative, patients are not considering suicide by physician for pain management. Rather, state reports show that patients seek assisted suicide

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[1] *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE (last visited Jan. 16, 2022), https://aul.org/law-and-policy/.
[2] *Defending Life: State Legislation Tracker*, AMS. UNITED FOR LIFE (last visited Jan. 16, 2022), https://aul.org/law-and-policy/state-legislation-tracker/.

because of the challenges they face living with severe illnesses or disabilities. In 2021, only 26.9% of Oregon patients and 46.0% of Washington patients cited "[i]nadequate pain control, or concern about it" as a reason for choosing suicide by physician.[3] As bioethicist Ezekiel Emanuel has noted, "the main drivers [of those contemplating suicide by physician] are depression, hopelessness, and fear of loss of autonomy and control. . . . In this light, assisted suicide looks less like a good death in the face of unremitting pain and more like plain old suicide."[4] Like Emanuel, many professionals in the bioethics, legal, and medical fields have seen the writing on the wall and have raised significant questions regarding the existence of abuses and failures in states with approved suicide by physician, including a lack of reporting and accountability, coercion, and failure to assure the competency of the requesting patient.[5]

In addition, the cultural narrative around legalizing physician-assisted suicide has led to a "suicide contagion," or the Werther Effect.[6] As an example, empirical evidence shows that media coverage of suicide inspires others to commit suicide as well.[7] Studies have demonstrated that legalizing suicide by physician in certain states has led to a *rise in overall suicide rates*—assisted and unassisted—in those states.[8] After accounting for demographic, socioeconomic, and other state-specific factors, suicide by physician is associated with a 6.3% increase in overall suicide rates.[9] Unfortunately, these effects are even greater for individuals older than 65, which has seen

[3] OR. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2021 DATA SUMMARY 13 (Feb. 28, 2022); WASH. DISEASE CONTROL & HEALTH STATS., 2021 DEATH WITH DIGNITY ACT REPORT 11 (July 15, 2022).

[4] Ezekiel J. Emanuel, *Four Myths About Doctor-Assisted Suicide*, N.Y. Times (Oct. 27, 2012), https://opinionator.blogs.nytimes.com/2012/10/27/four-myths-about-doctor-assisted-suicide/.

[5] José Pereira, *Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls*, 18 CURRENT ONCOLOGY e38 (2011) (Finding that "laws and safeguards are regularly ignored and transgressed in all the jurisdictions and that transgressions are not prosecuted."); *see also* WASHINGTON 2018 REPORT (In 2018, 51% of patients who requested a lethal dose of medicine in Washington did so, at least in part, because they did not want to be a "burden" on family members, raising the concern that patients were pushed to suicide.).

[6] *See, e.g.,* Vivien Kogler & Alexander Noyon, *The Werther Effect—About the Handling of Suicide in the Media*, OPEN ACCESS GOVERNMENT (May 17, 2018), https://www.openaccessgovernment.org/the-werther-effect/42915/. There is, however and more positively, a converse Papageno Effect whereby media attention surrounding people with suicidal ideation who choose not to commit suicide inspires others to follow suit. *See, e.g.*, Alexa Moody, *The Two Effects: Werther vs Papageno*, PLEASE LIVE (Jun. 5, 2015), http://www.pleaselive.org/blog/the-two-effects-werther-vs-papageno-alexa-moody/.

[7] *See id.*; *see also* S. Stack, *Media Coverage as a Risk Factor in Suicide*, 57 J. EPIDEMIOL. COMMUNITY HEALTH 238 (2003); E. Etzersdorfer et al., *A Dose-Response Relationship Between Imitational Suicides and Newspaper Distribution*, 8 ARCH. SUICIDE RES. 137 (2004).

[8] *See* David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 10 (2015) https://pdfs.semanticscholar.org/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf; *see also* David Albert Jones, *Suicide Prevention: Does Legalizing Assisted Suicide Make Things Better or Worse?*, Anscombe Bioethics Centre (2022), https://bioethics.org.uk/media/mhrka5f3/suicide-prevention-does-legalising-assisted-suicide-make-things-better-or-worse-prof-david-albert-jones.pdf.

[9] *Id.*

a 14.5% increase in overall suicide rates for that demographic.[10] As a result, suicide prevention experts have criticized suicide by physician advertising campaigns.[11]

HF1930 targets vulnerable individuals who are suffering from depression and hopelessness and communicates the message that their lives are not worth living. This bill will only stoke the flames of the suicide contagion, which may result in more unassisted suicides. However, vulnerable individuals are indeed worthy of life and equal protection under the law, and state prohibitions on assisted suicide reflect and reinforce the well-supported policy "that the lives of the terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy."[12]

II. *The Bill's Supposed Safeguards Are Ineffective in Adequately Protecting Vulnerable Patients*

Although this bill includes so-called "safeguard" provisions, in effect, these protections cannot adequately protect vulnerable end-of-life patients. Instead, this bill opens the door to the real abuse. For example, the bill's mental health assessment requirement is practically nonexistent for physician inclined toward assisting suicide. The bill requires the attending and consulting physician to determine that the individual making the request is a "mentally capable." "Mentally capable" is merely defined as someone "requesting medical aid in dying medication has the ability to make an informed decision." Yet, the patient is only referred to a "licensed mental health professional"[13] for a mental capacity assessment if the attending or consulting physician "cannot determine mental capability." A "licensed mental health professional" can either be a psychiatrist, psychologist, or a clinical social worker. Thus, this bill allows for social workers to perform these assessments and determine whether the individual is a "qualified individual" and can end their own life.

These safeguards are ineffective because the bill fails to define "capacity" or what makes an individual "capable of making an informed decision." Further, it only requires an assessment of "mental capacity" and not "mental health." This means that even if the individual is suffering from depression, that will not preclude a physician from prescribing them life-ending medication. Significantly, scholarship shows "[a] high proportion of patients who request physician-assisted suicide are suffering from depression or present depressive symptoms."[14] "[A]round 25–50% of

[10] *Id*.
[11] *See* Nancy Valko, *A Tale of Two Suicides: Brittany Maynard and My Daughter*, Celebrate Life, Jan-Feb 2015, available at https://www.clmagazine.org/topic/end-of-life/a-tale-of-two-suicides-brittany-maynard-and-my-daughter/ (suicide prevention experts criticizing a billboard stating, "My Life My Death My Choice," which provided a website address, as "irresponsible and downright dangerous; it is the equivalent of handing a gun to someone who is suicidal").
[12] *Washington v. Glucksberg*, 521 U.S. 702, 731-32 (1997).
[13] Defined in the bill to mean "one of the following, licensed by the profession's licensing board: psychiatrist, psychologist, or clinical social worker."
[14] Jonathan Y. Tsou, *Depression and Suicide Are Natural Kinds: Implications for Physician-Assisted Suicide*, 36 INT'L J. L. & PSYCHIATRY 461, 461 (2013).

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patients who have made requests for assisted suicide showed signs of depression and 2–10% of patients who have received physician-assisted suicide were depressed."[15] These patients' "desire for hastened death is significantly associated with a diagnosis of major depression."[16] Their psychiatric disability also may impair decision-making, "such as the decision to end one's life."[17]

Despite the high rates of depression in patients considering assisted suicide, counseling referrals are uncommon.[18] In Oregon in 2021, assisted suicide physicians prescribed lethal drugs to 383 patients yet only referred two of these patients for counseling—approximately 0.5% of patients.[19] Even when there is counseling, psychiatrists have limited ability in diagnosing depression. One study shows that "[o]nly 6% of psychiatrists were very confident that in a single evaluation they could adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide."[20] If trained psychiatrists have difficulty adequately assessing the mental wellbeing of end-of-life patients, social workers will encounter even more difficulties in making such assessments, especially given their limited training and qualifications compared to psychiatrists. Nevertheless, this bill allows for social workers to determine if an individual has the "capacity" to take their own life. This raises serious concerns because if the physician refers the patient to a "licensed mental health professional," the bill has no requirements that the mental health professional actually meet with the patient before the patient can be deemed to have the necessary "capacity" nor assess the patient's actual mental health. For these reasons it is difficult to argue that this "safeguard" in DE1-1 will allow for an accurate assessment of an individual's condition, capacity, and mental health.

In addition, the bill assumes that physicians can make the correct diagnosis that a patient has a terminal disease, injury, or condition which will "result in the patient's death within the next six months." This fails as a safeguard as well because terminality is not easy to predict, and doctors have difficulty accurately dating terminal illness life expectancy. As the National Council on Disability notes, "[a]ssisted suicide laws assume that doctors can estimate whether or not a patient diagnosed as terminally ill will die within 6 months. It is common for medical prognoses of a short life expectancy to be wrong."[21] Likewise, "[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival."[22]

[15] *Id*. at 466; *see also* Linda Ganzini et al., *Prevalence of Depression and Anxiety in Patients Requesting Physicians' Aid in Dying: Cross Sectional Survey*, 337 BMJ 1682 (2008) (finding 25% of surveyed Oregon patients who had requested lethal medication had clinical depression and the "[statute] may not adequately protect all mentally ill patients").

[16] *Id*.

[17] *Id*.

[18] Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 HUM. LIFE REV. 51, 54 (2018).

[19] Or. Pub. Heath Div., Oregon Death With Dignity Act: 2021 Data Summary 8 (Feb. 28, 2022).

[20] Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469 (1996).

[21] Nat'l Council On Disability, The Danger Of Assisted Suicide Laws, Bioethics And Disability Series 21 (2019).

[22] *Id*. at 22.

Studies have shown "experts put the [misdiagnosis] rate at around 40%,"[23] and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an "error"[24] which resulted in the individual's death. Prognoses can be made in error as well, with one study showing at least 17% of patients were misinformed of their diagnosis.[25] Nicholas Christakis, a Harvard professor of sociology and medicine, agreed "doctors often get terminality wrong in determining eligibility for hospice care,"[26] and Arthur Caplan, the director of the Center for Bioethics at the University of Pennsylvania, considers a six month requirement arbitrary.[27] Even the Oregon Health Authority admitted, "[t]he question is: should the disease be allowed to take its course, absent further treatment, is the patient likely to die within six months? . . . [Y]ou could also argue that even if the treatment [or] medication could actually cure the disease, and the patient cannot pay for the treatment, then the disease remains incurable."[28]

III. *Suicide by Physician Erodes the Integrity and Ethics of the Medical Profession and Allows for Physicians to Experiment with Lethal Drugs on End-of-Life Patients*

Prohibitions on suicide by physician protect the integrity and ethics of medical professionals, including their obligation to serve patients as healers, to "keep the sick from harm and injustice," and to "refrain from giving anybody a deadly drug if asked for it, nor make a suggestion to this effect."[29] Despite these ethical obligations, physicians are using experimental lethal drugs when assisting in suicide. There is no standardized drug nor required dosage for assisted suicide. "Of course, there is no federally approved drug for which the primary indication is the cessation of the mental or physical suffering by the termination of life."[30] The Food and Drug Act regulates pharmaceuticals at the federal level and requires "that both 'safety' and 'efficacy' of a drug for its intended purpose (its 'indication') be demonstrated in order to approve the drug for distribution and marketing to the public."[31] Lethal medication could never meet the safety or efficacy requirements for treating mental or physical ailments.

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[23] Trisha Torrey, *How Common is Misdiagnosis or Missed Diagnosis?*, VeryWell Health (Aug. 2, 2018), https://www.verywellhealth.com/how-common-is-misdiagnosis-or-missed-diagnosis-2615481

[24] *See, e.g.*, Malcom Curtis, *Doctor Acquitted for Aiding Senior's Suicide*, The Local, Apr. 24, 2014 (reporting the doctor was not held accountable for his negligence).

[25] Nina Shapiro, *Terminal Uncertainty*, Seattle Weekly, Jan. 13, 2009, http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.

[26] *See id.*

[27] *See id.*

[28] Fabian Stahle, *Oregon Health Authority Reveals Hidden Problems with the Oregon Assisted Suicide Model*, Jan. 2018 (emphasis added), available at https://www.masscitizensforlife.org/oregon-health-authority-reveals-hidden-problems-with-the-oregon-assisted-suicide-model.

[29] The Supreme Court has recognized the enduring value of the Hippocratic Oath: "[The Hippocratic Oath] represents the apex of the development of strict ethical concepts in medicine, and its influence endures to this day. . . .[W]ith the end of antiquity . . . [t]he Oath 'became the nucleus of all medical ethics' and 'was applauded as the embodiment of truth'" *Roe v. Wade*, 410 U.S. 113, 131-132 (1973).

[30] Steven H. Aden, *You Can Go Your Own Way: Exploring the Relationship Between Personal and Political Autonomy in Gonzales v. Oregon*, 15 Temp. PolL. & Civ. Rts. L. Rev. 323, 339 (2006).

[31] *Id*. at 340.

Around 2016, suicide doctors turned away from using short-acting barbiturates due to price gouging and supply issues.[32] Consequently, suicide doctors began mixing experimental drug compounds at lethal dosages to assist suicides.[33] As the U.S. Food and Drug Administration ("FDA") notes on its website, "[c]ompounded drugs are not FDA-approved. *This means that FDA does not review these drugs to evaluate their safety, effectiveness, or quality before they reach patients*."[34] This means physicians have experimented their lethal drug compounds on end-of-life patients with "no government-approved clinical drug trial, and no Institutional Review Board oversight when they prescribed the concoction to patients." Notably, the bill is silent as to what drugs doctors must use and there are no safeguards preventing doctors from using experimental lethal drug compounds directly on patients.[35]

Ultimately, HF1930 and amendment DE1-1 harm the medical profession, physicians, and people who may be struggling to process the shock of a difficult diagnosis. It opens the door for physicians to be forced to violate their conscience rights[36] and medical ethics, such as the Hippocratic Oath, and increases the risk that patients will be coerced or pressured into prematurely ending their lives when pitched with suicide by physician as a viable treatment option with alleged benefits. Even the U.S. Supreme Court has acknowledged that "[t]he State also has an interest in protecting the integrity and ethics of the medical profession."[37] In Justice Antonin Scalia's dissent to another Supreme Court case involving a ban on the use of controlled substances for suicide by physician, he pointed out: "Virtually every relevant source of authoritative meaning confirms that the phrase 'legitimate medical purpose' does not include intentionally assisting suicide. 'Medicine' refers to '[t]he science and art dealing with the prevention, cure, or alleviation of disease' . . . . [T]he AMA has determined that '[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer.'"[38]

IV. *The Majority of States Affirmatively Prohibit Medical Suicide*

The majority of states prohibit physician-assisted suicide and impose criminal penalties on anyone who helps another person commit suicide. Minnesota should remain in this majority. Since

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[32] Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. L. & BIOSCIS. 424, 429– 430 (2017).

[33] *See* Robert Wood et al., *Attending Physicians Packet*, End OF Life Wash. 1, 7 (Apr. 11, 2022), https://endoflifewa.org/wp-content/uploads/2022/04/EOLWA-AP-Packet_4.11.22.pdf (describing suicide doctors' experiments with different lethal drug compounds).

[34] Compounding Laws and Policies, U.S. Food & Drug Admin (Sept. 10, 2020), https://www.fda.gov/drugs/human-drug-compounding/compounding-laws-and-policies (emphasis added).

[35] Jennie Dear, *The Doctors Who Invented a New Way to Help People Die*, The Atl. (Jan. 22, 2019), https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/.

[36] *Cf. Christian Med. & Dental Ass'ns v. Bonta*, No. 5:22-cv-335 (C.D. Cal. Sept. 2, 2022) (issuing a preliminary injunction against California's requirement that doctors medically document a patient's lethal drug request, which counts towards the two required drug requests, despite doctors' conscientious objections to assisting a suicide); *Lacy v. Balderas*, No. 1:22-cv-953 (D.N.M. filed Dec. 14, 2022) (alleging New Mexico provisions that require doctors to tell patients of the availability of suicide assistance and refer for the practice infringe upon conscience rights).

[37] *Glucksberg*, 521 U.S. at 731.

[38] *Gonzales v. Oregon*, 546 U.S. 243, 285–86 (2006) (Scalia, J., dissenting) (third internal quotation citing *Glucksberg* 521 U.S. at 731).

Oregon first legalized the practice in 1996, "about 200 assisted-suicide bills have failed in more than half the states."[39] In *Washington v. Glucksberg*, the U.S. Supreme Court summed up the consensus of the states: "In almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide. The States' assisted-suicide bans are not innovations. Rather, they are longstanding expressions of the States' commitment to the protection and preservation of all human life."[40]

This longstanding consensus among the vast majority of states is unsurprising given the "opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal and cultural heritages."[41] Indeed, over twenty years ago, the Court in *Glucksberg* held there is no fundamental right to suicide by physician in the U.S. Constitution, finding instead that there exists for the states "an 'unqualified interest in the preservation of human life[,]' . . . in preventing suicide, and in studying, identifying, and treating its causes."[42]

Thus, only by rejecting HF1930 and amendment DE1-1 can this Committee further Minnesota's important state interest in preserving human life, as well as its duty to protect the lives of her citizens, especially the lives of the most vulnerable groups in our society

V. *Conclusion*

Minnesota should continue to uphold its duty to protect the lives of all its citizens—especially vulnerable people groups such as the ill, elderly, and disabled—and maintain the integrity and ethics of the medical profession by rejecting suicide by physician and voting against HF1930.

Respectfully Submitted,

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[39] Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 Human Life Rev. 51, 53 (2018).
[40] *Glucksberg*, 521 U.S. at 710.
[41] *Id.* at 711.
[42] *Id.* at 729–30.