PATIENTS RIGHTS ACTION FUND

Review of Minnesota House File 1358 and Senate File 1352

***Overview*:**

Neither the Minnesota constitution nor the U.S. Constitution contains a right to assisted suicide; therefore, no individual has the right to authorize another to kill him or her in violation of federal and state criminal laws. *Washington v. Glucksberg*, 521 U.S.702, 735 (1997). Instead, Minnesota has an "unqualified interest in the preservation of human life." *Id.* at 728. Minnesota's current statutory "prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to [preserving and protecting human life]." *Id.* at 735.

Importantly, suicide, including healthcare provider-assisted suicide, is not a typical reaction to an acute problem or life circumstance, and many individuals who contemplate suicide, including the terminally ill, suffer from clinical depression or other treatable emotional or mental issues, which frequently go undiagnosed and untreated by physicians. *See, e.g.*, New York State Task Force on Life and the Law, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 77-82 (May 1994). For this reason and many others, the medical profession as a whole opposes provider-assisted suicide because it is contrary to the medical profession's role as healer and undermines the provider-patient relationship. *Washington v. Glucksberg*, 521 U.S. at 731.

Minnesota House File (HF) 1358 and Senate File (SF) 1352 seek to obliterate the state's "unqualified interest" in protecting and preserving human life, including the lives of the vulnerable, sick, and disabled. Instead, the bill erroneously accepts a "sliding-scale approach" that claims certain "qualities of life" are not worthy of equal legal protection. *Id.* at 729.

Maintaining Minnesota's existing prohibition on assisted suicide, including provider-assisted suicide, is the only way to protect vulnerable citizens. *Id.* at 732.

***Specific Concerns with HF 1358 and SF 1352*:**

The bills purport to provide a legal mechanism under which certain patients are able to request assistance from a physician, clinical nurse specialist, or nurse practitioner in committing suicide. This usually involves the prescription of lethal medications that patients will "self-administer." There are many, significant problems with the bills' language that endanger the vulnerable, sick, and disabled.

* Dangerous Policy Decision to Decriminalize Assisted Suicide: Recognizing its "unqualified interest" in preserving and protecting all human life, Minnesota law currently classifies assisted suicide as a crime. MINN. STAT. § 609.215. HF 1358 and SF 1352 decriminalize healthcare provider-assisted suicide, deceptively reclassifying it as accepted medical treatment.

* Broad Definition of "Terminal Condition": To qualify for assisted suicide under HF 1358 and SF 1352, a patient must have a "terminal disease." However, the bills' definition of "terminal disease" is incredibly broad. For example, they do not differentiate between situations where death will occur within 6 months even with treatment from situations where death would not likely occur if the patient sought and received treatment. This means that someone who has a treatable disease or condition (*e.g.*, diabetes) who refuses treatment or who is denied insurance coverage for certain treatments is eligible to request and receive lethal drugs.

* Expansion of Categories of Healthcare Providers Who Can Prescribe Lethal Medication: HF 1358 and SF 1352 authorize certain "advanced practice registered nurses" to prescribe lethal medications. In contrast, most other states that have passed or even considered legislation to legalize assisted suicide have limited prescriptive authority to licensed physicians.

* Lack of Meaningful Mental Health Evaluation: Under HF 1358 and SF 1352, an attending or consulting provider is not required to refer a patient for a complete mental health evaluation or even counseling. Rather, the patient may be referred to a "licensed mental health care provider" (defined to include social workers and counselors) for an optional "referral for confirmation of mental capacity."

The bills define mental capacity as "the ability to make and communicate an informed decision." This illusory requirement utterly fails to protect vulnerable patients. Just because a patient has the capacity to make and communicate an informed decision does not mean he or she is, in fact, making a voluntary and truly informed decision.

The bills also do not require a patient requesting assisted suicide to be treated for any diagnosed psychiatric or psychological disorder or problem. Evidence suggests that many patients whose mental health concerns are properly diagnosed and treated change their minds about suicide. For example, in one study of assisted suicide in Oregon, 46% of patients seeking assisted suicide changed their minds when their physicians intervened and appropriately addressed suicidal ideations by treating their pain, depression, and/or other medical problems. Linda Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act," 342 NEW ENG. J. MED. 557, 557 (2000).

Concerns with Process for Requesting Lethal Medication:

* *No Requirement for In-Person Requests or Consultations*: The bills do not require that the oral or written requests for assisted suicide, any medical consultations, or even the optional "referral for confirmation of mental capacity" take place during in-person meetings or consultations. The bills require a patient to make a written request for lethal medication, witnessed by two others. But there is no explicit requirement that the written request be presented in-person to the attending provider. This opens the door to the inappropriate use of "telemedicine" for these requests and consultations, increasing opportunities for coercion of the patient and for abuse of the process.

* *Witnesses to Written Request Can Have Conflicts of Interest*: The bills require that the patient's written request for assisted suicide be witnessed by two persons. One of the witnesses can be a relative, heir, or someone with a claim to the patient's estate. There are also no requirements that the second witness (who is not a relative or heir) be completely independent and unrelated to either the patient or the other witness. This could easily result in abuses. For example, the second witness could be a friend of a person who stands to benefit financially from the patient's death.

* No Oversight of Lethal Drug Administration: HF 1358 and SF 1352 do not require that the attending provider be present when the lethal medication is ingested to ensure the patient's voluntary decision/action or to deal with possible complications. In fact, there is no requirement that any witness attest to the patient's physical or mental capacity when the drugs are ingested, to confirm that the drugs were actually self-administered (as required), or to confirm that the patient's decision was voluntary.

* HF 1358 and SF 1352 Perpetuate Dangerous Falsehoods: Attempting to maintain the fiction that provider-assisted suicide is legitimate medical treatment, the bills specifically provide that, despite the patient ending his or her life by suicide, "the death shall be attributed to the underlying terminal disease" and "that act of self-administering [lethal] medication … shall not be indicated on the death certificate."

* The Bills Compromise Constitutional and Conscience Rights: While HF 1358 and SF 1352 purported to permit individual healthcare providers and institutions to decline to participate in assisted suicides, proposed Section 145.873(b) provides that

> No provider, health care facility, professional organization, or association shall subject a [healthcare] provider to discharge, demotion, censure, discipline, suspension, loss of license, loss of privileges, loss of membership, discrimination, or any other penalty: (1) for providing [assisted suicide] … while engaged in the outside practice of medicine and off the facility premises; or (2) for providing scientific and accurate information about [assisted suicide] to an individual when discussing end-of-life care options.

This provision violates the First Amendment right to free association. Under the bills, a "professional organization or association" will not be able to limit its membership to those who do not support or participate in assisted suicide or require that its members affirm its opposition to the practice. Under this provision, for example, a Catholic medical association that publicly holds to the Church's teaching on the sanctity of life cannot exclude from membership healthcare providers who actively participate in assisted suicides.

Notably, the bills themselves perpetuate discrimination, seeking to primarily protect those who participate in or counsel in favor of assisted suicide. By their own terms, they do not similarly protect those who decline to participate in assisted suicides from discrimination.

Proposed Section 145.871, Subdivision 11 requires an objecting healthcare provider to "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 their end-of-life health care." This would require specific counseling on assisted suicide. Such counseling may violate the consciences of some healthcare providers and should not be mandated.