MINNESOTA'S ASSISTED SUICIDE BILL HAS SERIOUS SIDE EFFECTS

WARNING: THESE ARE ONLY SOME OF THE FLAWS IN PROPOSED LEGISLATION IN MINNESOTA TO LEGALIZE PHYSICAN-ASSISTED SUICIDE (H.F. 2998/S.F. 3215)

NO MENTAL HEALTH EVALUATION REQUIRED

Patients are not required to receive a psychological evaluation before the life-ending prescription is written. In some states, less than two percent of patients who die by physician-assisted suicide (PAS) receive a mental health referral (Oregon Death With Dignity Act 2018 Data Summary, p. 11).

ONLY ONE WITNESS REQUIRED

The current bill has removed a previous safeguard that required two witnesses be present when the patient requests PAS. Now, only one witness is required when the patient takes the suicide drug. Without supervision, patients can easily be coerced into ingesting the drug, or another person may administer the drug, leaving open the possibility for euthanasia.

NO DOCTOR OR NURSE MUST BE PRESENT

No doctor, nurse, or independently licensed aid worker is required to be present when the patient ingests the lethal dose. If something goes wrong, any physical or emotional complications must be handled solely by the patient and those witnessing the death.

NO FAMILY NOTIFICATION REQUIRED

The prescribing doctor must recommend that the patient inform their family members, but nothing in the law requires it.

FEW SAFEGUARDS AGAINST ELDER ABUSE

The legislation allows a beneficiary of the patient's estate to be one of the signers on the request for the lethal drug. This leaves room for fraud and coercion against vulnerable elderly persons, especially if they are wealthy. Furthermore, since no medical professional needs to be present at the suicide, caretakers and relatives can administer the drug.

INSUFFICIENT SAFEGUARDS FOR PEOPLE WITH DISABILITIES

Leading national disability rights groups recognize the many dangers this type of legislation poses to people with disabilities, including those with intellectual and developmental disabilities who are most vulnerable to coercion and undue influence from doctors and family members.

NO WAY TO PREDICT AN ACCURATE PROGNOSIS

Patients become eligible for PAS if they are diagnosed with a terminal illness and given "six months or less" to live. But the bill's language does not specify whether it is six months with the normal course of treatment or without it. In other words, someone who needs kidney dialysis could be considered terminal under this loose definition. Plus, people often long outlive medical prognoses, which are based on routinely imprecise averages.

INSUFFICIENT CONSCIENCE PROTECTION FOR DOCTORS

Doctors who do not wish to provide PAS face discharge or suspension if they do not refer patients to a doctor who will write the lethal prescription. Medical institutions that do not want to participate in PAS are still required to refer patients to another provider.

DENIGRATES THE "STANDARD OF CARE" THAT DOCTORS ARE EXPECTED TO PROVIDE

Forcing doctors, as part of their "standard of care," to advise patients of the opportunity for PAS as a treatment option undermines the trust between the doctor and patient, namely, that the physician is working to heal and never to harm. It injects a level of coercion and suspicion into the relationship that a provider's motives are based in part on economic concerns, which could hinder the patient's reception of counsel related to treatment options that he or she needs to hear in the context of a terminal illness.

The Truth About Assisted Suicide: IT'S NOT WHAT IT SEEMS

The vast majority of our nation does not allow physician-assisted suicide (PAS). But in recent years, several states have legalized it as a form of "medical treatment," and now Minnesota is considering what has been called one of the most aggressive PAS bills in the country.

IT'S NOT ABOUT CHOICE

Those in favor of PAS say it's about giving patients "one more option" to choose from. But patients already have autonomy and choice when it comes to their healthcare options at the end of life. No one ever has to undergo unwanted treatment. Providing PAS as a "treatment" option can actually limit choice by pressuring elderly, disabled, or sick people to end their own lives rather than pursue treatment to extend or even save their life, or to improve their quality of life.

IT'S NOT ABOUT TERMINAL ILLNESS

While PAS laws are usually passed with the promise that only the terminally ill will have access to it, advocates show their true intent to expand eligibility to non-terminal illnesses as soon as it is politically feasible. In fact, in some places such as the Netherlands, children and vulnerable adults are actively being euthanized. The slippery slope is really a cliff.

IT'S NOT ABOUT SUFFERING

Data from Oregon shows that current pain is not even in the top five reasons why people choose PAS. Rather, people tend to cite "fear of future pain" as a reason (Oregon Death With Dignity Act Data Summary 2018, p. 12). Competent medical professionals will tell you over and over again that we are very good at controlling pain, meaning that in many cases, PAS is a fear-based decision, rather than a true last resort for people who are suffering unbearably.

IT IS SUICIDE

Supporters of so-called "death with dignity" insist that this is not suicide. But studies show that in states where PAS is legal, non-assisted suicides are on the rise, suggesting either that the law does not prevent people from committing suicide, or that it actually encourages others to do so (*Southern Medical Journal*, "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" October 2015). This "suicide contagion" is alarming. It shows what supporters of PAS want to deny: that this is suicide. We should prevent suicide, not prescribe it.

Please oppose H.F. 2998/S.F. 3215.
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