"Compassionate care?"
What are we getting into?

Minnesota can do better than legalize physician-assisted suicide.

BY CORY INGRAM, MD, MS, FAAHPM

The Minnesota Compassionate Care Act of 2015 (SF1880) opens a new dialogue on living and dying in Minnesota. SF1880, which was introduced last year and is likely to be heard in the Legislature again this year, would give terminally ill people with fewer than six months to live the opportunity to end their life by self-ingesting a lethal cocktail prescribed by a physician. Under the proposed law, two physicians would have to certify the person's diagnosis and prognosis and rule out reversible causes of their illness.

Supporters of this legislation cite self-determination and allowing dying persons a sense of control over their destiny as arguments in favor of it. They often consider assisted suicide a good alternative to dying in untreatable physical misery or committing a violent, lonely suicide. Opponents have plenty of evidence to suggest there are better choices. They also recognize that the threshold for receiving assistance to end one's life has been steadily lowered in places where it is legal and that vulnerable populations would be harmed by such legislation.[1] As a society, we have genuine differences of opinion about how to responsibly alleviate suffering. I believe we need to find better, more compassionate ways to help the terminally ill and others who are suffering than legalizing assisted suicide.

History of assisted suicide in the United States

In the United States, federal law prohibits euthanasia; however, assisted suicide is governed at the state level. In Minnesota, where it is illegal, assisting in a suicide carries a penalty of up to 15 years in prison and a fine of up to $30,000.

Five states have legalized physician-assisted suicide. Oregon, which enacted its law in 1997, was the first to do so. Subsequently, Washington, Montana,* Vermont and California have enacted laws allowing for physician-assisted suicide.[2] In each of those states, the criteria and processes are similar: In general, terminally ill residents 18 years of age and older, with a life expectancy of fewer than six months, who are capable of self-ingestion and are of sound mind can request assisted suicide. They must submit their request both verbally and in writing on two occasions at least 15 days apart to a physician, who then confirms their diagnosis and prognosis with a consulting physician. If approved, the patient is then provided with a lethal cocktail to ingest at a moment of his or her choosing after a waiting period. SF1880 is similar to the laws crafted in those states.[2]

Learning from experience: A slippery slope

The Netherlands has more than 40 years of experience with assisted suicide and euthanasia, as both have been practiced and tolerated since the 1970s.[3,4] They were formally legalized in 2002, with passage of the Termination of Life Request and Assisted Suicide Act.[5] Belgium also legalized assisted suicide and euthanasia in 2002.

These laws have led to undesirable and unintended consequences. In the Netherlands, deaths caused by euthanasia *tripled* during the first 10 years after it was legalized. Today, one in every 30 deaths in that country is from euthanasia.[5,6] Requests for physician assistance with suicide in the Netherlands have risen by 40 percent since 2010,[7] and the number of requests for life-ending practices increased 10 percent from 2013 to 2014. In Belgium, one out of every 22 deaths is from euthanasia, representing an increase from 1.9 percent to 4.6 percent between 2007 and 2013.[8] Those increases are largely because the threshold for receiving assistance to end one's life has been steadily lowered.[9] In countries and states that have legalized assisted suicide, 76 percent of requests are for nonphysical reasons.[5,10] In the Netherlands, there has been an active campaign to allow anyone over the age of 70 to end their life. The only criterion in addition to age is a belief that one's life is complete.[11,12] In the first year of this campaign, 6.8 percent of people requesting euthanasia at the Life-Ending Clinic, which was established in 2012 for people whose personal physician refused to end their life or assist them with suicide, died by euthanasia solely because they were tired of living.[5]

In Belgium, requests for euthanasia increased dramatically for people over age 80 from 2007 to 2013.[8] There also is a trend for elderly couples in the Netherlands who wish to die together to request euthanasia. This is known as spousal self-euthanasia. Neither spouse needs to be suffering from a life-threatening disease. These are people who simply wish to avoid the functional decline commonly associated with getting

* Montana legalized physician-assisted suicide through a special court ruling.

older.[13] Is old age, by definition, suffering? Does it justify termination of life?

Since 2012, depression and personality disorders have been the top diagnoses among people in Belgium with psychiatric illness who request euthanasia.[14] From 2012 to 2013, the number of people in the Netherlands dying from euthanasia for relief from psychiatric illness increased from 14 to 42.[7] In the Life-Ending Clinic in the Netherlands, euthanasia recipients cited the following as contributing to their reasons for wanting to end their lives: loneliness (49.1 percent); tiredness (83.9 percent), loss of strength (89.4 percent), loss of autonomy (81.4 percent) and loss of dignity (73.9 percent).[5] Eighty-one people with dementia died by euthanasia at the clinic in 2014, up from 43 in 2012.[7,15]

In Oregon, the three most frequently mentioned end-of-life concerns among those requesting physician-assisted suicide are loss of autonomy (91.4 percent), decreasing ability to participate in activities that make life enjoyable (86.7 percent) and loss of dignity (71.4 percent). Three percent of those in Oregon who end their lives choose to do so because of financial concerns.[10]

In addition to these troubling trends are many troubling cases. For example:

- Last March in the Netherlands, a 47-year-old woman with two young children received euthanasia for severe ringing in her ears. Since her death, the Dutch Euthanasia Review Committee has determined that the decision to grant her request was reckless because she had not been adequately evaluated and treatment options had not been explored.[7,16]
- In Belgium in 2013, 45-year-old twin brothers who were deaf were granted euthanasia for ensuing blindness. They did not want to become more dependent.[17]
- Also in Belgium, a 64-year-old woman received euthanasia for chronic depression following her retirement from teaching school. Her family was notified the following day.[18]

Even more chilling, the *Economist* reported that seriously ill people are being involuntarily euthanized in Belgian hospitals and that clinical teams are doing so without the patients' consent.[19]

Some health care professionals, in places where euthanasia and assisted suicide are practiced, are protesting the rapid changes that are occurring in their countries. For example, Dutch pharmacists have refused to dispense lethal medications, citing the ease with which some people are qualifying for euthanasia and concerns that practice standards have become too lax.[20] Additionally, one of the original architects of the Dutch law, Dr. Boudewijn Chabot, considers current practices in the Netherlands a derailment of the legislation. This is because of the steep increase in the number of people with psychiatric illnesses who are having their lives ended without an adequate evaluation of their condition.[21]

My prediction is that if SF1880 becomes law in Minnesota, we will, over time, see a similar loosening of our qualifying criteria for assisted suicide. I believe SF1880 is the first step down the slippery slope. It may take decades, but it will gradually become easier for people to qualify for assisted suicide and eventually euthanasia. Just as it has in other countries and states where euthanasia and assisted suicide are legal, the criterion of being terminal eventually will go away. The criterion of self-ingestion also will go away, as people with ALS and other neurodegenerative diseases will demand that they should be able to have someone end their life. The criterion of serious illness will go away, too. People who want to die will have the opportunity, almost whatever their reason.

No solution, just another problem

I don't question that suffering is real. It is also not my intent to compare the suffering of one individual to that of another. I acknowledge that suffering is a part of life. But I don't support assisted-suicide legislation for two reasons: 1) It doesn't help us provide better care to seriously ill and dying people; and 2) it will harm vulnerable Minnesotans.

Why it won't help us care for the seriously ill and dying

I am concerned that if we legalize assisted suicide, we as a society will cease to look for ways to prevent and treat suffering. I am convinced that we can do better than simply offering to end a person's life. We already can treat the most severe symptoms with interdisciplinary medical care. We are creating systems to make those treatments available to all patients near and far. That hospice and palliative care are not available to all is no justification for ending lives.

We are learning from data gathered from Oregon that most people choose to end their lives for nonphysical reasons. That suggests that building medical care to address whole-person suffering must be part of the task at hand. Society should demand comprehensive whole-person care, not life-ending practices.[22,23]

I'm concerned that if SF1880 becomes law, it will make it easier for people to qualify for lethal prescriptions rather than receive care from teams of well-trained specialists who can alleviate their suffering. I'm concerned that such a law would make it easier for insurance companies to refuse to pay for treatment and instead offer to pay for assisted-suicide prescriptions.[24]

SF1880 won't better educate health care professionals about how to comprehensively alleviate suffering, nor will it place more hands-on, caring staff in nursing homes, in home care organizations or in hospitals. Such a law won't do anything to make it affordable or feasible for families to care for their loved ones at home through the end of life. In fact, SF1880 addresses none of the Institute of Medicine's recommendations for improving living and dying in the United States.[25]

Why it will harm vulnerable Minnesotans

It is common to hear patients say they wish to die, rather than go on suffering. In a moment of true despair, death and nonexistence can seem better than living in their current state. The waning will to live and the desire to die is common to the

human experience and goes along with the ups and downs of living with serious illness.[26] My experience is that people who at one moment voice the desire to die often later say how grateful they are to still be alive once their symptoms are under control.

With assisted suicide as an option, vulnerable people with a fluctuating will to live may see suicide as their only option. Someone who receives a refusal letter from his insurer and can't get pain-relieving chemotherapy or radiation treatment, for example, may then seek approval for a lethal cocktail.[24,27] Patients who may be very sick but not yet eligible for hospice may instead turn to assisted suicide. Certainly, we might argue that SF1880 would afford them the liberty to choose to die; but some patients may view assisted suicide as the only choice they have. Keep in mind that 3 percent of patients in Oregon choose to end their lives by assisted suicide because of financial reasons.[24] Are these vulnerable individuals choosing freely? Or do they lack choice?

If I could give Minnesotans a law …

As a palliative medicine physician, I can't support a law that allows physicians to provide patients with a lethal prescription to end their life at a moment of their choosing. Nor can I support the idea of clinicians administering lethal doses of medications to patients. Rather than make SF1880 law, we need to make dignified, compassionate care a core value in our society. Dame Cicely Saunders, founder of the modern hospice movement, said: "You matter because you are you, and you matter through the end of your life." Every day, I see people with preventable and treatable suffering who would benefit from the services of well-trained clinical teams that can treat both their physical and nonphysical needs. Every day, I see vulnerable people agonizing over the financial burden illness places on their family during their last months of life. SF1880 won't help these people get good care; it will just enable them to take their life.

If I could give Minnesota a useful law, it would be one that would mandate education for health care professionals about the principles of palliative medicine so that every patient's suffering could be properly addressed. My law would make seamless, high-quality, comprehensive, interdisciplinary, around-the-clock, affordable care available in all settings. Don't give Minnesotans a law that will help them die. Give them a law that will help them live well until the end. **MM**

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