February 1st, 2021

Testimony in support of HB1415

On July 12, 2013 I administered medications that hastened my terminally ill father's death. Since the primary goal and intention of administering those medications was to relieve his suffering, the secondary outcome, his death coming sooner than it would have naturally, was an expected and acceptable side effect. Because of this rule of double effect, rendering my father unconscious and ultimately apneic, in order to relieve end of life pain, was supported by medical professional societies, court decisions, and considered justified.

Proponents have argued successfully in several states and the District of Columbia Death with Dignity legislation that legalizes physician-assisted suicide. I urge North Dakota to follow suit and I'm not alone. According to a 2018 Gallup poll, 7 out of 10 Americans believe doctors should be able to help terminally ill patients die.

Rather than list arguments in support of HB1415, I'll focus my testimony this morning on two common opposition arguments and perhaps open a door for you to actively reconsider personal beliefs you may have against death with dignity legislation.

The most common opposition to die with dignity legislation involves the sanctity of life. The belief that human life is sacred because it's a gift from God or because of some more general religious commitment, and therefore it can never be taken by man. Through this lens, physician-assisted death is morally wrong because it's viewed as diminishing the sanctity of life. And with this sanctity, we are permitted liberty interests through the 14th amendment. The US Supreme Court has established through a long line of cases that personal decisions relating to who we marry, which form of contraception we use, if we elect to have children, the intricacies of our family relationships, and how we raise and educate our children are constitutionally protected. We have the freedom to make choices according to our individual conscience about matters which are essential to personal autonomy and basic human dignity. Along these lines, my father had the right to decline medical treatment – in fact, when his cancer returned, he was offered enrollment in a trial out of state but he declined. He made the decision to forgo additional treatment, an immensely personal decision, free from any government interference, knowing the result surely would be death. I'd ask you, what's the real distinction between a cancer patient declining additional cancer-directed therapies, which will result in death, and a cancer patient asking a physician to prescribe medications that he can take voluntarily that will result in death? We permit patients to make their own healthcare decisions throughout life. Patients should also be permitted to control the circumstances of their own death.

Another common opposition argument relates to an ensuing slippery slope if die with dignity legislation was permitted. The idea that if ND were to allow physician-assisted suicide, what prevents the killing of patients who actually want to live? Opponents talk about the potential

for abuse. Vulnerable populations, those lacking access to quality care and support, may be pushed into physician-assisted suicide. It might become a cost-containment strategy; burdened family and healthcare workers may encourage loved ones to opt for physician-assisted suicide. The notion that, if legalized, the right to die will be abused and that no legal safeguards can prevent that abuse. I'd have you consider that citing examples of abuse of a legal right is not sufficient to justify withholding that right. If merely the likelihood of abuse were thought to be grounds for withholding a right, then much more than physician-assisted suicide would have to be banned. Driving, for example, would have to be prohibited on the grounds that this right is abused and that none of the safeguards we have against such abuse are completely effective – people drive faster than the speed limit, they go through red lights, they drive while impaired but I think we'd agree that we accept the fact that abuse of this legal right occurs and we build proper regulation to deter such activity. There is no reason to withhold from some people a legal right merely because other people might abuse that right. Additionally, twenty plus years after passage of Oregon's Death with Dignity Act, there is no evidence of abuse of vulnerable populations. In fact, most patients who accept end of life prescriptions in Oregon are white, well-educated, on hospice and suffering from end stage cancer.

In summary, while protecting the lives of its citizens is within the government's interest, a person's fundamental right to decide how and when to end their life outweighs the government's interest because of America's respect for individual liberty and autonomy. And turning your back to this legislation and prolonging patient suffering because of a slippery slope concern and a potential for abuse has little merit and is not supported by decades of Die with Dignity data.

My father didn't fear the moment of death, I asked him. He feared the moments just before death – wondering would he suffer, would he be in pain, would he lose his ability to care for himself, speak, hear, interact, would we, his family, suffer? Please consider HB1415 so other North Dakotans, similar to my father, have the right to die with dignity.

Respectfully,

Meredith K. Wold, PA-C