

**2021 HOUSE HUMAN SERVICES**

**HB 1415**

# 2021 HOUSE STANDING COMMITTEE MINUTES

## Human Services Committee Pioneer Room, State Capitol

HB 1415  
2/1/2021

Relating to end-of-life health care decisions; and to provide a penalty
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**Chairman Weisz** opened the hearing at 10:08 a.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

### Discussion Topics:

- Medical diagnosis and prognosis
- Adult resident of the state
- Qualified patient
- Terminal disease

**Rep. Pamela Anderson, District 41 (10:09)** introduced the bill.

**Mark Schneider, Fargo (10:15)** testified in favor and submitted testimony #4574.

**Meredith Wold PA-C, Edina, MN (10:22)** testified in favor and submitted testimony #4425.

**Sen. Janne Myrdal, District 10 (10:33)** testified in opposition on behalf of North Dakota Life Caucus.

**Paula Moch, North Dakota Nurse Practitioner Association (10:39)** testified in opposition and submitted testimony #4404.

**Donna Thronson, North Dakota Medical Association (11:01)** testified on behalf of Courtney Koebele, Executive Director North Dakota Medical Association in opposition and submitted testimony #4348.

**Christopher Dodson, North Dakota Catholic Conference (11:05)** testified in opposition and submitted testimony #4463.

**Mark Jorritsma, Executive Director Family Policy Alliance of North Dakota (11:14)** testified in opposition and submitted testimony #4314.

**Sierra Heitkamp, Executive Director North Dakota Right to Life (11:24)** testified in opposition and submitted testimony #4575.

**Linda Thorson, Concerned Women for America of North Dakota (11:27)** testified in opposition and submitted testimony #4290.

**Additional written testimony:** #4310, #4327, #4328, #4329, #4330, #4375

**Chairman Weisz** adjourned at 11:33 a.m.

*Tamara Krause, Committee Clerk*

House Human Services Committee

Robin Weisz, Chairman

End of Life Health Care, HB 1415

**Testimony of Mark G. Schneider**

*February 1, 2021*

Chairman Weisz and Members of the Committee:

I am Mark Schneider from Fargo, and I am testifying in support of HB 1415.

I appear before you with the simple premise that: No one can speak to dying with dignity more credibly than someone who is dying. I am dying.

I have terminal urothelial cancer in my kidney that has spread to my back, liver and maybe lung. It was diagnosed in November 2019. Surgery would not have been helpful. I have had extensive unsuccessful chemotherapy and unsuccessful immunotherapy. I have had radiation for cancer on my spine.

On May 27 last year my oncologist at Mayo Clinic estimated that I would have a year to live. I am currently on a new chemo medication that is palliative only, but may extend a certain quality of life for an average additional 14 months. With that drug, I have experienced pernicious side effects like painful mouth sores and lip sores, and--all too obviously-- hair loss. This is not a complete list of my side effects, so I might not be able to continue the medicine, but I do enjoy a quality of life that was absent without that palliative drug.

In the past I have experienced sustained and severe levels of pain, 8-10 (on a scale of 10), despite being on both morphine and high levels of Fentanyl. I have also suffered from severe nausea. I chose to endure the pain and side effects because all alternatives for treatment were not exhausted at that time, and some quality of life was possible.

But the end game—which is inevitable—presents me and those like me with the prospects of unbearable pain and deterioration, and the certain loss of physical and mental function that will render me an empty shadow of my former self. “Quality of Life” then? Impossible. I suggest to you that this is an intolerable prospect and that everyone must be able to make an intelligent and informed decision on when to say, “enough is enough”.

Since I was a child selling newspapers and working in our neighborhood Mom and Pop grocery store, I have had responsibilities, earned money, taken care of myself and made mostly all of my decisions—for better or worse—on my own.



As an attorney for over 40 years, I have made important decisions for my legal practice, my family, my healthcare, indeed all aspects of life. I was paid handsome fees to make decisions with and for others who relied on that advice, often on matters of profound consequences to the lives of my clients and their families.

The point is, having made these decisions my entire life, should I-- or anyone else in my situation-- be denied the ultimate decision of deciding whether to end my life when any quality of life is hopeless and the future holds only misery and pain?

As simply as I can put it: Why should decisions about my condition, healthcare choices, and life be dictated by others not living my life?

I urge a do pass on HB 1415.

February 1<sup>st</sup>, 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 14<sup>th</sup> 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



Written testimony to:

67th Legislative Assembly  
House Human Service Committee

HB 1415

Chairman Representative R. Weisz and Committee Members

I am Paula Moch, FNP-BC, Legislative Liaison for the North Dakota Nurse Practitioner Association (NDNPA). I am submitting this written testimony on behalf of the NDNPA in opposition of HB 1415 as written.

The NDNPA opposes this bill, as written, due to the exclusion of the Advanced Practice Registered Nurse (APRN) in the verbiage of this bill. Since 2011, the APRN has had full practice authority in the state of North Dakota, including prescriptive authority. The APRN is a primary care provider or specialist care provider for many residents of North Dakota. By excluding the APRN in this bill, the patient's health care provider may be excluded from participating in this personal decision with their patient. This means the patient may have to search out an unknown health care provider to determine the appropriateness of this lvery personal life ending decision.

Starting with line 9 page 1 "attending physician", "means the the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal illness." This excludes the health care provider APRN who has the primary responsibility for the care of the patient. This may be the APRN primary care provider or specialist in Palliative Care, Hospice, Oncology, Cardiology, Pulmonology, Neurology and other specialities that has diagnosed and treated the patient with the terminal, end stage illness.

Section 23-06.7-01.3 uses the term physician. This eliminates the APRN health care provider from determining capability It is within the scope of practice of the APRN to determine an individuals capability to communicate a health care decision. Not only the capability but also the individuals capacity to understand the consequences of their decision. In line 13 page 1, the term health care provider is used This is defined in Section 23-06.7.8a of this bill, "as a person licensed, certified, or otherwise authorized by the state to administer health care or dispense medication in the ordinary course of business or practice of a profession", such as the APRN.

Line 16, page 1 physician should be changed to health care provider

Line 12 page 2 physician should be changed to health care provider.

Section 23-06.7-01.10 on 2 physicians confirm; not only should the term physician be changed to health care provider as defined by the NDCC and in this document 23-06.7-01.8a, but is also unrealistic. In a rural state like ND, there is rarely 1 physician in a rural community much less 2. This puts undue hardship on the patient who is seeking death with dignity under HB 1415 to travel and search out unknown/unfamiliar physician health care providers.

There are at least 24 other references to physician in HB 1415 that need to be changed to health care provider as defined in HB Bill 1415, section 23-06.7-01.8a, with authority of ND Administrative Code 54-03-03.1 and NDCC 43-12.1

This concludes the written testimony in opposition of HB 1415 as written on behalf of the NDNPA. I am happy to answer any questions.

Thank you for your time.

Paula M Moch BSN, MSN, FNP-BC  
NDNPA Legislative Liaison 2021  
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## **House Human Service Committee**

### **HB 1415**

**February 1, 2021**

Chairman Weisz and Committee Members, I'm Courtney Koebele and I serve as executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students.

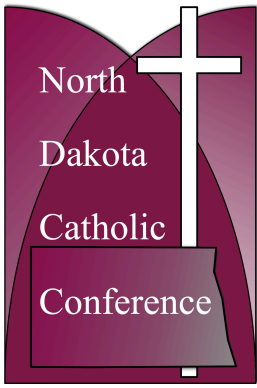
NDMA is opposed to HB 1415 and urges a DO NOT PASS.

In 2017, the NDMA House of Delegates adopted a resolution formally adopting the position against Physician-assisted suicide and euthanasia in that they are fundamentally incompatible with the physician's role as healer.

In adopting this position, NDMA determined that allowing physicians to engage in either would ultimately cause more harm than good, sending a message that suicide or euthanasia is a socially acceptable response to aging, terminal illness, disabilities, depression, and financial burdens.

Instead of engaging in either physician-assisted suicide or euthanasia, physicians must firmly respond to the needs of patients at the end of life while respecting patient autonomy. They must provide good communication, emotional support, adequate pain control, and appropriate comfort care while never abandoning the patient.

Thank you for the opportunity to testify today. I would be happy to answer any questions.



*Representing the Diocese of Fargo  
and the Diocese of Bismarck*

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**To:** House Human Services Committee  
**From:** Christopher Dodson, Executive Director  
**Subject:** House Bill 1415 - Physician-Assisted Suicide  
**Date:** February 1, 2021

The North Dakota Catholic Conference opposes House Bill 1415. HB 1415 legalizes physician-assisted suicide and makes the people of North Dakota complicit in the taking of innocent human life. It is contrary to building a culture of life. It is contrary to our commitment to the common good and the least among us. It is contrary to good public policy to prevent suicide.

"I have set before you life and death, the blessing and the curse. Choose life, then, that you and your descendants may live." (Dt. 30:19). This invitation from Moses is not just a call to choose life at an individual level. It is the basis for building a culture of life, one where all of society, including our laws and practices, affirm life and reject anything that intentionally kills an innocent person before natural death.

HB 1415 legalizes assisting a suicide. Euphemisms and legalese cannot hide what the bill actually does. The act of taking the prescribed medication under HB 1415 is an act of suicide. Assisting in the provision of that medication is assisting a suicide.<sup>1</sup> The reason assisting a suicide is a crime in North Dakota is because of our commitment to the principle that every human life matters. HB 1415 embraces the culture of death rather than the culture of life.

HB 1415 is contrary to our commitment to the common good and the least among us. In fact, it abandons a subset of our population. If enacted, the state of North Dakota would essentially be saying that it will protect everyone's life — but not those facing a terminal illness. HB 1415 says that those lives are not worthy of protection. Once we abandon them and say not only that it is okay for them to take their own lives but that, with the state's approval, those who assist them can do so with impunity, what incentive is there for the state and society to put resources into hospice, palliative care, pain management, and mental health services?

Proponents will argue that HB 1415 does not abandon North Dakotans, but provides compassion in their suffering. HB 1415, however, does not require the person receiving assistance to take their life be in pain or have any type of suffering.<sup>2</sup> Despite the appearance of "safeguards" and "restrictions" the only real criterion for qualifying for assisted suicide under HB 1415 is that person have a disease that "within reasonable medical judgment, will produce death within six months." In other words, be dying.

All of us, however, are dying. Our lives are no less worthy because we may die six months from now, seven months from now, or seventy years from now. Nor are our lives deserving of less respect because we might have a diagnosed terminal illness. HB 1415 abandons that subset of our population for no other reason than they are possibly dying within six months.

Once we abandon that subset of our population, what segment of our population would be next? Those with Alzheimer's or dementia? Those with intellectual disabilities? What about those who have intractable pain? The list could go on. Whether we look at it from the perspective of rights or protection, there is no logical reason to limit assisted suicide to one particular group.

Finally, HB 1415 is contrary to the state's public policy against suicide and undermines our efforts to prevent suicide in our state. Suicide is the first leading cause of death for North Dakotans of ages 10-24 and the second leading cause of death for ages 25 - 34. On average, one person dies by suicide every 60 hours in the state.<sup>3</sup> We cannot in good faith say that North Dakota wants to prevent suicide while permitting one segment of the population to commit suicide with physician assistance. It is illogical and counterproductive.<sup>4</sup>

The people of North Dakota deserve better than House Bill 1415. It embraces a culture of death, rather than life. It violates our commitment to the common good. It contravenes our state's efforts to prevent suicide. It has no place in North Dakota law or policy.

We urge a **Do Not Pass** recommendation.

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<sup>1</sup> N.D.C.C. sec. 12.1-16-04.

<sup>2</sup> The absence of any requirement that the individual be suffering from any pain is just one of the many flaws in the bill. Others include:

- No requirement for a mental health assessment. Even if a mental health assessment occurs, the existence of a psychological or psychiatric disorder or depression is not itself a bar to receiving assisted suicide. Only if, in the opinion of the psychologist or psychiatrist, those conditions lead to "impaired judgment" would it be a bar to receiving the medication. However, since there is no requirement that the attending physician refer the patient for a mental health consultation, that restriction could be bypassed.
- No requirement for family notification;
- No requirement that someone be present and witness the taking of the drug;
- No requirement that a health care professional be present at the taking of the drug;
- No requirement that the suicide not occur in a public place, such as a school, public park, or mall;
- Limited and cumbersome conscience protection provisions; and
- Possible requirement for insurance coverage for assisted suicide.

<sup>3</sup> Statistics compiled by the American Foundation for Suicide Prevention based on Center for Disease Control data. <https://aws-fetch.s3.amazonaws.com/state-fact-sheets/2020/2020-state-fact-sheets-north-dakota.pdf>

<sup>4</sup> In fact, research indicates that legalization of physician-assisted suicide leads to an increased inclination to suicide in others; Jones DA, Paton D. *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?* South Med J. 2015 Oct;108(10). <https://pubmed.ncbi.nlm.nih.gov/26437189/>





## Testimony in Opposition to House Bill 1415

Mark Jorritsma, Executive Director  
Family Policy Alliance of North Dakota  
February 1, 2021

Good morning Chairman Weisz and members of the House Human Services Committee. My name is Mark Jorritsma and I am the Executive Director of Family Policy Alliance of North Dakota. I am testifying in opposition to House Bill 1415 and respectfully request that you render a "DO NOT PASS" on this bill.

### Every life is worth fighting for

Family Policy Alliance of North Dakota firmly believes that every person is valued and worth fighting for, because every person is made and loved by God. None of us knows the moment we will die, but we are all worthy of love, respect and compassion every moment we live. I can guarantee no one will regret spending more time with those they love, walking with them during some of their most difficult days for the sake of every moment together. We all wish we had more time, but the best thing we can do with the time given to us is spend it in service and love to those our lives touch. We are each part of a story that's worth reading till the end.

### We have the responsibility and moral duty to pursue every option to fight for our sickest patients and their families

Let's stop wasting time talking about the right moment to die when we could be helping people find the right way to live every moment they have. I would much rather give a person with a terminal disease access to a drug that may help them than a drug that will end their life. An experimental new drug may not work, but if the child with the terminal illness was yours, wouldn't you want your doctor to help give your child the chance, rather than help get them access to a drug that will definitely kill them?

Health care options, like palliative care, have been shown to reduce hospitalizations, improve length of life, quality of life, family wellbeing, stress, and all the while decreasing costs in healthcare. Why would we not work to strengthen the quality and availability of services like palliative care to our sickest populations before considering abandoning them to assisted suicide?

### Human dignity is part of our DNA, not something defined by our abilities, limitations, or circumstances

It is wrong to measure human dignity by someone's physical or mental capacity, income, or other status. The moment we label suicide an act of dignity, we've implied that people with terminal illnesses or disabilities are undignified for not ending their lives. Is it "undignified" to fight for your life?

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UNLEASHING CITIZENSHIP

[FamilyPolicyAlliance.com/NorthDakota](http://FamilyPolicyAlliance.com/NorthDakota)

Dignity and honor are certainly exhibited by those who fight for their lives bravely until the natural end, for as many moments as possible with those they love. True compassion means walking with a loved one through the last days of their life. That affirms our dignity, rather than denies it.

Making decisions about someone's life or death based on money also doesn't dignify them, it commodifies them. Assisted suicide permits government and insurance companies to decide whose life has "dignity" and is worth living. Assisted suicide can force decisions to be made based on money rather than true care.

### **Suicide is not the prescription for pain relief**

Physicians don't need to assist with suicide to adequately manage pain. Medicines and advanced techniques for pain management are available to relieve pain and allow our loved ones to live every moment. Every person has the right to refuse any treatment and instead receive full palliative care, including pain-relieving medication. Many people suffer from intense emotional or physical pain every day, and we work tirelessly to get them the relief they need. Suicide is never offered as an option for pain relief, and a terminal illness shouldn't change that.

### **Afraid of being a "burden" to one's family is never a reason for assisted suicide**

Studies show that requests for assisted suicide increase when a family member believes they are a burden to their family and others. Family is a commitment to care no matter what—and for family, every moment matters. Loved ones have reported amazing conversations and deeper relationships with their dying loved ones that never would have happened had they ended their lives prematurely. The fullest expression of human caring and love is not abandoning someone to death, but walking with them through the end of life. Family is our safe harbor of love, security, and compassion.

### **Assisted Suicide Experiences**

So what have the experiences been with assisted suicide laws in other places? In the Netherlands, where it has been legal for quite a while, assisted suicide continues to expand. They now prescribe it for psychiatric patients and deformed babies. In Norway, where assisted suicide has been legal since 2002, the law has already been expanded to include those with treatable mental illnesses. Closer to home, Oregon reports already confirm insurance companies refusing to pay for treatment, but offering to pay for assisted suicide drugs. I won't belabor these examples, but the takeaway is that the allowable reasons for assisted suicide expand once the foot is in the door with a bill like this.

### This bill is deeply flawed

- No Liability: Assisted suicide bills, such as this one, are written to ensure doctors can help you kill yourself without legal repercussions. This bill is focused on protecting doctors, not patients. Further, requiring two doctors to sign off on the lethal prescription is a recipe for doctor-shopping, not a “safeguard.” The prescribing doctor simply seeks out a second opinion from a doctor who will sign off on it. The proponents of assisted suicide will often also “helpfully” provide a list of doctors who will support assisted suicide and sign off as a second opinion.
- Discretionary Counseling: Referring the patient for counseling is only necessary “as appropriate”. The bill essentially is asking the attending physician to diagnose a patient’s psychological and emotional state associated with the most important decision of their life, while not being a specialist in mental health issues such as a psychiatrist or psychologist.
- Family Exclusion: A patient who declines or is unable to notify their next of kin may not have their request for medication denied for that reason. In other words, a patient can hide the entire assisted suicide process from their family and have their family only find out after they are dead.

### Closing Thoughts

We all probably know one or more people who have passed away due to some sort of terminal illness.

My mother was diagnosed with Alzheimer’s in 1994. It was a difficult revelation, but our family was there to support her. More importantly, her husband of 50+ years, my father, was there for her.

Most Alzheimer patients live for 4-8 years. My mother lived her last 8 years in a nursing home, after already having lived 7 years at home, for a total of 15 years after being diagnosed with Alzheimer’s. That meant 15 years of time with her family. So much for predicting how long someone with a terminal illness will live!

Obviously, most of the latter years were difficult and she was not in a mentally clear state of mind many times. Nevertheless, she had moments of lucidity where the “old mom” was back. At these times, she knew who we were, laughed with us, and told stories to her children and grandchildren about her life – some stories we had never heard before and that rounded out our view of who she was as a person.

While these occurrences were a blessing, here is the more important part of the story. During those eight years in the nursing home, my father visited my mom every single day. No matter what, whether she recognized him or not, whether he was tired that day or not, he was always there.

Those visits showed something I will never forget – the true meaning of unconditional love. If my mother had committed suicide, that lesson would never been taught. Instead, it has changed me forever, and profoundly altered my view of life and relationships for the better.

Those are precisely the reasons we need to let our fellow North Dakotans live out their lives to their natural end. We do not stop influencing the world around us when we face death. It can be precisely in those moments that we often influence the world and those around us the most. Let's not take that away.

I respectfully ask for you to vote a "DO NOT PASS" on HB1415 for all these reasons. Please affirm to your fellow North Dakotans that we value life in all its forms.

I would now be happy to stand for any questions.

Chairman Weiz and members of the House Human Services Committee,

My name is Sierra Heitkamp, Executive Director of North Dakota Right to Life. At North Dakota Right to Life, we have been dedicated to defending life from conception to natural death for over 50 years. With over 2,000 members, our statewide organization focuses on change through legislation and educational programming. As the oldest, pro-life organization in the state, we believe it is our duty to stand up for life at all stages. Even though there are many sections of this bill that raise concerns to our members, I wanted to take this opportunity to outline two major arguments against this legislation.

First, there is no requirement in this bill that the patient requesting this action must be suffering from any sort of pain. Out of the top five reasons to have a physician assisted-suicide, pain is ranked as the lowest reasoning with the other four being: the loss of autonomy, the inability to engage in physical activity, loss of dignity, and burden to family. With modern advances in science, I believe we should be looking for treatment options to address any sort of physical pain a patient may be experiencing. As a society, we should be able to find ways to help these patients find hope and healing in their final days, instead of having their feeling of guilt make a life-ending decision.

A second concern is that this bill does not require a mental health assessment after a patient's formal request. On page 4 line 17 & 18, there is an option for the doctor involved in a case to decide on recommending an evaluation. Based on a study performed from 1998 to 2007 on patients who requested physician-assisted suicide the percentage of patients who received psychiatric examinations before being given lethal injections dropped from a mere 31% to 0%. Currently, the language of this bill does not provide patients with guaranteed counsel during times of intense emotional and physical distress.

Any country or state that legalizes physician-assisted suicide has ultimately failed the emotional and physical needs of its citizens. If we are concerned for this vulnerable population, shouldn't we be looking further into finding viable solutions for easing these patient's suffering? I am asking you all today to defend the sanctity of life and move forward with a **do not pass recommendation on this bill** to show the state of North Dakota and the rest of our country that we respect the dignity of human life.

I will now stand for any questions.

Sierra Heitkamp – Executive Director  
North Dakota Right to Life

<https://alexschadenberg.blogspot.com/2020/06/five-reasons-to-oppose-euthanasia-and.html>

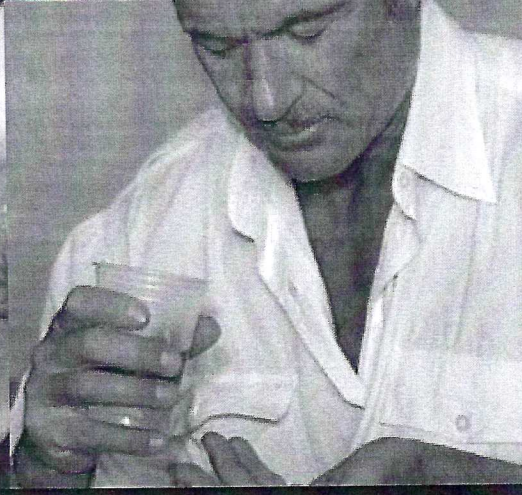
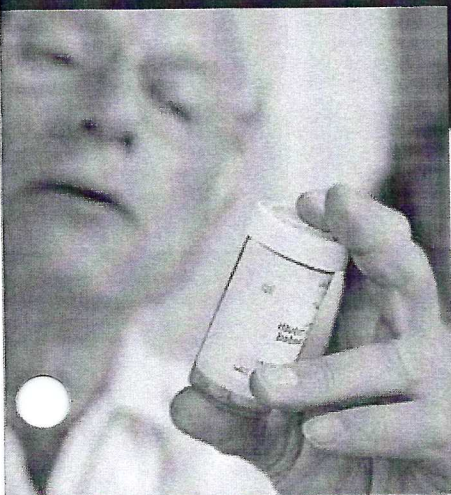
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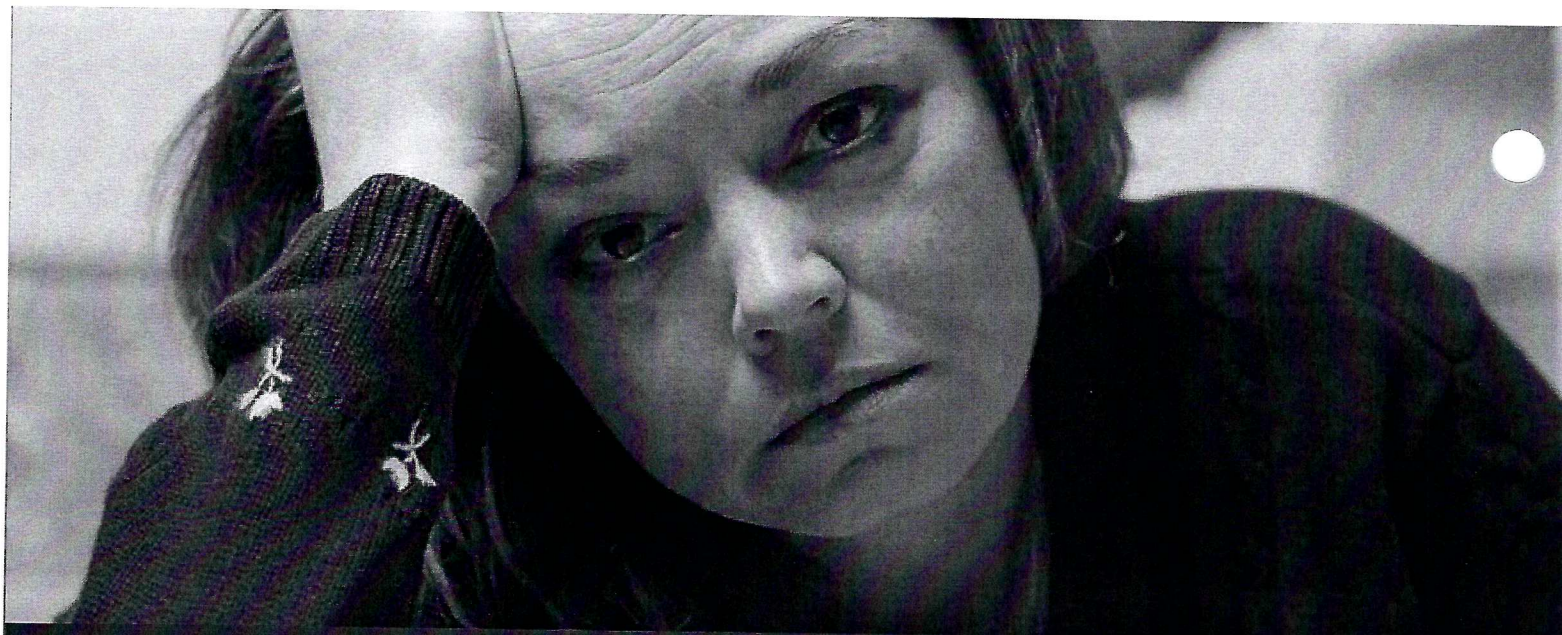


# Oregon's Assisted Suicide Law

**Safeguards Don't Work**







# What is Physician-Assisted Suicide?

Physician-assisted suicide involves a physician prescribing lethal drugs for a patient with the knowledge that the patient intends to use the drugs to commit suicide. Refusing a ventilator, or some other life sustaining machine or treatment is not assisted suicide and is legal. The intent of refusing medical treatment is not to end life, but to allow nature to take its course. With physician-assisted suicide the intent is to kill the patient.

***Once assisted suicide is legalized, it becomes impossible to contain. Once assisted suicide is legalized, it becomes impossible to protect the vulnerable and mentally ill. Once assisted suicide is legalized, it becomes, essentially, death on demand.***



## Facts Vs. Fiction.... Oregon's Failed Experiment



### The myth of "intractable pain"

Supporters of assisted suicide have long maintained that assisted suicide is necessary for those suffering from intractable pain; however, to date, there still is no documented case of assisted suicide being needed for untreatable pain. In fact, **in the list of reasons patients choose to use assisted suicide, pain, or fear of pain, is the least used reason!** Dr. Linda Ganzini, professor of psychiatry at Oregon Health & Science University,

surveyed family members of Oregon patients who requested assisted suicide. Her published report emphasizes this truth: "No physical symptoms experienced at the time of the request were rated higher than 2 on a 1 to 5 scale. In most cases, future concerns about physical symptoms were rated as more important than physical symptoms present at the time of the request." The study found that many physicians

are surprised at the lack of suffering experienced by a patient who is requesting assisted suicide.

### The myth of "rational" suicide

National studies show that among patients requesting assisted suicide, depression is the only factor that significantly predicts the request for death. An estimated 90% of suicides in the U.S. are associated with mental illness, most commonly depression. Diagnosing depression can be challenging, but is often found with

good psychiatric care. In spite of these facts, in Oregon's 10th year, not even one suicide victim received psychiatric counseling.

### Needless suicides by abandoned patients

Ganzini's study also confirmed what has been seen in publicized cases of physician assisted suicide: instead of patients having their fears and concerns addressed by physicians, once the request for assisted suicide is made, other care options are abandoned. The majority of physicians

### Reasons Assisted Suicide Victims Expressed Before Ending Their Lives. (Some Victims Had More Than One Reason)

Reasons for Victims:	Number of Victims for Each Reason					
	50	100	150	200	250	300
300 Losing Autonomy						
292 Decreasing Participation in Activities						
196 Losing Control of Bodily Functions						
171 Loss of Dignity						
132 Burden on Family and Friends						
92 Fear of Inadequate Pain Control						

Compared from 1998 to 2007. Total Number of Patients Over 9 Years = 341

## History of Physician Assisted Suicide in America

On November 8, 1994, Oregon became the first government in the world to legalize physician-assisted suicide when voters passed a statewide ballot measure. After a lengthy court battle and the failure of a 1997 ballot measure to repeal the law, Oregon's assisted suicide law became functional in November, 1997. That year Oregon became the first jurisdiction in the world to begin experimenting with legalized assisted suicide.

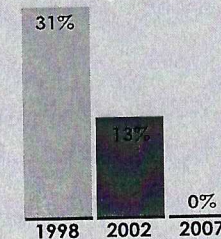


Since the passage of Oregon's physician-assisted suicide law, many states have attempted to pass similar laws. Maine and Michigan voters rejected statewide ballot measures to legalize assisted suicide in their states. Legislators in Hawaii, Vermont, California, and other states, have rejected bills to legalize assisted suicide. Courts in Florida and Alaska turned back lawsuits from patients demanding they be given a right to physician-assisted suicide.



In the 1997 Supreme Court case, *Washington v. Glucksberg*, physician-assisted suicide was rejected as a constitutional right when the Court upheld both the New York and Washington statutes prohibiting assisted suicide by a 9-0 vote. Physician-assisted suicide is not a right protected by the U.S. Constitution.

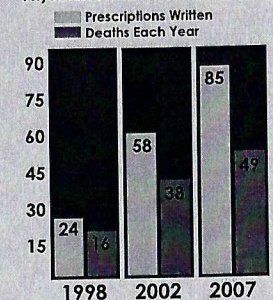
### Percentage of Patients



This chart follows the percentage of patients who receive psychiatric examinations before being given lethal drugs.

**"The study found that many physicians are surprised at the lack of suffering experienced by a patient who is requesting assisted suicide."**

### Physician-Assisted Suicide in Oregon





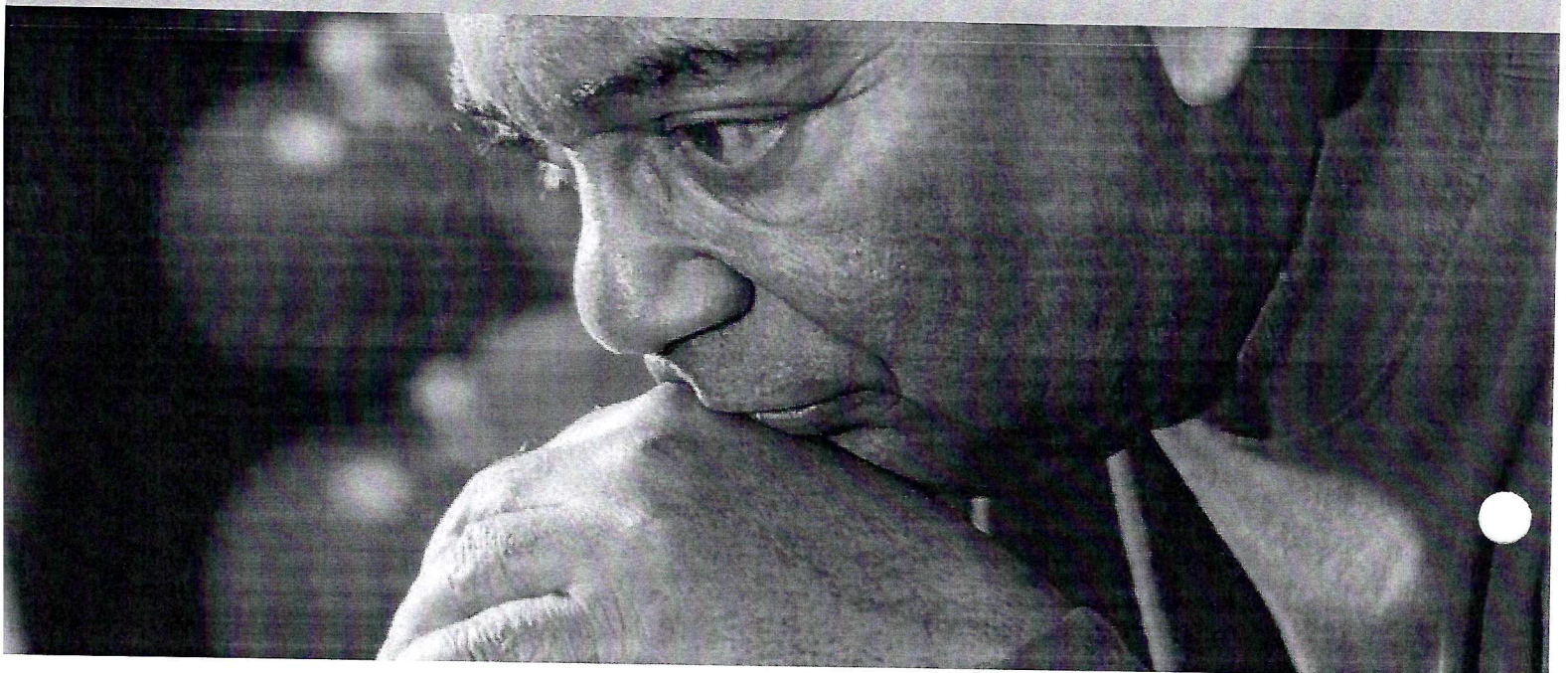
# Safeguards Don't Work...

## Facts You Need to Know

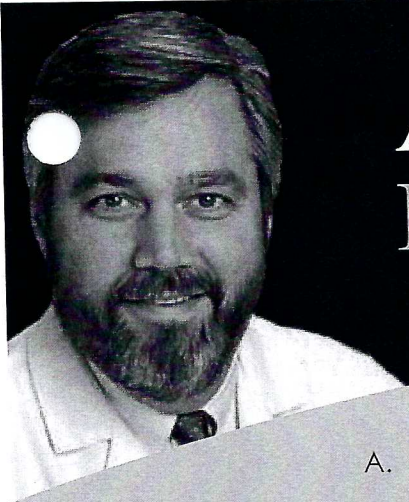
The main concern about physician-assisted suicide is the inability to create safeguards or contain assisted suicide to any boundaries. Since legalizing assisted suicide, Oregonians have seen first-hand what really happens. When physician-assisted suicide is legalized, Oregonians have found out that safeguards don't work.

A shroud of secrecy encompasses the reporting process of assisted suicide. The Oregon Department of Health's annual report publishes raw statistics and no inquiry is held to verify even the most rudimentary of figures. No oversight exists to insure patients are safeguarded from negligence or abuses of the law. However publicized assisted suicide cases have proven:

- "Doctor shopping" is common. A network of assisted suicide proponents insure that patients will receive assisted suicide, even when their family doctor knows their desire for death could be alleviated.<sup>4</sup>
- Familial pressure is applied on patients to commit assisted suicide.<sup>5</sup>
- Patients suffering from depression and dementia are receiving physician-assisted suicide.<sup>6</sup>
- Once receiving a drug overdose prescription from a pro-assisted suicide doctor, patients no longer receive concerned medical care, but instead are abandoned to die.<sup>7</sup>
- While some pain-relieving and life-saving medications are not paid for by Oregon's Health Plan, assisted suicide is. In rejecting payment for these medications, the Health Department informs patients about the availability of assisted suicide.<sup>8</sup>







# A conversation with Dr. Charles Bentz...

## **A. What did you think about assisted suicide when Oregon's law was first passed?**

A. I voted against physician assisted suicide and I was very surprised when the law passed in 1994 (Measure 16). I could not believe that people would allow doctors to intentionally cause death by giving out lethal medications.

## **A. What was your initial response to this law?**

A. I worked in the campaign to repeal the law (Measure 51) but when this failed, my next response was to work on educating doctors and other health care providers about improving end-of-life care, and I was the program chair of the first statewide conference for physicians on improving end of life care in 1997.

## **A. Have you continued to oppose the law?**

A. Absolutely. Today I am very opposed to the law, and am, in fact, the President of Physicians for Compassionate Care, which represents hundreds of Oregon physicians who are opposed to assisted suicide. We believe in the original Hippocratic Oath, which first says a physician should "do no harm" to his patient.....and specifically that we will not write lethal prescriptions or counsel others to do so.

## **A. Why are you so opposed to this law?**

A. Let me tell you about a patient of mine. I was the primary care physician for an elderly gentleman, in whom I unfortunately made a diagnosis of cancer (melanoma) and referred him to an oncologist. He eventually asked this oncologist to give him physician-assisted suicide, and this physician called and asked me to provide the "second opinion" (as required by Oregon's assisted suicide law).

I told my colleague that I objected and that I would not participate. My concerns were ignored and two weeks later my patient was dead from an overdose of barbiturates prescribed by this medical oncologist. I later found out that a different physician had recently documented that my patient was depressed. Upon learning this, I wondered what else could have been done. If his oncologist had addressed his suicidal ideation, or if I had intervened, things might have turned out differently.

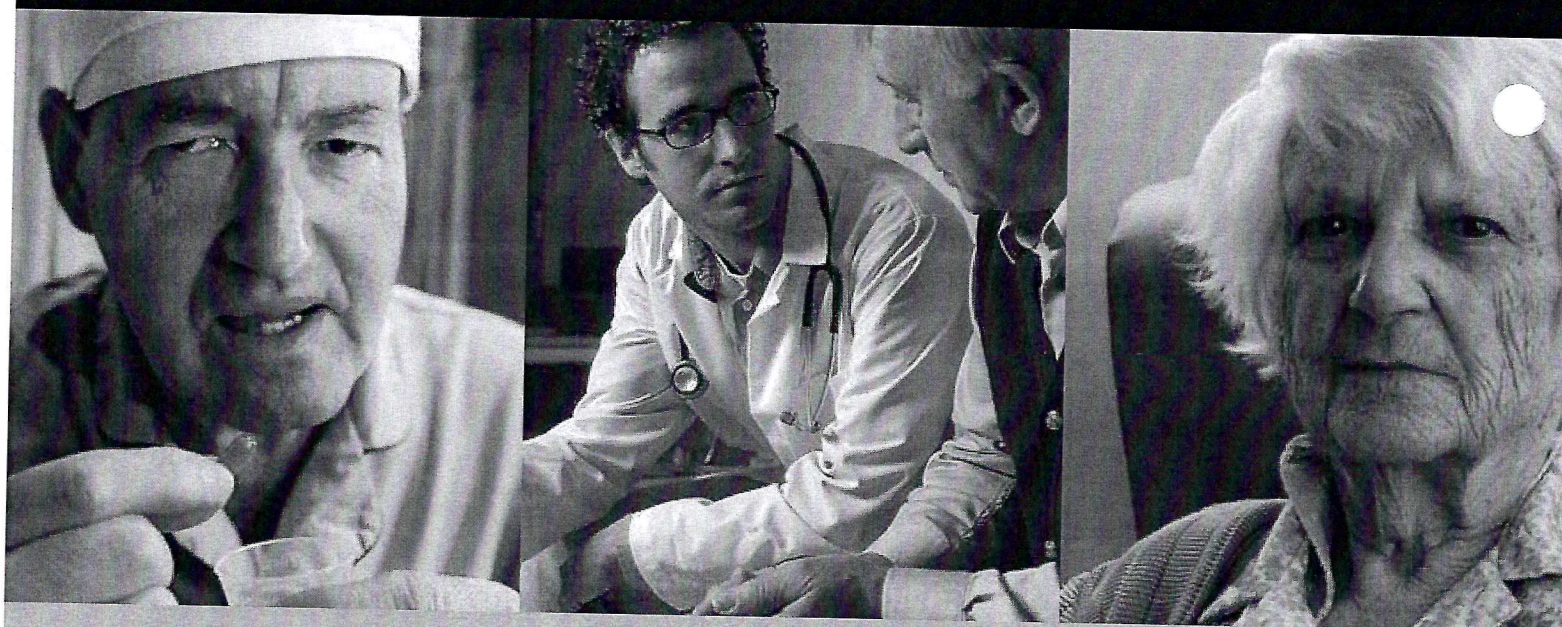
Instead of helping my patient, this once-trusted colleague decided he was "better off dead" and became an accomplice in his suicide. This is the real tragedy of assisted suicide in Oregon. Instead of doing the right thing, which is to provide excellent care, my patient's life was cut short by a physician who did not address the issues underlying his suicidality. Many who are opposed to assisted suicide, are on the sidelines, as I was in this case.

This is a change in the direction of our profession, which has followed the principle of "Do No Harm" for over 2400 years. I have decided to work against this insidious practice and I am joined by many others.

### **Charles J. Bentz MD, FACP**

*Clinical Associate Professor of Medicine  
Department of General Internal Medicine and Geriatrics  
Oregon Health & Sciences University, Portland, Oregon*





***“Those promoting assisted suicide promised Oregon voters that it would be used only for extreme pain and suffering. Yet there has been no documented case of assisted suicide being used for untreatable pain. Instead, patients are being given lethal overdoses because of psychological and social concerns, especially fears that they may no longer be valued as people or may be a burden to their families.”***

***—Dr. Greg Hamilton, Portland psychiatrist.***

<sup>1</sup> Ganzini et al: Journal of General Internal Medicine (J Gen Intern Med) 2008 Feb; 23(2):154-7

<sup>2</sup> Institute of Medicine. Reducing Suicide: A National Imperative. Washington, DC: National Academies Press 2002:99

<sup>3</sup> Tenth Annual Report on Oregon's Death with Dignity Act, Oregon Department of Human Services, Office of Disease Prevention and Epidemiology, April 2008.

<sup>4</sup> Erin Hoover Barnett, "Is Mom Capable of Choosing to Die?" The Oregonian, October 17, 1999, G2.

<sup>5</sup> Ibid.

<sup>6</sup> Erin Hoover and Gail Kinsey Hill, Two Die Using Suicide Law, The Oregonian, March 26, 1998, A1.

<sup>7</sup> American Journal of Psychiatry, volume 162, June 2005 Competing Paradigms of Response to Assisted Suicide Requests in Oregon.

<sup>8</sup> Eugene Register Guard, June 11, 2008 "A Gift of Treatment".

For further information visit  
[www.nightingalealliance.org](http://www.nightingalealliance.org)  
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CONCERNED  
**WOMEN** *for* **AMERICA**  
 LEGISLATIVE ACTION COMMITTEE

February 1, 2021  
 House Human Services Committee  
 Testimony in Opposition to HB1415

Chairman Robin Weisz and members of the Committee, my name is Linda Thorson, and I am the State Director for Concerned Women for America (CWA) of North Dakota. We are the state's largest public policy women's organization and our country's largest public policy women's organization with hundreds of thousands of members. I am here today on behalf of our North Dakota members in opposition to HB 1415, relating to physician-assisted suicide.

Concerned Women for America has established the sanctity of life as one of its seven core issues on which we focus our efforts. CWA supports the protection of all human life from conception until natural death.

Physician-assisted suicide devalues human life. There is no "death with dignity" when a person is helped to end their own life; suicide is still suicide, no matter how you spin it. God, and God alone, is the author of life. We must not take on the role of God and take life based upon our inconsistent judgment.

Here are just some of the many concerns we have about [physician-assisted suicide](#):

- It is not possible to have sufficient safeguards against coercion and elder abuse. At least one in [ten older adults](#) is the victim of domestic abuse, which is difficult for a healthcare provider to identify. Because any doctor can write a lethal prescription, an abuser can "doctor shop" until they find a provider willing to assist them in killing their victim.
- Oregon, the first state to legalize assisted suicide, provides the most complete data available on the practice of assisted suicide in the United States. [Oregon reports](#) that individuals primarily choose assisted suicide because of reasons related to a disability: loss of autonomy, loss of enjoyable life activities, and loss of dignity.
- Modern medicine has made significant advances in pain control. Doctors now have a range of options to treat pain in terminally ill patients, including even palliative sedation as a last resort.
- [Oregon reports](#) that the dominant reasons motivating patients to choose assisted suicide have nothing to do with pain management. The primary concerns center around having a disability: losing autonomy (92%), being less able to engage in activities making life enjoyable (90%), and losing dignity (79%). Fear of inadequate pain control is one of the patients' least cited reasons.
- A physician will also have to play the role of God to conclusively determine the timeline of a person's life, regardless of how conclusive a diagnosis may seem at any given time.
- Physician's assisted suicide preempts the possibility of a favorable change in the patient's health. It also might be so premature that we can erroneously make a permanent decision based on a temporary health situation.

- There is no guarantee in this bill that the adult resident, as defined, would not give this same medicine to someone else, whether that other person was even aware that they had been given this medicine. In other words, there is no guarantee that the original adult who obtained the prescription would not somehow decide to encourage or force someone else, even a child, to consume this medicine.
- A patient who declines or is unable to notify their next of kin may not have their request for medication denied for that reason. (23-06.7.07)

Victoria Reggie Kennedy, the widow of Democratic Sen. Edward Kennedy, “Physician assisted suicide is not about bringing family together to make end-of-life decisions; it’s intended to exclude family members from the actual decision-making process.”

Sen. Kennedy spent a great deal of his career focusing on health care policy. His wife Victoria spoke out powerfully against patient suicide after his death. She remarked that she did not wish to preach or judge others in their decisions but wanted all to know the facts.

Assisted suicide devalues life, diminishes care, and disincentives research. We must stand against it in our state.

God has given us the gift of life; He is the only one who can take it away. We cannot take on the role of God and take life based on our inconsistent judgment.

We urge your “Do Not Pass” vote on HB 1415. Your consideration of this request is appreciated.

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February 1, 2021  
House Human Services Committee  
Testimony in Opposition to HB1415

Chairman Robin Weisz and members of the Committee, I am submitting my testimony today as a concerned citizen, a caregiver and someone who has cared for loved ones with long-term, difficult conditions. Today I am sharing in opposition to HB 1415 relating to medical/physician assisted suicide.

As a former professional caregiver, I have had the duty and the privilege of caring for people with different abilities (physically, mentally as well as socially “disabled”). Some could not walk or talk, some could not feed themselves or handle personal care of any kind. Some of my patients were born with these limitations, some had injuries or illnesses that lead to them. The one thing that made them the same as everyone else, was their humanity. Their right to have human dignity and compassion. Their loved ones may have been given grim possibilities for their long-term outcomes, but in truth, their existence brought much joy to those who knew them. Even as their days seemed impossible and challenging, their life had meaning and value. To walk with them and their family to the process of their end of life transition, was something I regard as one of the most meaningful responsibilities I have ever had.

More importantly, I speak in opposition to HB 1415 as someone who tended to my loved ones who had life changing diagnoses, that ultimately lead to their deaths. My hope is the experiences I share will help you to see the importance of support from loved ones (which this bill does not require) and the fact that assisted suicide is still a devastating force, as any suicide or homicide is, to a family.

When I consider that this bill is directed to people given 6 months or less to live, it terrifies me. My grandmother, who was also my legal guardian and raised me during her “golden years” was given a lung cancer diagnosis, with the prognosis of 6-12 months to live. She was an educated woman, a retired Registered Nurse, not a deeply religious person and she valued her life. She attempted aggressive measures to end the cancer, however they did not work. But what did happen was she lived somewhat comfortably and happily for almost 36 months. She witnessed the births of two great grandchildren and was able to attend the wedding of two other grandsons. She had pain and problems, but she had purpose. Even in her limitations she had value. She suffered, but she knew her life was more than just her cancer. Our family helped care for her until the very last breath. Those last breaths were hard, very scary and difficult to watch, but we wouldn’t trade them for a moment, and neither would she, because each moment with her was precious. She died with dignity.

Another example was my grandfather, also my legal guardian (and husband and former caregiver to my grandma mentioned above). He was a retired evolutionary biologist, university professor and author of numerous college textbooks. Not only did he help raise me and my brothers, when our parents were absent, he also helped modernized a rural, all-risk volunteer/reserve fire department (when he was in his 70’s). He walked 6-8 miles per day and was a modern day “superman”. Until 2014, when his previous problems with “Mild Cognitive Impairment” transitioned into the “A” word (Alzheimer’s). A man who lectured in front of 200

hundred students now had to be reminded to take his dentures out of his mouth to clean them (even though he argued they were his real teeth). He needed to be prompted to eat, when to sleep and where it was appropriate to go to the bathroom. Many would say, that is not a life worth living. He could have made the argument that he wanted to die with dignity and choose when and how to end his alleged suffering. But he knew that was not his decision to make. His experience as a biologist and later as an EMT/Firefighter engrained deep in his brain, that all life had a purpose. He knew suicide was not going to take away the pain we all were experiencing with his changes. There were days he even questioned that he truly had Alzheimer's (even though the scans, tests and behaviors were conclusive). He had a contagious laugh, he loved to talk about his childhood on Long Island and his time in the Navy during the Korean War.

Towards the end of 2019, we were told that he would probably die from aspiration pneumonia within the year. As we watched him struggle with a few bouts of pneumonia, we knew that was going to be his reality. On April 11, 2020, amid global chaos because of COVID-19, I began the death-watch of my real-life superhero. It was awful, it was painful, it made me cry. He slept through most of it and as his breathing got more labored, his loved ones took turns whispering words of love and admiration into his ear. Friends from all over the country called to say a few last words, even though he could not respond, just to have the opportunity to share how much they appreciated his time on earth with them. As the clock ticked, and during his last repositioning, his eyes opened wide, he looked into my face. I held his cheeks and told him it was ok, he was safe, he was loved. He seemed a little scared, a little apprehensive, but he also knew he was not alone. He knew his time to die had come, and it was a natural process. He died with dignity.

Even more recently, I had a vastly different experience. In early December of 2020, I received a text message from my aunt, she was 62 years old, and was in the end stages of COPD. She had been struggling for about a year with the process of her lungs failing. She had been a bitter woman, who lived a challenging life. She lived in a state that has already legalized medical/physician assisted suicide. Her text read, "I have decided to exercise my right to die with dignity, if you would like to talk to me, you are welcome to call." How do I, respond to that kind of message? As, a person who values life, who sees all people as important and deserving of dignity, this concept of her committing suicide, and at the hands of her doctors and loved ones, was so tormenting. I let her know how valued her life was, and that every moment on earth has meaning, and not shortchange herself or her loved ones those precious days of life she had left. Later that night, she chose to commit suicide with the help of her children and husband. She used medication prescribed to her by a medical doctor who went to medical school with the express purpose to learn to help heal, offer comfort and ultimately save lives. Within hours after her death, her family was devastated. They questioned if it was the right time. They did not feel the peace and release they expected. Not only did they feel grief that is typical of any loss of a loved one, but they also felt fear and regret and confusion. This was not what was supposed to happen. Where is the dignity here?

When a person is faced with life altering news, they are in turmoil. They need support, they need care, they need to trust that they have value and their life, whatever the condition, will be protected and honored.

Suicide is defined as self-injurious, with the intent to take one's life. Dignity is defined as the quality or state of being worthy, honored, or esteemed. How can we, as conscionable people favorably use the word suicide in the same sentence as the word dignity?

Please vote, "Do not pass" on HB1415, it denies both the protection and dignity our fellow citizens deserve.

**Written Testimony of Salesha Olson  
in OPPOSITION of HB 1415 relating to end-of-life healthcare  
January 30, 2021**

As a bible-believing North Dakotan (born and raised), I strongly oppose HB 1415. The farther through this bill I read, the more my stomach began to churn. Calling this bill "end-of-life healthcare" might make it seem more acceptable to help a person commit suicide, however, it is still suicide. This isn't a healthcare bill, it is an elderly suicide bill.

I try to be understanding of those who are to the point in life where they're struggling to care for themselves, losing their cognitive abilities, and feeling ill or in pain constantly. I sympathize with them and I am the granddaughter of some who are struggling now. However, at no juncture in life is it acceptable for us to decide to play "god" and help a person end their life.

The potential for manipulation and misuse of the "acceptable practices" in this bill is enormous. We can do better than this for our terminally ill family members.

I am asking you to recommend a DO NOT PASS on HB 1415.

A handwritten signature in cursive script that reads "Salesha Olson".

Salesha Olson  
Larimore, ND



# Euthanasia and Physician-Assisted Suicide in Patients With Multiple Geriatric Syndromes

Vera van den Berg, MA; Ghislaine van Thiel, PhD; Margot Zomers, MSc; Iris Hartog, MA; Carlo Leget, PhD; Alfred Sachs, MD, PhD; Cuno Uiterwaal, MD, PhD; Els van Wijngaarden, PhD

**IMPORTANCE** The Dutch Regional Euthanasia Review Committees (RTEs) reviewed and reported an increasing number of cases of euthanasia and physician-assisted suicide (EAS) requested by older people with multiple geriatric syndromes (MGS). Knowledge of the characteristics of cases of EAS for MGS is important to facilitate societal debate and to monitor EAS practice.

**OBJECTIVE** To examine the accumulation of patient characteristics, geriatric syndromes, and other circumstances as reported in the case summaries of the RTEs that led to unbearable suffering associated with a request for EAS and to analyze the RTEs' assessments of these cases of EAS.

**DESIGN, SETTING, AND PARTICIPANTS** A qualitative content analysis was conducted of all case summaries filed from January 1, 2013, to December 31, 2019, under the category MGS and published in a national open access database. These case summaries were selected by the RTEs from the total of 1605 reported cases of EAS in the category MGS.

**RESULTS** The RTEs published 53 cases (41 [77%] female) under the category MGS. A total of 28 patients (53%) had always perceived themselves as independent, active, and socially involved. None of the patients suffered from life-threatening conditions. Multiple geriatric syndromes, such as visual impairment (34 cases [64%]), hearing loss (28 cases [53%]), pain (25 cases [47%]), and chronic tiredness (22 cases [42%]), were common. The request for EAS was often preceded by a sequence of events, especially recurrent falls (33 cases [62%]). Although physical suffering could be determined in all cases, the case descriptions found that suffering occurred on multiple dimensions, such as the loss of mobility (44 [83%]), fears (21 [40%]), dependence (23 [43%]), and social isolation (19 [36%]).

**CONCLUSIONS AND RELEVANCE** This qualitative study suggests that an accumulation of geriatric syndromes leading to a request for EAS is often intertwined with the social and existential dimension of suffering. This leads to a complex interplay of physical, psychological, and existential suffering that changes over time.

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[+ Editorial](#)

[+ Supplemental content](#)

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Since 2002, Dutch physicians are allowed to perform euthanasia and physician-assisted suicide (EAS) when the due care criteria laid down in the Dutch Termination of Life on Request and Assisted Suicide Act (hereafter referred to as the Dutch euthanasia law) are met.<sup>1</sup> One of the 6 criteria for legally permissible EAS is that “the physician must be satisfied that the patient’s suffering is unbearable, with no prospect of improvement.” (For the other criteria, see **Box 1**.) Each case of EAS is reported to the Dutch Regional Euthanasia Review Committees (RTEs). These committees assess and determine whether the physician acted in accordance with the due care criteria in the Dutch euthanasia law.<sup>2</sup> (See the eAppendix in the **Supplement** for information about the RTEs’ review procedure.)

Most Dutch EAS cases involve patients who suffer unbearably because of cancer in the last phase of life. In recent years,

however, an increase has been reported in EAS performed in patients with dementia, psychiatric disorders, or multiple geriatric syndromes (MGS).<sup>3,4</sup> Following the Euthanasia Code 2018, a geriatric syndrome is defined as degenerative in nature, often occurring in older patients. With regard to MGS, such as sight impairment, hearing impairment, osteoporosis, osteoarthritis, balance problems, or cognitive deterioration, the Dutch RTE guidance for physicians states that these geriatric syndromes may cause unbearable suffering without the prospect of improvement “in conjunction with the patient’s medical history, life history, personality, values and stamina.”<sup>5(pp 23-24)</sup> Although acceptance of EAS in cases of MGS is increasing in Dutch society, a majority of Dutch physicians are reluctant to grant a request for EAS on these grounds.<sup>6</sup> Such requests are considered to be much more complex than those

made by patients with a terminal disease, not only in ethical terms but also in legal and medical terms. For example, when does an accumulation of geriatric syndromes cause unbearable suffering without prospect of improvement? Are physicians sufficiently equipped to assess this suffering? Are these requests caused by a trend of people increasingly regarding normal decline as a disease?

This study aims to contribute to the further debate on dealing with requests for EAS from older persons with MGS. To this end, we (1) describe the patient characteristics, including the geriatric syndromes, that are associated with the request for EAS in cases of MGS; (2) explore which accumulation of syndromes and circumstances are associated with unbearable suffering in cases of MGS; and (3) attempt to gain a better understanding of the RTEs' assessment practice.

## Methods

We studied all 53 anonymized case summaries filed under the category MGS from an open access database on the RTE website.<sup>1</sup> These cases are selected by the RTEs from all 1605<sup>2</sup> reported EAS cases in the category MGS from January 1, 2013, to December 31, 2019. An overview of total numbers of deaths, EAS cases, and EAS cases of MGS per year is given in **Table 1**.<sup>7-9</sup> The Medical Research Ethics Committee Utrecht confirmed that our study was exempt from further ethical review, so no informed consent was required. All patient data were deidentified. This study followed the Standards for Reporting Qualitative Research (SRQR) reporting guideline. The selection of cases for publication on the website is guided by the aim to give an overview of the spectrum of cases reviewed and to contribute to the understanding of complex or controversial cases among physicians and the general public. In a meeting with a member and the chairman of the RTEs, we discussed the question of which cases are to be published in the national database. They confirmed that not only cases that address questions and dilemmas were selected but also cases representing situations that often occurred and were therefore

### Box 1. Criteria for Due Care in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2002)<sup>1</sup>

Requirements physician must satisfy:

- A. Must be satisfied that the patient's request is voluntary and well considered.
- B. Must be satisfied that the patient's suffering is unbearable, with no prospect of improvement.
- C. Must have informed the patient about the situation and prognosis.
- D. Must have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation.
- E. Must have consulted at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled.
- F. Must have exercised due medical care and attention in terminating the patient's life or assisting in suicide.

## Key Points

**Question** What are the patient characteristics and circumstances associated with the request for euthanasia and physician-assisted suicide (EAS) in cases of multiple geriatric syndromes as reported in the case summaries of the Dutch Regional Euthanasia Review Committees?

**Findings** In this qualitative study of 53 case summaries published by the Dutch Regional Euthanasia Review Committees, a combination of multiple geriatric syndromes, such as visual impairment, hearing loss, pain, and chronic tiredness, may have led, in most cases, to an accumulation of suffering on multiple dimensions, resulting in a request for EAS because of unbearable suffering.

**Meaning** This study suggests that unbearable suffering leading to a request for EAS in older persons without a life-threatening condition is often associated with a combination of medical, social, and existential issues.

considered common (oral communication, February 28, 2019). The length of the case summaries varies from 567 to 3130 words (approximately 2-6 pages), with a median of 1132 words. Among the more extensive case reports are the ones in which the RTE asked the physician (and sometimes also the consultant) for additional information. In these cases, the RTE had a face-to-face discussion with the physician (and consultant).

We conducted a directed qualitative content analysis<sup>10</sup> of the cases using the analysis program ATLAS.ti, version 8.4.15 (ATLAS.ti Scientific Software Development GmbH). One author (V.v.d.B.) read all 53 documents completely to acquire an overall picture of the nature of the cases, repeatedly comparing variables of interest in light of the main research question of the study. The coding scheme was developed by 2 authors (V.v.d.B. and E.v.W.) and discussed with another (G.v.T.). All documents were coded by 1 author (V.v.d.B.) based on the predetermined codes. New findings beyond the scheme and discrepancies were discussed and resolved among 4 authors (V.v.d.B., E.v.W., G.v.T., and M.Z.) and assessed by the whole team. Given the descriptive goals of this study, the emphasis was on frequency tabulation.

## Results

The RTEs published 53 cases (41 [77%] female) under the category MGS, which were reported between 2013 and 2019. In **Box 2**, we first present 3 of the analyzed cases to illustrate how the combination of medical conditions and other characteristics accumulate to create a situation in which the physician became convinced that the patient was suffering unbearably without prospect of improvement.

### Patient Characteristics

Patient characteristics and circumstances are given in **Table 2**. All 53 patients were 80 years of age or older and 41 (77%) were 90 years of age or older. In 28 cases (53%), it was reported that patients had always perceived themselves as independent, active, and socially involved persons.

Table 1. Numbers of Deaths, EAS Cases, and EAS for MGS Cases per Year<sup>a</sup>

Year	Total No. of deaths	No. of deaths per age category	Total No. of deaths by EAS <sup>b</sup>	No. of deaths by EAS per age category	Total No. of EAS deaths for MGS
2013	141 245	80-89 Years of age: 49 583; ≥90 years of age: 25 229	4829	NA	251
2014	139 223	80-89 Years of age: 48 182; ≥90 years of age: 25 676	5306	NA	257
2015	147 134	80-89 Years of age: 51 283; ≥90 years of age: 27 962	5516	NA	183
2016	148 973	80-89 Years of age: 51 665; ≥90 years of age: 28 649	6091	80-89 Years of age: 1487; ≥90 years of age: 522	244
2017	150 027	80-89 Years of age: 52 397; ≥90 years of age: 29 640	6585	80-89 Years of age: 1634; ≥90 years of age: 653	293
2018	153 328	80-89 Years of age: 53 203; ≥90 years of age: 30 401	6126	80-89 Years of age: 1442; ≥90 years of age: 512	205
2019	151 793	80-89 Years of age: 52 810; ≥90 years of age: 30 089	6361	80-89 Years of age: 1628; ≥90 years of age: 504	172

Abbreviations: EAS, euthanasia and physician-assisted suicide; MGS, multiple geriatric syndromes; NA, not available.

<sup>a</sup> Data are based on information from the Dutch Central Bureau of Statistics<sup>7</sup> and the Dutch Regional Euthanasia Review Committees (<http://www.euthanasiecommissie.nl>).<sup>8</sup>

<sup>b</sup> According to the Third Evaluation of the Euthanasia Law,<sup>9</sup> 55% of the expressed requests for euthanasia are honored. It is not known how many of these cases are associated with MGS.

### Box 2. Descriptions of Cases of Multiple Geriatric Syndromes<sup>a</sup>

#### Case 1

A woman in the age range of 90 to 100 years had progressive vision loss and hearing impairment. She also experienced chronic pain in her legs, loss of mobility, and balance problems. A few weeks before the euthanasia and physician-assisted suicide, she fell out of bed and suffered several fractures. Since that moment, her fear of a repeated fall made it difficult for her to sleep. Because of her condition, she felt lonely and cut off from her social environment. She was not able to read or watch television and was not up to any activities anymore.

#### Case 2

A woman in her 90s had been suffering from the consequences of osteoporosis for several years. Recurrent falls caused multiple fractures. A month before her death, she underwent surgery for a hip fracture. Her recovery did not go well, and the prognosis was bleak. Loss of mobility and pain prevented her from sitting comfortably. The lack of any prospect of improvement, the loss of autonomy, being completely dependent, and the fear of losing clarity of mind together caused the unbearable suffering that was the medical grounds for euthanasia and physician-assisted suicide.

#### Case 3

A woman older than 90 years whose physical health was deteriorating was dealing with hearing loss, severe fatigue, uncontrollable headaches, restless legs, and incontinence. All her life she had been a very independent, active, and engaged person. She hated accepting help from others, and because of her worsening hearing impairment, she was not able to participate in social activities. She felt excluded from society. She feared further physical decline, with her greatest fear being forced to move to a nursing home environment.

<sup>a</sup> These case descriptions illustrate the most important findings of this study: (1) that falls often occur and can be a tipping point that leads to a request for euthanasia; (2) that the consequences of a single geriatric syndrome can, in some cases, be sufficient to grant a request for euthanasia; and (3) that suffering has multiple intertwined dimensions.

Table 2. Patient Characteristics and Circumstances

Characteristic	No. (%) of cases (N = 53)
Age group, y	
80-89	12 (23)
90-100	41 (77)
Sex	
Male	12 (23)
Female	41 (77)
Geriatric syndrome <sup>a,b</sup>	
Visual impairment	34 (64)
(Chronic) pain	25 (47)
Hearing loss	28 (53)
(Chronic) tiredness or fatigue	22 (42)
Osteoporosis	17 (32)
Arthrosis	16 (30)
Incontinence	14 (26)
Decubitus	10 (19)
Other characteristics	
Gloomy feelings	2 (4)
Depressive feelings <sup>c</sup>	4 (8)
Always independent	18 (34)
Always active	10 (19)
Refuses medical examination or medical treatment	7 (13)
Recurrent falls	33 (62)
Sequence of events	39 (74)

<sup>a</sup> Numbers in this category do not total 53 because most patients had more than 1 health problem.

<sup>b</sup> Geriatric syndromes that occurred in at least 10 cases are presented in this table. Other medical syndromes or diseases included chronic obstructive pulmonary disease, dizziness, heart failure, constipation, and fractures.

<sup>c</sup> In some of these cases, additional psychological examination was conducted because of the depressive feelings. In these cases, depression was not diagnosed.

## Geriatric Syndromes

All but 1 patient had more than 1 medical condition that caused multiple symptoms. In none of the cases were the health problems caused by a life-threatening disease. Visual impairment was the most reported symptom (34 cases [64%]), followed by hearing loss (28 cases [53%]) and chronic pain (25 cases [47%]).

## Sequence of Events and Falls as Recurrent Themes

In most cases, 2 types of circumstances were reported to be important for the patient's wish to receive EAS. First, in 39 cases (74%), there was a sequence of events set off by an incident (the tipping point). The older patients in these cases had been dealing with multiple health problems for several years. The patients judged their suffering to be sufficient to request EAS.

Table 3. Elements of Suffering<sup>a</sup>

Element	No. (%) of cases (N = 53)
Loss of mobility	44 (83)
Decline of mobility	16 (30)
All day sitting in a chair	12 (23)
Bedridden	9 (17)
Unable to do anything	8 (15)
Fears	21 (40)
Fear of further physical decline	20 (38)
Fear of losing independence	11 (21)
Fear of falling	11 (21)
Fear of having to move to a foster care home	10 (19)
Dependence	23 (43)
Becoming more dependent	19 (36)
Completely dependent on others	8 (15)
Social isolation	19 (36)
Loss of meaning in daily life	19 (36)
Unable to read or watch television	15 (28)
No meaningful activities	12 (23)
Loss of quality of life	9 (17)
Loss of control	5 (9)
Loss of dignity	6 (11)

<sup>a</sup> Numbers do not total 53 because patients could list multiple elements of suffering.

after a decline in physical health because of the incident (eg, a fall, an infection, a hospitalization, or the loss of a close relative). Second, partly overlapping the first circumstance, in 33 cases (62%), falls and their consequences were reported. Recurrent falls caused complicated fractures in 7 cases (13%) and fear of falling in 11 cases (21%), which contributed to the experience of unbearable suffering.

### Description of Elements of Suffering

Each case summary contained a characterization of the patient's suffering caused by MGS. These characterizations show an association between medical conditions and losses in several dimensions of life (ie, physical, psychological, social, and existential) (Table 3). In 44 cases (83%), loss of mobility was an element in the suffering of the patient. The loss of mobility ranged from not being able to go outside for a walk to being bedridden and inactive. Different kinds of fears were also an element in the experience of suffering. In addition, patients experienced social isolation and loneliness (19 [36%]). Not being able to read, watch television, or undertake meaningful activities was also an element of suffering in 19 cases (36%).

### Conjunction of Symptoms and Events

The cases reported under the category MGS all described patients whose suffering was caused by a combination of symptoms attributable to an accumulation of syndromes. There was 1 exception, which demonstrates that a singular syndrome in combination with related experiences can be accepted by the RTEs as sufficient to meet the due care criterion of unbearable suffering without prospect of improvement.

### Practical and Procedural Aspects

All case summaries, in line with the standard procedure and the due care criteria stipulated in the Dutch law, stated that the physicians were convinced that the request was voluntary, which means that the patients made their wishes known without pressure or undue influence from others, such as family members. In addition, all published cases reflect that the physician saw no alternatives for improvement. In a number of cases, the physician had consulted a geriatric psychiatrist to rule out a reversible depression. With the exception of 1 person who received assisted suicide, all patients received euthanasia. In 32 cases (60%), a general practitioner performed the EAS; in the other 21 cases (40%), a physician from the Expertise Center Euthanasia<sup>3</sup> (formerly the End-of-Life Clinic) was involved.

During the review process of 9 cases (17%), the RTEs had additional questions (25 in total) concerning the physician's justification. Five questions were whether the patient's unbearable suffering originated in a medically classifiable disease. The question regarding additional information at the request of the patient was asked by the RTE in 5 cases. Three times the RTE wanted additional information on possible alternatives for the EAS, and 3 times they requested information on how the physician came to be satisfied that the patient's suffering was unbearable. Two times the RTE wanted to know more about the psychological aspect of the patient's suffering, including the question regarding whether the patient was suffering from depression. Examples of other questions were whether consultation of an independent expert had been necessary and whether due medical care was exercised in the performance of the EAS.

After obtaining additional information from the physician who performed the EAS, the independent consultant, and other involved medical specialists, the RTEs concluded that the EAS was in accordance with the due care criteria in all but 1 case (eAppendix in the Supplement). In the case that was not approved, several due care criteria were not met. The physician was not prosecuted in court. Compared with EAS in cancer cases, cases of MGS had a greater chance of generating more questions during the review procedures of the RTEs. Physicians of the Expertise Center Euthanasia were 5 times more likely to be questioned.<sup>4</sup>

### Discussion

The patients who received EAS because of MGS were the oldest old. Most (77%) of the patients were women. None of them had a life-threatening condition, and all except 1 patient with a single geriatric condition had MGS, such as visual impairment and hearing loss. Pain and chronic tiredness were also common.

This study is the first, to our knowledge, to describe case reports of EAS for MGS. Two studies<sup>11,12</sup> have analyzed cases of EAS for patients with psychiatric illnesses. Additional literature on the experiences concerning end-of-life decisions for the oldest old is scarce. Available studies<sup>13,14</sup> reveal that fear of suffering, the wish to remain living at home, and the need



for control are important elements in end-of-life decision-making. Although a medical condition associated with old age with symptoms could be determined in all 53 cases analyzed in this study, the case descriptions show that suffering occurred on multiple dimensions besides the medical one. This finding corresponds with the influential view of Cassell<sup>15</sup> that the interconnectedness and the interplay among physical, psychological, social, and existential experiences are crucial for a deeper understanding of suffering.<sup>16</sup> Suffering not only is a matter of pain and other physical symptoms but also has psychological, social, and existential dimensions.<sup>15</sup> In addition, suffering has a temporal dimension: it can be triggered by becoming aware of what the future holds.<sup>17</sup> The present analysis shows that fearing the future, fearing further physical decline, becoming more dependent, or losing control over the situation are important aspects of suffering. This finding is in line with previous research<sup>18</sup> into requests for EAS by patients with end-stage cancer. In patients with MGS, these fears seem to emerge after a sequence of events. Furthermore, in 74% of the cases, an incident was reported as a decisive factor in the request for EAS. These incidents did not merely add to the accumulation of health problems. It has been observed that such incidents can be seen as a “tipping point, a warning of functional decline, dependence and isolation.”<sup>19(p 904)</sup> In 33 of the 39 cases with incidents, this point concerned a fall that negatively affected different life dimensions. This finding confirms previous studies in which falls were interpreted as a starting point for reflection on life<sup>20</sup> and a factor associated with the development of a wish to die.<sup>21</sup>

### Strengths and Limitations

This study has strengths and limitations. Its primary strength is its exploration of the case summaries of the RTEs in the category of MGS. These summaries describe real EAS cases and are the only accessible source to study EAS in patients suffering from MGS. Nevertheless, this study is limited by the fact that the published cases are a selection of a larger number of dossiers. For example, in 2018, the RTEs reviewed a total of 205 cases of EAS for patients with MGS. In addition, data were extracted from secondary official state documents. Such documents represent a shortened and specific version of realities, suitable for publication on an open access website<sup>22</sup> and there-

fore containing little social history. Occasionally, a spouse or children are mentioned, but neither a person's family structure nor living arrangement could be reconstructed.

In addition, there is a risk of underreporting cases of euthanasia. Two partly overlapping sources of underreporting exist. First, physicians sometimes misclassify their actions. Second, physicians who perform euthanasia do not always report this action to the RTEs. With regard to reporting to the RTEs, 81% of all cases of euthanasia were reported in 2015.<sup>4</sup> Conclusions about the numbers and characteristics of patients with MGS among these misclassified and/or unreported cases cannot be drawn because specific data are not available.

### Conclusions

According to these findings, an accumulation of geriatric syndromes alone is insufficient to explain the unbearable suffering that leads to a request for EAS in older persons with MGS. In this study, all cases referred to patients who had been suffering from MGS for several years. At a certain moment in time, the suffering resulted in a request for EAS. Given that patients were already suffering from the geriatric syndromes for a long time, the findings suggest that it is not only the total number of these geriatric syndromes that is associated with unbearable suffering (and a granted request) but also the sum of these problems (often in combination with a tipping point incident) in conjunction with the patient's medical history, life history, personality, and values that gives rise to suffering that the patient in question experiences as unbearable and without prospect of improvement. This finding also may also explain why, in some exceptional cases, the medical dimension of the suffering can also be based on only 1 geriatric syndrome that, in combination with social and existential problems associated with that syndrome, may result in unbearable suffering. In summary, in most cases, experiences in the social and existential dimensions are intertwined with the medical dimension of suffering. The variety of relevant elements in these complex cases raises the question of what the role of these different elements should be in the assessment of requests for EAS and which expertise is needed for optimal care for these older persons.

#### ARTICLE INFORMATION

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Dear House Human Services Representatives:

I oppose House Bill 1415.

House Bill No. 1415 would establish legal Physician Assisted Suicide (PAS). The North Dakota Medical Association considers PAS unethical as Resolution No. 4 (see attached) was passed unanimously by NDMA on Friday October 6, 2017:

***RESOLVED**, that the North Dakota Medical Association formally adopt the position against Physician-assisted suicide and euthanasia in that they are fundamentally incompatible with the physician's role as healer*

1415 is unnecessary for terminally ill people since North Dakota has superb hospice and palliative care capabilities.

People with dementia are particularly at risk since decisional capacity is suspect in all. Depending on other person's memory of "what he would like" is extremely problematic.

People with a terminal medical condition are significantly at risk for anxiety, depression and coercion.

1415 severs the trusted "do no harm" bond between physicians. Physicians intentionally dispatch patients. Do patients know which physician would end their life?

North Dakota "...has seen the second highest rise in suicide rates since 2000 in the U.S...: InForum reported on July 26<sup>th</sup> 2020  
<https://www.inforum.com/newsmd/health-news/6588770-North-Dakota-had-second-highest-rise-in-suicide-rates-from-2000-to-2018-study-says> This begs the issue of sending a strong negative message to those North Dakotans struggling with suicidal thoughts and intentions. Legalizing PAS has been associated with an increased rate of total suicides relative to other states and no decrease in non-assisted suicides.

The history of PAS in other countries have documented advancing suicide initiatives in many age groups and reasons other than terminal disease and including persons 18 and older.

The Journal of the American Medical Association published on December 7, 2020 documents the long term effect of PAS (attached); "*Patient despair and suffering should be met with human connection and support to relieve suffering and improve quality of life, not a rush to put an end to things to reduce collective distress at the confrontation with finitude.*"

**Raymond Gruby, M.D., F.A.C.S.**

### **Resolution No. 3**

**Introduced By:      Raymond Gruby, MD**

**Subject:              Physician Assisted Suicide**

1    **WHEREAS**, Physician-assisted suicide occurs when a physician facilitates a patient's death  
2    by providing the necessary means and/or information to enable the patient to perform the life-  
3    ending act (e.g., the physician provides sleeping pills and information about the lethal dose,  
4    while aware that the patient may commit suicide); and

5    **WHEREAS**, Euthanasia is the administration of a lethal agent by another person to a patient  
6    for the purpose of relieving the patient's intolerable or incurable suffering; and

7    **WHEREAS**, Physician-assisted suicide and euthanasia are fundamentally incompatible with  
8    the physician's role as healer, would be difficult or impossible to control, and would pose  
9    serious societal risks; and

10   **WHEREAS**, permitting physicians to engage in either would ultimately cause more harm  
11   than good, sending a message that suicide or euthanasia is a socially acceptable response to  
12   aging, terminal illness, disabilities, depression and financial burdens; and

13   **WHEREAS**, instead of engaging in either physician-assisted suicide or euthanasia,  
14   physicians must firmly respond to the needs of patients at the end of life while respecting  
15   patient autonomy. They must provide good communication, emotional support, adequate pain  
16   control, and appropriate comfort care while never abandoning the patient; and

17   **WHEREAS**, the American Medical Association has established policy against both  
18   physician assisted suicide and euthanasia, which has been re-endorsed many times as per  
19   AMA Principles of Medical Ethics 5.7 and 5.8. **THEREFORE**,

20   **BE IT RESOLVED**, that the North Dakota Medical Association formally adopt the position  
21   against Physician-assisted suicide and euthanasia in that they are fundamentally incompatible  
22   with the physician's role as healer.

*Adopted October 6, 2017  
Joshua Ranum, MD  
Speaker of the House*



## EDITORIAL

## HEALTH CARE POLICY AND LAW

# The Treatment of Patients With Unbearable Suffering— The Slippery Slope Is Real

Diane E. Meier, MD

**Physician-assisted death (PAD)** is now legal in 9 US states and the District of Columbia and is under consideration in 17 more.<sup>1</sup> Legalization generally follows ballot, as opposed to legislative, initiatives in the setting of extensive marketing



[Related article](#)

efforts by advocacy groups focused on convincing the public that they face a future of unbearable suffering if PAD is not available. Whereas fear of unbearable suffering at the end of life is a commonly expressed concern, most Americans should be able to expect reliable and expert relief of suffering as a result of medical advances in geriatrics and palliative care. The fact that the public is so easily persuaded at the ballot box that suffering is inevitable and that they cannot trust the health care system to be responsive to their suffering should give us pause. The report by van den Berg et al<sup>2</sup> in the current issue of *JAMA Internal Medicine* of 53 cases of PAD or euthanasia in the Netherlands with unbearable suffering attributable to multiple geriatric syndromes should cause alarm.

Existing PAD laws in the US contain fairly strict safeguards, requiring that the patient have a terminal illness (is likely to die within 6 months) and intact decisional capacity, and that there be no evidence of coercion from family or others or evidence of depression or other psychiatric disease. In contrast, countries where PAD has been legal for considerably longer than the US have revised their original laws to remove prognostic requirements, eliminate psychiatric exclusions, broadly define unbearable suffering (to include such conditions as geriatric syndromes and existential distress), and reduce reporting requirements. For example, in the Netherlands, physicians must now follow only vague due care criteria before administering euthanasia or physician-assisted suicide (EAS). Only 75% of EAS cases are reported to regional euthanasia committees as required by law, and nonreporting is rarely punished,<sup>3</sup> and EAS in children, people with mental illness, and dementia further illustrates the impossibility of limiting the practice and safeguarding vulnerable patients once it is permissible.<sup>4,5</sup> The study by van den Berg et al<sup>2</sup> points to expansion of EAS to another, potentially very large, group of eligible patients: those with multiple geriatric syndromes.

Between 2013 and 2019, a total of 1605 occurrences of EAS in people with multiple geriatric syndromes were recorded in the Netherlands, accounting for 4% of all EAS cases in that period. We can assume this number is an underestimate given the level of failure to report. We know little about the 53 cases described by the regional euthanasia committees as represen-

tative. Seventy-seven percent were women and older than 90 years, and approximately 1 in 10 was described as having gloomy or depressive feelings. No information on cognitive or functional capacity is given, no psychiatric evaluation is described for any patient, no information on family or physician efforts to identify remediable issues or to provide support and encouragement is given, and the possibility that perceived or actual burdens on caregivers motivated the requests is not considered.

Although the case studies acknowledge remediable sources of distress, such as falls, loneliness, social isolation, and fewer life pleasures, the only intervention offered appears to be an assisted death. Does the (quick, easy, and inexpensive) option of EAS reduce the medical profession's responsibility to advocate for the continued value of the patient's life? It is inarguable that both time and money are scarce in health care, both globally and in high-income nations. How should we think about the balance of benefits and burdens of easier access to PAD in the current context of the increasing numbers of older persons, increasing income inequality and poverty, resource stresses on families and health systems, and the already well-documented inadequacy of government-funded health care<sup>6</sup> in ensuring high-quality medical care for older persons in our society? Will legal access to PAD serve as a quick, easy, and inexpensive means of handling the needs of an increasing aging population here and around the globe?

Proponents argue that access to PAD supports the autonomy of individuals who have concluded that death is preferable to the burdens of their continued life. Most healthy Americans have favored legalized PAD in polls.<sup>7</sup> As with any public policy, however, potential benefits must be weighed against societal harms. The expansion of eligibility criteria and the failure of the initial regulatory constraints to contain PAD to a narrowly defined and small group of patients demonstrated by the study underscore real societal harms in the Netherlands and the potential for such harms in the US. Once access to PAD becomes legal, when does a right become an obligation, especially when families are strained and society denies patients and families the resources needed to receive safe and reliable care? The more than 50 000 nursing home deaths from COVID-19 have exposed the lack of investment and years of underfunding in the care and safety of our most vulnerable adults.

Requests for PAD may result from many modifiable stressors.<sup>8</sup> Depression is frequently a concomitant component of requests for a hastened death and is routinely under-

diagnosed and undertreated<sup>9</sup> despite the availability of effective therapies. Pain is underrecognized and undertreated in people of all ages but is especially prevalent among the oldest old<sup>10</sup> and was reported in 41 of 53 of the cases in the series reported by van den Berg et al.<sup>2</sup> Regulations on PAD assume that practitioners have both the training and the time to carefully explore the meaning of the request with patients and families, to understand the sources of the despair, to offer and try alternative approaches to reduce suffering, to be present during that suffering, and to provide encouragement and validation to the patient regarding the value and meaning of their continued life. Most do not.<sup>11</sup> The epidemic of loneliness and social isolation among older persons further threatens society's ability to surround its citizens with care, attention, and human support.

Permissive access to PAD in this social context comes close to societal validation, supported by policy, that some lives are no longer worth the investment required to preserve them—the implicit belief that both the individual and the society would be better off if the patient were dead. This is precisely the type of thinking that led first to the 1927 US Supreme Court's 8 to 1 decision to uphold a state's right to forcibly sterilize persons considered unfit to procreate, then to the German physicians' advocacy of and participation in the eugenic sterilization policies of the early 1930s, and finally to Germany's involuntary euthanasia of those “lives unworthy of life”—

children with disabilities beginning in 1939 and aged people and people with disabilities beginning in 1940.

Fear of aging-related illness, dementia, and functional decline is widespread, and physicians are not immune to these fears. Indeed, surveys consistently demonstrate that physicians consider profound debility or cognitive impairment to be fates worse than death. In contrast, diverse older people living with age-related disability rate their own quality of life as fair to very good and point to preservation of dignity and a sense of control as key enabling factors.<sup>12</sup> Physicians' fear of their own futures, as exemplified by the patients they treat, may result in the unconscious projection of support for a hastened death. The growth in the fields of geriatrics and palliative care exist precisely to help reduce suffering, ensure dignity, and restore control, with the goal of helping patients and their loved ones regain a quality of life that makes life worth living.

Patient despair and suffering should be met with human connection and support to relieve suffering and improve quality of life, not a rush to put an end to things to reduce collective distress at the confrontation with finitude. David Barnard wrote, “The sting of illness and death is the specter of broken relationships and the loss of the world. Over and against this threat stand the efforts of caregivers and companions to embrace the sufferer and continuously reaffirm his or her capacity for relationship.”<sup>13(p 26)</sup> Meaningful and committed human connection—not 2 g of secobarbital—is the right prescription.

#### ARTICLE INFORMATION

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I am strongly opposed to HB 1415.

As an attorney practicing primarily estate planning, I know that the stated goals of this bill can be accomplished easily with simple end of life documents and a notary. Anyone who has the capacity to execute assisted suicide consent forms also has the capacity to execute a DNR or a Healthcare Directive indicating their wishes, and with a lot less stress than under the requirements in this bill. We do not need overlapping, redundant legislation.

Furthermore, given the startling rise of mental health issues we are seeing in this country, do we really want to be a state that in any way promotes or endorses suicide? I am concerned when I read about the rising rates of suicides and attempted suicides, including the rising number of suicides among minors (some as young as 9 years old, see Clark County School District, Las Vegas, Nevada). I believe we should embrace and celebrate life, and teach our kids to do the same, rather than inadvertently or overtly endorse doctor-assisted death.

Finally, I do not believe it is fair to the physicians who would be called upon to perform these procedures. I think it's safe to assume that doctors choose their field in order to preserve life and learn life-saving skills and techniques. Performing doctor-assisted suicide isn't normally a reason someone would choose to go to medical school.

# 2021 HOUSE STANDING COMMITTEE MINUTES

## Human Services Committee Pioneer Room, State Capitol

HB 1415  
2/9/2021

Relating to end-of-life health care decisions; and to provide a penalty
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**Chairman Weisz** opened the hearing at 10:38 a.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	A
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

### Discussion Topics:

- Physician verbiage elimination
- Practitioner verbiage addition

**Rep. Robin Weisz (10:38)** presented **Amendment #21.0649.01001** - #6096. No discussion or action on amendment.

**Rep. Matthew Ruby (10:38)** moved **Do Not Pass**

**Rep. Chuck Damschen (10:38)** second

Representatives	Vote
Representative Robin Weisz	Y
Representative Karen M. Rohr	Y
Representative Mike Beltz	Y
Representative Chuck Damschen	Y
Representative Bill Devlin	Y
Representative Gretchen Dobervich	A
Representative Clayton Fegley	Y
Representative Dwight Kiefert	Y
Representative Todd Porter	Y
Representative Matthew Ruby	Y

Representative Mary Schneider	N
Representative Kathy Skroch	Y
Representative Bill Tveit	Y
Representative Greg Westlund	Y

**Motion Carried Do Not Pass 12-1-1**

**Bill Carrier:** Rep. Karen Rohr

**Chairman Weisz** adjourned at 10:40 a.m.

*Tamara Krause, Committee Clerk*

**REPORT OF STANDING COMMITTEE**

**HB 1415: Human Services Committee (Rep. Weisz, Chairman)** recommends **DO NOT PASS** (12 YEAS, 1 NAY, 1 ABSENT AND NOT VOTING). HB 1415 was placed on the Eleventh order on the calendar.

21.0649.01001  
Title.

Prepared by the Legislative Council staff for  
Representative P. Anderson  
February 2, 2021

# PROPOSED AMENDMENTS TO HOUSE BILL NO. 1415

Page 1, line 9, after "2." insert "Advanced practice registered nurse" means an advanced practice registered nurse licensed under chapter 43-12.1.

3."

Page 1, line 9, replace the first "physician" with "practitioner"

Page 1, line 9, after "physician" insert ", physician assistant, or advanced practice registered nurse"

Page 1, line 11, replace "3." with "4."

Page 1, line 11, replace "physician" with "practitioner"

Page 1, line 12, replace "physician" with "practitioner"

Page 1, line 16, replace "4." with "5."

Page 1, line 16, replace the first "physician" with "practitioner"

Page 1, line 16, after "physician" insert ", physician assistant, or advanced practice registered nurse"

Page 1, line 18, replace "5." with "6."

Page 1, line 22, replace "6." with "7."

Page 2, line 1, replace "7." with "8."

Page 2, line 4, replace "8." with "9."

Page 2, line 9, replace "9." with "10."

Page 2, line 12, replace "physician" with "practitioner"

Page 2, line 18, replace "10." with "11."

Page 2, line 18, replace "physician's medical" with "practitioner's professional"

Page 2, line 19, replace "physician" with "practitioner"

Page 2, line 21, replace "11." with "12."

Page 2, line 21, after "physician" insert ", physician assistant, or advanced practice registered nurse"

Page 2, line 22, replace "12." with "13."

Page 2, line 24, replace "13." with "14." "Physician assistant" means a physician assistant licensed to practice under chapter 43-17.

15."

Page 2, line 26, replace "14." with "16."

Page 2, line 29, replace "physician" with "practitioner"

Page 2, line 30, replace "physician" with "practitioner"

Page 2, line 31, replace "physician" with "practitioner"

Page 3, line 11, replace "physician" with "practitioner"

Page 3, line 15, replace "physician" with "practitioner"

Page 4, line 1, replace "physician" with "practitioner"

Page 4, line 5, replace "**physician**" with "**practitioner**"

Page 4, line 17, replace "physician" with "practitioner"

Page 5, line 4, replace "physician" with "practitioner"

Page 5, line 6, replace "**physician**" with "**practitioner**"

Page 5, line 7, replace "physician" with "practitioner"

Page 5, line 8, replace "physician" with "practitioner"

Page 5, line 10, replace "physician" with "practitioner"

Page 5, line 10, replace "physician's" with "practitioner's"

Page 5, line 16, replace the first "physician" with "practitioner"

Page 5, line 16, replace the second "physician" with "practitioner"

Page 5, line 18, replace "physician" with "practitioner"

Page 5, line 20, replace "physician" with "practitioner"

Page 5, line 27, replace "physician" with "practitioner"

Page 5, line 30, replace "physician" with "practitioner"

Page 6, line 1, replace "physician" with "practitioner"

Page 6, line 2, replace "physician" with "practitioner"

Page 6, line 3, replace "physician" with "practitioner"

Page 6, line 9, replace "physician" with "practitioner"

Page 6, line 17, replace "physician's" with "practitioner's"

Page 6, line 19, replace "physician's" with "practitioner's"

Page 6, line 22, replace "physician's" with "practitioner's"

Page 6, line 24, replace "physician" with "practitioner"

Page 8, line 1, replace "physician" with "practitioner"

Page 8, line 28, replace "physician" with "practitioner"

Page 9, line 12, replace "physician" with "practitioner"

Page 9, line 13, replace "physician" with "practitioner"



Page 9, line 26, replace the first "physician" with "practitioner"

Page 9, line 26, replace the second "physician" with "practitioner"

Page 10, line 4, after "physician" insert ", physician assistant, or advanced practice registered nurse"

Page 10, line 5, replace "physician" with "practitioner"

Page 10, line 6, replace "physician" with "practitioner"

Page 10, line 27, replace "physician" with "practitioner"

Page 10, line 28, replace "physician" with "practitioner"

Page 11, line 1, replace "physician" with "practitioner"

Page 11, line 11, replace "physician" with "practitioner"

Page 11, line 23, replace "physician" with "practitioner"

Renumber accordingly