

Testimony

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203 451-0384

Public Health Committee Hearing,
March 20, 2013

Physician Assisted Suicide HB ~~6445~~ 6645
Legislative Office Building, Rm 1D

Testimony - 4 Pages

In 2010 Superior Court Judge Julia Aurigemma rejected an attempt to legalize physician assisted suicide at that time. She warned that if, at some time in the future, a bill is proposed, "the legislature would have to consider the ramifications of legalized physician-assisted suicide" to patients and to the state. My talk focuses on this.

An attachment provides detail, links to sources of information, and shows associated case studies.

There are concerns regarding the statistics, reports and information coming out of Oregon, which is the model state for this law. The data indicates this is not what we need or should want for Connecticut or our people.

- **Since Oregon implemented assisted suicide, state suicide rates have climbed** year after year and as of 2010 were **41% higher than the national levels** (*not including patients who died through physician assisted suicide*). How can a state call suicide a "medical treatment" and effectively lower suicide rates at the same time. **For teens in Oregon, suicide is the second leading cause of death** (*not the third as it is for the nation*).
- **Physician assisted suicide doctors and medical consultants, who are aligned with promoters of the law, become involved with patients**, approve suicides for patients, and participate in their deaths, reported as corruption by a reputable Oregon doctor and the Oregonian Newspaper.
- **Palliative care -- is the cornerstone of excellence for managing pain & other distressing symptoms (like nausea)**, but Oregon state agencies fail to successfully ensure it was offered to patients, the disabled & elders.
- **OHSU Study: In Oregon, after 4 years of assisted suicide, there was a decline in end-of-life pain-control** which was improved by local doctors as reported in the Oregonian Newspaper.
- **Dept of Health Reports Show Patients Ask for Suicide for Psychological and Quality of Life Reasons, NOT for pain.**

- **Since 1998, just after the PAS law was enacted, according to the Oregon Dept of Health Annual Reports, patient referrals for counseling (psychological or psychiatric treatments) -- dropped, leaving patients stranded with their mental anguish and in some cases less-treated pain for the duration of their illness.**
 - In 2009 none of the 59 patients were referred
 - In 2010 only one of 65 patients were referred
 - In 2011 only one of 71 patients were referred
 - In 2012 only two of 77 patients were referred

- **A Six Month Prognosis - Is More Often Wrong - 5 Testimonies, 3 Case Studies including Ted Kennedy.** How many patients, who did not know this, have accepted the prognosis, given up medical treatments to cure or prolong life, and opted for suicide...unnecessarily. In a Position Statement representing 600 oncologists -- from key national associations including the American College of Physicians -- doctors who see terminal patients daily say they are "more often" wrong in their prognosis than right. The National Cancer Institute agrees and explains, in a fact sheet, "End of Life Care for People Who Have Cancer", that there are variables such as type of cancer, its location, and whether the patient has other illnesses. They say, doctors can only "estimate" the amount of time a patient has to live. See attachment for details.

- **In Oregon The State's Healthcare Plan Refused Patients Cancer Treatments Based on Costs and Instead Offered Physician assisted suicide** (2 well publicized cases were Barbara Wagner and Randy Stroup - these studies are included in the attachment).

- **Suicide Law & Procedures -- Ignore Pertinent Medical Facts and keep the focus on physician assisted suicide** (For example, that the AMA reports that palliative care successfully protects even end of life patients from pain, which may explain why patients are not asking for suicide for pain. Also, the National Alliance on Mental Illness repeatedly says the desire for "suicide is almost always the results of untreated or under-treated mental illness" In the Position Statement by over 600 oncologists -- from key national associations including the American College of Physicians -- doctors clearly communicate We should not give up on these patients, who have a six-month because prognosis's can be wrong" -- they say "more often" than they are right including a prognosis by two doctors. "A consulting physician who examines the patient and reviews the medical records is prone to the same errors in judgment that the attending physician may make when faced with the same data."

- **Physician Assisted Suicide – Laws & Procedures Ignore Key Legal Facts (For example,** In response to a law suit by two doctors, in June – **2010, Connecticut, Superior Court Judge Julia Aurigemma,** countered the artificial definition of physician assisted suicide as a medical treatment, and said "Assisting a suicide, even for humanitarian reasons, is a crime", said that **'aid in dying'— is, in fact, 'suicide'** (as the law and the American public understand the term) and she discussed the severe consequences to Connecticut if such a bill is passed -- to the extent that she warned -- **if a case comes before the legislature,** it would have to consider the ramifications of legalizing physician-assisted suicide" including how assisted suicide, "threatens the most vulnerable in society;" and incentivizes physicians and insurers "away from vitally important tasks such as identifying and TREATING DEPRESSION and providing end-of-life pain control and palliative care"

- **Physician Assisted Suicide Gives Opportunities for Patient Coercion & Abuse, Especially Elders:** Pressure may be brought to bear from one who stands to benefit from the patient's death. A beneficiary may be a witness to the patient's request for suicide, may help the patient shop for a doctor who will approve the suicide, is qualified to speak for the patient, and there is no requirement that a disinterested witness be present when the patient ingests the lethal dose. How do we know the patient consented. [Note: A right to rescind a request for the lethal dose "at any time is not the same thing as a right to consent when the lethal dose is administered."]
- **Wait Times" between Time of Ingestion & Time of Death – In 1998 - 2005, from 4 minutes to 48 hours. In 2012, no improvement. 2 Days – Some regain Consciousness. The DOH reported, "Among those those patients, time of ingestion to time of death ranged from 10 minutes to two days"....** The DOH

For example, the 2012 Annual Dept of Health Report reads, " Of the 115 patients for whom Death With Dignity DWDA prescriptions were written during 2012, 67 ingested the medication; 66 died from ingesting the medication, and one patient ingested the medication but regained consciousness before dying of underlying illness and is therefore not counted as a DWDA death. The patient regained consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion."..."Fourteen of these patients died, but follow-up questionnaires indicating ingestion status have not yet been received".

Attorney Catherine Foster, Litigation Counsel, Alliance Defending Freedom

The New York Times lists some of the ways an assisted suicide can "go wrong". Patients...don't take enough pills. They wake up instead of dying. Patients in [a study from the Netherlands] vomited up their medications in 7 percent of cases; in 15 percent of cases, patients either did not die or took a very long time to die – hours, even days; in 18 percent, doctors had to intervene to administer a lethal medication themselves, converting a physician-assisted suicide into euthanasia.

She adds that, "This kind of legislation also lends itself to sloppiness on the part of doctors – after all, a patient whom you help kill is not going to be around to complain about pain, abuse of informed consent, or any of the other steps you took – or didn't take – along the way.

- **PAS Could Jeopardize Connecticut's Hospital Rankings -- which companies and families look in relocation choices. Connecticut already has a Low "C" Level Ranking** – where rankings are not only about curing or prolong life, they are also about how patients are treated based on inputs from patients and families.

We cannot afford the negative publicity physician assisted suicide will bring as doctors, nurses, and lawyers speak out against it -- as they are doing in Oregon and Washington state.

- **To Lower Healthcare Costs, Ignore Assisted Suicide & Plan to Lower Preventable Medical Errors.** American Association of Justice: According to the Department of Health and Human Services, about 100,000 Americans die every year from **preventable errors in hospitals, at cost of \$29 billion.**Preventing medical errors will lower health care costs, reduce doctors' insurance premiums, and protect the health and well-being of patients, and improve hospital rankings. Even errors that the government and private health insurers have classified as **"never events,"** events that should never happen in a

hospital, are occurring at alarming rates. For example, in 2003 alone, the Congressional Budget Office (CBO) found that there were **181,000 severe injuries** attributable to medical negligence.

- **IN SUMMARY: Only two states have legalized assisted suicide -- Oregon and Washington. Attempts have been made to legalize assisted suicide in all states, multiple times. These attempts failed; states rejected this law. During the last decade, a total of 121 attempts were made and were rejected.** For Connecticut's safety, two states is *not a big enough trial*. If other states do not want this law, why should Connecticut. Connecticut should not take a chance with such an unproven -- untested law -- and suspect law.

It is hoped that you will consider the ramifications to the state and patients, and decide with the other states not to proceed with physician assisted suicide.

Attachment:

"RAMIFICATIONS" -- Physician Assisted Suicide, 30 pages

Testimony Attachment
Eileen Bianchini, Chair, CT Right to Life Corporation
203 451-0384

Public Health Committee
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Testimony - 30 Pages

"RAMIFICATIONS" -- Physician Assisted Suicide



THREATENS THE MOST VULNERABLE & THE STATE OF CONNECTICUT

(AS SEEN IN OREGON - THE MODEL STATE FOR THIS INITIATIVE)

"We have obligations to one another -- that to threaten any one of us is to threaten all of us. No one has a right to inflict harm on another except in self-defense. From abortion to assisted suicide, let us fully support the value of human life". Eileen Bianchini, Chairperson, Connecticut Right to Life

Introduction

In 2010 Superior Court Judge Julia Aurigemma rejected an attempt to legalize physician assisted suicide at that time. She warned that if, at some time in the future, a bill is proposed,

"the legislature would have to consider the ramifications of legalized physician-assisted suicide" and she provided the list below.

- how assisted suicide, "threatens the most vulnerable in society;"
- incentivizes physicians and insurers "away from vitally important tasks such as identifying and TREATING DEPRESSION and providing end-of-life pain control and palliative care;"
- compromises "the physician-patient relationship and the integrity of the medical profession;" and
- even may open up the possibility of "involuntary euthanasia," which has been documented in the Netherlands.

We are at that time now. Several bills have recently been proposed to legalize physician assisted suicide (PAS) in Connecticut. Promoters of legalized suicide point to Oregon – their model state -- as an example of the benefits of such a law for individuals and for the state. However, there are serious concerns. There are contradictions in some of the key statistics and medical reports coming out of Oregon. The data shows this is not what we should want for Connecticut or our people. For example:

- **Since Oregon implemented assisted suicide, state suicide rates have climbed year after year and as of 2010 were 41% higher than the national levels (not including patients who died through physician assisted suicide). How can a state call suicide a "medical treatment" and effectively lower suicide rates at the same time.**
- **For teens in Oregon, suicide is the second leading cause of death (not the third as it is for the nation).**
- **Physician assisted suicide doctors and medical consultants, who are aligned with promoters of the law, become involved with patients, approve suicides for patients, and participate in their deaths,** reported in by a reputable Oregon doctor in the Oregonian Newspaper.
- **Palliative care -- is the cornerstone of excellence for managing pain & other distressing symptoms (like nausea), but state agencies have repeatedly failed to successfully ensure it is offered to patients in Oregon**
- **In Oregon, after 4 years of assisted suicide, there was decline in end-of-life pain-control** which was improved by local doctors as reported by Dr. Stevens in the Oregonian Newspaper.
- **Dept of Health Reports Show Patients Ask for Suicide for Psychological and Quality of Life Reasons, NOT for pain.**
- **Since 1998, just after the PAS law was enacted, according to the Oregon Dept of Health Annual Reports, patient referrals for counseling (psychological or psychiatric treatments) -- dropped, leaving patients stranded with their mental anguish and in some cases less-treated pain for the duration of their illness.**
 - In 2009 none of the 59 patients were referred
 - In 2010 only one of 65 patients were referred
 - In 2011 only one of 71 patients were referred
 - In 2012 only two of 77 patients were referred

- **6-month prognosis's - often wrong (case studies included).** . How many patients, who did not know this, accepted the prognosis, gave up treatments, and opted for suicide...unnecessarily. In a Position Statement representing 600 oncologists -- from key national associations including the American College of Physicians -- doctors who see terminal patients daily say they are "more often" wrong in their prognosis than right.

The National Cancer Institute agrees and explains, in a fact sheet, "End of Life Care for People Who Have Cancer", that there are variables such as type of cancer, its location, and whether the patient has other illnesses. They say, doctors can only "estimate" the amount of time a patient has to live.

One has to wonder, how many patients, who did not know this, accepted the prognosis, gave up treatments, and opted for suicide...unnecessarily.

These doctors also say a prognosis by two doctors. "A consulting physician who examines the patient and reviews the medical records is prone to the same errors in judgment that the attending physician may make when faced with the same data."

- **In Oregon, patients have been refused treatments by the state's healthcare plan (Medicare) to prolong or cure** and instead offered cheap physician assisted suicide (2 case studies included)
- **Suicide Law & Procedures -- Ignore Pertinent *Medical* Facts and keep the focus on physician assisted suicide.** For example, the Oregon Dept of Health Reports show patients ask for PAS for quality of life reasons. The AMA reports that palliative care successfully protects even end of life patients from pain, that the National Alliance on Mental Illness repeatedly says the desire for "suicide is almost always the result of untreated or under-treated mental illness". We should not give up on these patients, who have a six-month because prognosis's can be wrong"
- **Suicide Law & Procedures -- Ignore Pertinent *Legal* Facts and keep the focus on physician assisted suicide**

Oregon – Suicide Rates are 41% Higher than National Levels:

Since Oregon legalized assisted suicide, in 1997, the Oregon suicide rate climbed.

In Oregon, according to the Oregon Health Authority:

- Since 2000, after the Oregon PAS bill was instituted in 1997, suicides of teens through elders has been increasing.
- Between 2003 and 2010, Oregon suicide rates were significantly higher than the national average among all age groups except ages 10-17 and women ages 18-24.
- In 2010, the age-adjusted suicide rate among Oregonians was 17.1 per 100,000 which is 41% higher than the national average, 48 suicides per month and
- 2003 – 2010 there were five suicide incidents that involved more than one death.

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

- **In Oregon, suicide is the second leading cause of death among persons 15-24 (not the third cause of death as it is across the nation). See:**
 - Between 2004 and 2006, suicide claimed the lives of over 200 youth.
 - Over 90% were males.
 - Firearms were used 56%
 - There were over twice as many suicides as homicides in this age group.
 - In just 2006, over 1400 youth, ages 10 to 17 were treated at hospitals for attempting suicide.
 - There are an estimated 134 attempts for every death.
 - 476 Oregon youth 10-24 were hospitalized in 2006 for attempted suicide.
 - Nearly 1 in 12 eighth graders and 1 in 16 eleventh graders reported attempting suicide in the last twelve months.

<http://public.health.oregon.gov/PreventionWellness/SafeLiving/SuicidePrevention/Pages/sdata.aspx>

- In each age group, men were 3.7 times more likely to die by suicide than women. Overall, white men had the higher suicide rate. This is due to extremely high suicide rates among older white men aged 60 and over.
- Methods of suicide; Of the 2,632 firearm suicides, 69% involved a handgun, 14% a rifle, 11% a shotgun, 6% unknown. Of the 938 suicides due to poisoning, more than 60% resulted from a single substance. Most often reported poisoning substances were medications.
- Psychological, behavioral and health problems co-occur and are known to increase suicide risk.
- **Major depression/dysthymia (74%)** was the most frequent diagnosed mental health condition, followed by anxiety disorder (14%), and bipolar disorder (14%).
- Most common circumstances reported for men was problem with an intimate partner, physical health problems, lost job/job problem, financial problem, crime legal, and family stressors. Among women, a problem with an intimate partner, physical health, family stressors, lost job/job problem, and financial problem.
- The cost in 2010 rose:
 - self-inflicted injury hospitalization charges exceeded **\$41 million**
 - the estimate of total lifetime of suicide in Oregon was over **\$680 million dollars.**
 - **Not calculated is the rise state costs to sustain a family whose father died by suicide** and must seek low-income financial aid through various agencies for healthcare, for housing, etc.
 - The loss to families and communities broadens the impact of each death.
 - Public health reports says that the deaths by PAS were not included in the counts.

More detail at <http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/NVDRS/Suicide%20in%20Oregon%202012%20report.pdf>

It is important to know this because our Connecticut legislators may believe that with physician assisted suicide law, the suicides in our state will decrease. We see that in Oregon, the model state for this law, this is not the case.

Discussion: Socially, we see that patterns of behavior and trends migrate across demographics and to other population segments. The suicide of patients by physicians will naturally influence suicides among out-patients and non-patients of all ages. Also, by making suicide more socially acceptable, it may decrease the probability that the suicide prone people and teens will seek treatment.

National - Suicide 2012 Statistics – Horrific!

Suicide is the:

- **third leading cause of death among persons aged 15-24** *In 1997, more teenagers and young adults died from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined.*

(Note: In Oregon where physician assisted suicide is enacted and suicide is 41% higher than the national average, it is the second leading cause of death among persons 15-24)

- **second among persons aged 25-34**
- fourth among persons aged 35-54
- eight among persons 55-64
- almost twice as many people die from suicide as by murder

For more statistics, see the National Center for Injury Prevention and Control
<http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.PDF>

The National Alliance on Mental Illness (NAMI) reports:

- We lose one life to suicide every 15.8 minutes.
- Suicide is the eleventh-leading cause of death overall and confirms it is the third-leading cause of death among youth and young adults aged 15-24. See:
<http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93484> CDC 1 800 cdd info (232-4636)
- Suicide is almost always the result of untreated or under-treated mental illness, as is mass murder.
- For the “full period from FY2009 to FY2012...more than \$1.6 billion was cut from state funds for mental health services
<http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=147763>
- According to the National Association of State Mental Health Program Directors, approximately 4,000 psychiatric hospital beds have been eliminated since 2010. At the same time, community services have been eliminated and mental health providers reduced. For more data see
<http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=147763>

See the below videos

It discusses need to remove the stigma and the need to reaching to encourage people to receive treatment.

http://www.youtube.com/watch?feature=player_embedded&v=zgPN7vnOd-Y

<iframe width="420" height="315" src="http://www.youtube.com/embed/zgPN7vnOd-Y" frameborder="0" allowfullscreen></iframe>

Mother on Suicide of Son -- says we need to encourage suicide prone to seek help

<http://www.burlingtonfreepress.com/videonetwork/2193840008001/Preventing-suicide>

Gov. Christie

In lieu of the **Sandy Hook** suicide and mass killings, Gov. Christie similarly recommends that we need to eliminate the:

- stigma attached to mental illness
- make psychological and psychiatric treatment more accessible
- encourage people who are prone to suicide to sign up for it
- With treatment and help, people with mental illness can successfully function and excel in society; as long as their loved ones and doctors do not give up on them and the doors for treatment remain wide open

Instead, this law does the opposite.

Dr. Gregory Hamilton, M.D. N. Gregory Hamilton, M.D., President, Physicians for Compassionate Care, Portland, Oregon May 14, 2000 says, "It endangers mentally ill and infirm and/or alcoholics and other groups, who have a differentially high suicide rate", and should be seeking medical help. It is the furthest from "welcoming".

Dr. Hamilton says,

"It is harmful to society, it is destructive to the doctor-patient relationship, is impossible to control, and poses serious societal risks.

Connecticut's Suicide Rate – is Already at a High

Because of the mass murders and suicide at the Sandy Hook Elementary School, Newtown, a number of organizations, legislators, and committees are concerned about our state's suicide rate.

Proposing bills to legalize suicide just afterward seems insensitive and inappropriate at this time, and over time may go against current attempts to reduce suicide rates in Connecticut rates and contribute to even higher rates. Look at Oregon's numbers since PAS was enacted.

At the same time, Connecticut is reacting to massive layoffs from New York's top Banking and Finance companies involving blue-collar, service, and management levels employees, across ages and including retirees. Experts believe this has contributed to higher suicide rates among middle aged working men.

How then, can we possibly call suicide a "**medical treatment**" and continue to successfully discourage suicides, among the suicide-prone, at all age levels, in the same state?

- **In April 2012, the Courant reported we are "at a 20-year high in the last year..."** fueled by a jump in deaths among men ages 40 to 59 — and experts suggest it might have something to do with the economic downturn according to state statistics. There were a total of 371 suicides in 2011, including 83 women.
- A Swedish study found a direct correlation between the amount of time a man remains unemployed and the risk of suicide.
- If depression leads to increased drug and alcohol abuse, the suicide rate can increase even more".
- James Siemianowski, state Dept of Mental Health & Addiction Services, said "Experts have been seeing an uptick in suicide among middle-aged men and women for a mix of reasons, including unemployment, failing health and poor relations with family" ...and pointed out that the economic crisis is a force that may increase suicide rates across all age groups, particularly, those contemplating retirement".
- Suicide rates increase with age, however, and are highest among white American males age 65 years and older.
- Last year, United Way, 211 Connecticut counselors handled more than 2,000 suicide-related calls. See ... http://articles.courant.com/2012-04-30/news/hc-ct-suicide-rate-20-year-high-0501-20120430_1_suicide-rate-women-middle-aged-men
- In 2011, the Courant which reported that in 2008 and 2009, Connecticut had the second-highest rate of suicide attempts in the nation among people 18 and older, according to a new report by the U.S. Centers for Disease Control and Prevention. http://articles.courant.com/2011-10-22/health/hc-connecticut-suicide-1022-20111021_1_suicide-rate-suicide-prevention-actual-suicides
- The Litchfield County Times reported 2012 that deaths are part of a state suicide total that has been rising for five years to more than one per day, according to the newly updated statistics from the Office of the state's Chief Medical Examiner. See <http://countytimes.com/articles/2012/04/30/news/doc4f9e70f650cf6057647156.txt>

Corruption Behind the Scenes - Physician Assisted Suicide -

The Oregonian Newspaper Reports:
In An Article, "Assisted suicide: Conspiracy & Control"
Details Corruption Behind the Scenes at Hospitals & Hospice

The editorial board of the Oregonian Newspaper reports, "We must comment on two realities:

- first, the group controlling assisted suicide in Oregon is also the group controlling what the public is told;
- second, the claim that Oregon is a leader in improved end-of-life care because of assisted suicide is inaccurate.

The editorial board correctly notes "a coterie of insiders run the program, with a handful of doctors and others deciding what the public may know".

The group promoting assisted suicide, so-called "Compassion and Choices (C&C)", are like the fox in the proverbial chicken coop; in this case the fox is reporting its version to the farmer regarding what is happening in the coop. Members of C&C authored and proclaim they are the stewards of Oregon's assisted suicide law. They call it "their law". They have arranged and participated in 3/4ths of Oregon's assisted suicide cases. Their medical director reported she'd participated in more than 100 doctor-assisted suicides as of March 2005. A physician board-member reported in 2006 that he'd been involved with over forty such patients. Their executive director reported in September 2007 that he has attended more than 36 assisted suicide deaths. He has been involved in preparing the lethal solution. Yet, he is not a doctor

Regardless of one's perspective on assisted suicide, all citizens should be concerned about the controlling influence of this death-promoting organization. In all other areas of medicine, we are striving for increased transparency---not conspiracy and control.

What about assisted suicide causing improved end-of-life care?

There is improved end-of-life care in Oregon. In training physicians, we have sought to improve patient-physician communication, and improve patient care at many levels. We have made improvements. However, similar improvements have occurred in other states that have not legalized assisted suicide. Many states do better than *Oregon in this area*.

The latest data ranks Oregon 9th (not 1st) in Medicare-age hospice-utilization; 4 of the top 5 states have criminalized assisted-suicide. The Wisconsin Pain Policies Studies Group issues grades regarding states' pain-policies. While Oregon & Washington both have high grades on their pain-policies, an OHSU study documented that after 4 years of assisted suicide in Oregon there was a decline in end-of-life pain-control. This doesn't prove that the pain-control decline was due to assisted suicide. At the same time, the data doesn't support the claim that legalization of assisted suicide improved care at the end-of-life.

In summary, we should all be wary of the false "C&C" claims.

See the whole article at

http://www.oregonlive.com/opinion/index.ssf/2008/09/assisted_suicide_conspiracy_an.html

Palliative Care -- Successfully Manages Pain - But State Agencies Failed to Successfully Ensure It was Offered to Patients in Oregon

All patients deserve it – Everyone of Every Age Should Know

In an article called, Death with Dignity Or Obsenity?" by Jean Echlin, nurse consultant palliative care & gerontology, the author says, "Death is not the appropriate solution to pain and suffering; good palliative care is. The disciples of the cult of euthanasia and assisted suicide would have society believe that the logical solution for pain and suffering is death...vs. pain and symptom management for individuals experiencing life-threatening, life-limiting, progressive, or terminal disease. The cornerstone of excellence in this newer health care reform is the management of pain and other distressing symptoms. A person in pain is unable to focus on anything except their need for pain relief. Having to cry or plead for pain or anxiety medication leaves the patient feeling degraded demoralized and dehumanized. In cases like these their desperation is often distressing enough to make them wish for death".

Discussion: Palliative care manages pain successfully by gradually increasing doses as pain increases. It does not wait for pain to become intolerable, so much so that death is wished for. Further, the method of "stepped" pain management lets the patient's body accept slightly increased increments of pain medication and not react against it (as some people do to the lethal dose). Simultaneously palliative care also involves multidisciplinary help for the patient that includes psychological, psychiatric, physical therapy, social and pastoral help.

If the law is changed to allow assisted suicide, those at highest risk for the lethal dose will be the below, especially if pain management is simultaneously reduced after the law is enacted (which happened in Oregon -- it is documented in the below paragraph) would include:

- Older women (55 and above) or elderly fragile men
- Individuals with physical or mental disabilities
- Partners in scenarios of domestic violence
- Babies and children born with disabilities and birth anomalies
- Persons who are poor and disenfranchised
- Members of minority groups

Implementation of such this type of law is complex. It requires involvement of multiple state agencies to ensure that the law is being followed.

In Oregon, the flagship for this law, agencies were not able to provide the level of support that this complex law requires. We have no reason to believe that Connecticut will do any better.

In her article, nurse Echlin points out,

"According to researchers Hendin and Foley [*Physician-assisted suicide in Oregon: a medial perspective*" see www.michiganlawreview.org/rchives/106/8/hendinfoley.pdf], safeguards for the care and protection of terminally ill patients under this law are being

circumvented.

One of the key problems seems to be the lack of appropriate data collected by the Oregon Public Health Division (OPHD) who are charged with monitoring the law. This organization failed to "ensure that palliative care alternatives to physician assisted suicide (PAS) are made available to patients" and they also failed to protect vulnerable patients by not ensuring that the safeguards are upheld.

For more detail stop to read this enlightening and well written article:
<http://www.pcccf.org/DOWNLOADS/DeathWithDignityOrObscenity.pdf>

OHSU Study: Pain Control Degraded in Oregon After Assisted Suicide was Legalized

In 2008, Dr. Kenneth Stevens Jr., Oregon, wrote in his news release to the Oregonian Newspaper—" The latest data ranks Oregon 9th (not 1st) in Medicare-age hospice-utilization; 4 of the top 5 states have criminalized assisted-suicide. The Wisconsin Pain Policies Studies Group issues grades regarding states' pain-policies. While Oregon & Washington both have high grades on their pain-policies, an OHSU study documented that **after 4 years of assisted suicide in Oregon there was a decline in end-of-life pain-control.** This doesn't prove that the pain-control decline was due to assisted suicide. At the same time, the data doesn't support the claim that legalization of assisted suicide improved care at the end-of-life" or for a patient, that signing up for assisted suicide will include more focused pain management. See
http://www.oregonlive.com/opinion/index.ssf/2008/09/assisted_suicide_conspiracy_an.html

A Paper, "Physician Assisted Suicide In Oregon – A Physicians' Perspective, by doctors at **Sloan Kettering Cancer Center**, Suicide Prevention International, NY Medical College opposes Physician-Assisted Suicide and confirms that since the law went into effect inadequate pain treatment increased. They wrote, "**A Study at the Oregon Health & Science Univ.** indicated that there has been a greater percentage of cases of inadequately treated pain in terminally ill patients since the Oregon law went into effect" See:
<http://www.michiganlawreview.org/assets/pdfs/106/8/hendinfoley.pdf>

Discussion: Also to be considered is that the decline in pain management may actually push some patients toward assisted suicide.

Notes:

In Oregon, Dr. Stevens and other good doctors have been working to expand palliative care in hospitals. Any improvements are due to their efforts, separate from PAS. PAS has had nothing to do with it.

It is important to know this because legislators may believe that patients who sign up for physician assisted suicide will be provided with best of care and pain management, and these practices will carry over to other patients. We see in Oregon, that this is not the case.

Dept of Health Reports Show Patients Ask for Suicide for Psychological & Quality of Life Reasons - NOT for Pain:

In Oregon and Washington, where assisted suicide is legalized, the Departments of Health (DOH) in both states collect statistics on why patients ask for suicide, which contradict the claims of promoters of PAS who say it is required for uncontrollable pain. They show that, year after year, patients who ask for PAS, do not ask for pain but for quality of life issues, In the four years, 2008 through 2011, they asked for suicide for these reasons -- recorded by the Dept of Health (DOH):

- loss of autonomy
- decreasing ability to participate in activities that made life enjoyable
- loss of dignity
- feeling like a burden

We need to ask what percentage of these cases might have been helped by aggressive psychiatric intervention or spiritual counseling?

Other reasons, provided by the patients and family members to family doctors center on anticipated fear which can be relieved through palliative care's multidisciplinary approach established by a national AMA training program for doctors across the nation since 2000.

- concern about the extent of pain to come as the disease progresses
- inadequate knowledge of other options
- perceived lack of value to loved ones and friends within inner circles and support systems
- perception of being a personal burden (requiring help from family and friends or a caregiver) or financial burden (using resources or depending on others for financial aid)

See:

2008:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year11.pdf>

2009:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year12.pdf>

2010:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year13.pdf>

2011:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf>

2012:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf>

For all Annual reports

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

From 1998, Just after Physician Assisted Suicide was Passed, Patient Referrals to Counseling Dropped Off

The Oregon Revised Statute: Under para. 127.800 s.1.0.1 Definitions (5), the definition for counseling calls for counseling for patients. It reads,

Counseling Defined:

The Death with Dignity (Physician Assisted Suicide) Document, defines "Counseling" for patients. "Counseling means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment". See:

<http://public.health.oregon.gov/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ors.aspx>

This is discussed in a "Position Statement opposing Physician-Assisted Suicide" that represents over 600 oncologists and Leading Medical Institutes :

Association of Northern California Oncologists &
Medical Oncology Association of Southern California
California Medical Association
American Medical Association
American College of Physicians
April 16, 2007

[http://dredf.org/assisted_suicide/Oncology%20Statement%20on%20AB%20374%20\(Berg\).pdf](http://dredf.org/assisted_suicide/Oncology%20Statement%20on%20AB%20374%20(Berg).pdf)

In their Position Statement doctors point out that they work with people with terminal diseases daily. They share a serious concern about an alarming decrease in patient "referrals for psychological evaluations that " decreased from 27% in 1998 to 5% in 2005".... They said, "*It seems implausible that over that same time period physicians prescribing lethal medications were 22% more capable of diagnosing depression or psychiatric illness.*"

Further, the Oregon Dept. of Health Annual Reports show these percentages dropped to almost no referrals in the years from 2009 to 2011. These facts show patients in any possible mental condition, including depression over their isolation or illness, are just simply terminated. Is this what we want for Connecticut residents?

- o In 2009 none of the 59 patients were referred for psychological or psychiatric help
- o In 2010 only one of 65 patients were referred
- o In 2011 only one of 71 patients were referred
- o In 2012 only two of 77 patients were referred

In summary, out of a total of 272 patients who died from 2009 - 2012, only 4 were referred. Links to the reports are below:

2009:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year12.pdf>

2010:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year13.pdf>

2011:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf>

2012:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf>

For all Annual reports

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

Attorney Thomas E. Dwyer Jr. and James C. King Massachusetts Lawyers Weekly

Attorney Dwyer and King point out that lacking referrals to a state licensed psychologist or psychiatrist, "The key decision point is the conversation between the treating or attending physician and the patient who wishes to hasten his death. The physician is bound to make the determination that the patient understands the nature of the request and is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. Since oncologists do not practice psychiatry, the opportunity for medical error resulting in a wrongful hastened death is very probable".

Attorney Catherine Foster expounds further:

Defenders of the bill contend that because it applies only to "a competent person," its provisions will be difficult to abuse. However, in saying this, they miss the fact that the person killing himself or herself takes "prescribed medication," which necessitates the involvement of a second party – a doctor. That opens the door for people, particularly those who depend on others in some way and are most in need of care and protection, to be influenced toward death. In fact, an article in the New York Times summarized that based on numerous studies of patients with severe, and in many cases, terminal illnesses, the reason for assisted suicide is rarely pain, or even fear of pain. Instead, patients have reported that their reason for killing themselves is "depression, hopelessness and fear of loss of autonomy and control. ... In this light, physician-assisted suicide looks less like a good death in the face of unremitting pain and more like plain old suicide." with most of these suicide-prone being unseen by qualified psychological or psychiatric doctors.

In the "Position Statement", doctors share the below deadly flaws in this law that ignore medical reality -- so serious, as to make this law inhuman as it stands.

- Only after months of visits would a psychologist or psychiatrist be able to reliably identify depression or other mental problems...

Department of Health Records show that most patients from 2008 to 2012 were not seen by a state licensed psychiatrist or psychologist at all. These patients were allowed to linger in mental distress for the duration of their illness and then were killed – this is like -- a death penalty and execution without a jury.

[Discussion: If we care about the vulnerable, we should not let ourselves believe that this will not happen in our hospitals. It happened in Oregon, even though Oregon is a showcase for this law.]

- Only 6% of Oregon psychiatrists are 'very confident' they can determine in a single visit when depression may be affecting decisions to commit assisted suicide in the absence of a long-term relationship".
- A person can be competent enough to understand the physician assisted suicide procedure and results, while still being depressed, or even have a more severe mental problem through psychosis. Being competent does not mean they are okay to be assisted to die.

[http://dredf.org/assisted_suicide/Oncology%20Statement%20on%20AB%20374%20\(Berg\).pdf](http://dredf.org/assisted_suicide/Oncology%20Statement%20on%20AB%20374%20(Berg).pdf)

Discussion: To adjust the law -- to reduce the risk of needlessly ending lives prematurely -- patients would have to be required to first establish a relationship with a psychiatrist or psychologist for at least several months before being approved.

[Note: If their prognosis of the disease and six months to live is correct, they will have to rely on palliative care for pain management, while at the same time receiving some genuine and skilled mental help. If the prognosis is not correct, and patients live longer than the six months predicted, they will have the required time to receive mental help they need.]

Nevertheless, lives can still be lost needlessly through an erroneous prognosis of only six months to live (see below paragraphs). It seems to me, as Chairperson of the CT Right to Life, this is a law that cannot protect patients enough and should not be enacted.

A Six Month Prognosis to Live – More Often Wrong -- 5 Testimonies, 3 Case Studies

Promoters say PAS is only for people who with a six month prognosis and who will die ANY WAY. Not true.

Testimony 1:

"Position Statement on Physician-Assisted Suicide and Opposition to AB 374" by doctors at:
Association of Northern California Oncologists &
Medical Oncology Association of Southern California
California Medical Association
American Medical Association
American College of Physicians
April 16, 2007
[http://dredf.org/assisted_suicide/Oncology%20Statement%20on%20AB%20374%20\(Berg\).pdf](http://dredf.org/assisted_suicide/Oncology%20Statement%20on%20AB%20374%20(Berg).pdf)

This position statement, represents the medical experience and opposition to physician assisted suicide by over 600 oncologists. Because these doctors work with people with terminal diseases daily, their professional recommendations on this issue are reliable. Here are excerpts:

Physicians are wrong about a given patient's prognosis "more often" than they are right. A consulting physician who examines the patient and reviews the medical records is prone to the same errors in judgment that the attending physician may make when faced with the same data.

Two doctor opinion can also be wrong. Despite skill and experience, physicians often make errors in estimating a patient's prognosis, not because of a lack of information, but because new information (test results, observations of interventions, etc.) comes to light.

As oncologists, every week in our practices we see patients surviving many months or even years longer than originally estimated because of variability in disease manifestations or unanticipated benefits from treatment, and we rejoice with our patients in these "errors."

The National Cancer Institute agrees and explains, in a fact sheet, "End of Life Care for People Who Have Cancer", that there are variables such as type of cancer, its location, and whether the patient has other illnesses. They say, doctors can only "estimate" the amount of time a patient has to live.

However, patients who do not realize this, may stop treatment to prolong life or cure, and worse yet, may sign up for assisted suicide. These doctors say,

But if our prognosis were wrong in regards to a patient choosing a lethal ingestion, the patient pays the ultimate penalty - Section 7196.2.

Testimony 2:

The National Cancer Institute agrees and explains, in a fact sheet, "End of Life Care for People Who Have Cancer", that there are variables such as type of cancer, its location, and whether the patient has other illnesses. They say, doctors can only "estimate" the amount of time a patient has to live.

Testimony 3:

Dr. Stuart Farber,
Head of palliative care at
the University of Washington Medical Center,

"Even when applying the rigid criteria for hospice eligibility, doctors often get it wrong, according to Nicholas Christakis, a professor of medicine and sociology at Harvard University and a pioneer in research on this subject. Note: As a child, his mother was diagnosed with Hodgkin's disease. "When I was six, she was given a 10 percent chance of living beyond three weeks," he writes in his 2000 book, *Death Foretold: Prophecy and Prognosis in Medical Care*. "She lived for nineteen remarkable years...I spent my boyhood always fearing that her lifelong chemotherapy would stop working, constantly wondering whether my mother would live or die, and both craving and detesting prognostic precision."

Testimony 4:

Attorney Thomas E. Dwyer Jr. and James C. King, Massachusetts
Massachusetts Lawyers Weekly

- "In order to qualify for assisted suicide, the language of the initiative requires that a patient be suffering from a terminal illness, defined as a disease that "will, within reasonable medical judgment, produce death within **six months**."
- "While a time-delimited prognosis may seem like a sound medical determination, the fact that **only 20 percent of patients die when their physicians predict** renders the six-month requirement arbitrary and unworkable".
- "**Studies indicate that 13 to 17 percent of patients outlive their physicians' expectations**, raising concerns that some patients who obtain lethal medication may have months or years of life beyond their erroneous prognoses".
- "The practice is fundamentally different from a patient's refusal of unwanted life-sustaining treatment and from a physician's use of opioids to relieve a patient's pain — rights already secured to patients nationwide under the Constitution and in tort.

To transmute those recognized rights into a right to assistance in suicide would be to abandon a long-standing distinction critical to legal and ethical decision-making.

Testimony 5:

Attorney Margaret Dore, in her article, "Physician Assisted Suicide: A Recipe for Elder Abuse and the Illusion of Personal Choice" confirms that "Doctor prognoses can be wrong", and further points out that "**Treatment can lead to recovery**. Oregon resident, Jeanette Hall, who was diagnosed with cancer and told that she had six months to a year to live, states:

"I wanted to do our law and I wanted my doctor to help me. Instead, he encouraged me to not give up and ultimately I decided to fight. I had both chemotherapy and radiation ... It is now nearly 10 years later. If my doctor had believed in assisted suicide, I would be dead".

Discussion: It is easy to wonder here **why physician assisted suicide is needed** if patients already have the right to stepped palliative care that includes end-of-life sedation to unconsciousness combined with mental help and the right to refuse unwanted life-sustaining treatment.

Below is Jeanette Halls and two other well publicized examples of patients who lived years longer than the six month prognosis and gave their oncologists reasons to rejoice!

Case Study: Maryanne Clayton

In Oregon, two doctors must say a patient has six months or less to live before suicide medication can be prescribed. Maryanne was diagnosed with Stage IV lung cancer and given two to four months to live. The tumor metastasized up her spine. She sought treatment from Dr. Renato Martins, a lung cancer specialist at Fred Hutchinson Cancer Research Center, started with radiation, participated in the clinical trial of a new drug called pemetrexate and then went on a world tour with her son. <http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/>

Case study: Jeannett

Kenneth Stevens, MD Sherwood, Ore.

"At our first meeting, Jeanette told me that she did not want to be treated, and that she wanted to opt for what our law allowed – to kill herself with a lethal dose of barbiturates.

I did not and do not believe in assisted suicide. On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated, and her cancer was cured. Five years later she saw me in a restaurant and said, "Dr. Stevens, you saved my life!" See: http://www.ravallirepublic.com/news/opinion/mailbag/article_34acbde8-3686-11e2-b260-0019bb2963f4.html

Case study: Ted Kennedy – by Victoria Reggie Kennedy

When diagnosed with cancer, his prognosis was that he only had 2-4 months to live. The prognosis was wrong. He lived 15 more productive months.see

Mrs. Kennedy adds: "My husband used to paraphrase H.L. Mencken: for every complex problem there is always an easy answer. And it's wrong. That's how I feel about this case. See <http://bostoncatholicinsider.wordpress.com/2012/10/31/kennedy-widow-says-no-on-assisted-suicide/>

In Oregon, State Healthcare Plan Refused Treatments based on Cost & Instead Offered Physician Assisted Suicide

- o Could Pressure Poorer Patients to Sign Up for Suicide
- o Could trigger State Healthcare Plans to Refuse Treatments to Cure or Prolong Life

Some terminally ill patients in Oregon who turned to their state for health care were denied treatment and offered physician-assisted suicide instead, a proposal some experts have called a "chilling" corruption of medical ethics.

Case Study: Barbara Wagner -

The Oregon Health Plan did not support the required treatment to prolong life. It did support PAS. Barbara appealed the verdict twice, and lost twice, even though a representative from the company that manufactures the treatment called the cancer patient to say they would give her the medication for free. See:

<http://www.lifesitenews.com/news/archive//ldn/2008/jun/08060402>

See video at <http://www.mofopolitics.com/2009/08/03/video-oregon-says-no-to-chemotherapy-offers-doctor-assisted-suicide/>

Case Study: Randy Stroup

Randy Stroup who had prostate cancer was also offered doctor-prescribed suicide by the Oregon Health Plan. Read his story at:

Physician Assisted Suicide Law & Procedures -- Ignore Key Medical Facts

Medical Fact 1 –

Palliative doctors have been successfully helping patients to avoid pain for decades.

Since 2000, the AMA and medical societies across the nation have been preparing to better address quality of life issues with patients through an improved form of palliative care that includes multidisciplinary patient caring, and by improving pain management technologies to the extent that a terminal or dying person should not feel pain.

Further, Dr. Gomez, M.D., AMA says, "We now have lots of documented evidence that AMA's aggressive drug regimen can effectively protect dying patients from pain. Doctors won't have any trouble prescribing medication if they are careful and document their actions."

The American Medical Association in its Opinion 2.211 Column, entitled "Physician Assisted Suicide", reported that "Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication."

...and summing it up, the AMA says, "There is, in short, compelling evidence of the need to ensure that all patients have access to quality palliative care, but not of any need for physician-assisted suicide. For the whole report, see <http://www.pregnantpause.org/euth/amagomez.htm>

The below report and testimony clearly explains the advantages of palliative care rather than physician assisted suicide. They discuss the form of palliative care offered by the AMA and other leading medical associations vs. the type introduced by promoters of physician assisted suicide to various states.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 5-A-08, Subject: Sedation to Unconsciousness in End-of-Life Care, Presented by: Mark A. Levine, MD, Chair. For additional information see: <http://www.ama-assn.org/resources/doc/code-medical-ethics/2201a.pdf>

Nurse Eva Cestari, West Haven, also testifies: The American Medical Association has taken a strong position against PAS legislation, citing that pain management is available for the dying person in pain. I can attest to this in the situation of my husband throughout his illness, and especially in his last days. Pain management was compassion-motivated, readily available, precise, and effective.

Discussion: In evaluating palliative care programs -- beware.

In some states in the United States promoters of assisted suicide are also proposing a form of palliative care that includes aspects of physician assisted suicide. For example,

through forms signed by unsuspecting and vulnerable patients, they unwittingly agree to go without food and water to rush death. They are taking the right to refuse unwanted excessive medical treatment at end-of-life to include life sustaining food and water.

- **Dangers of Living wills** -- Living wills are distributed to hospitals for patients to sign. The American Life League provides ample information on the dangers of living wills that can result in shortened lives and death, when patients or their families are offered the option to stop food and water – which is happening. <http://catholicexchange.com/a-living-will-is-not-about-living/>
- The Connecticut Right to Life has been educating its members through speakers on these topics at its Annual advising members of dangers and the need to use advance directives other than the Living Will -- The American Life League provides a Loving Will, the USCCB provides advanced directives customized for Connecticut, and the Patients Rights Council provides directives customized for each state. <http://www.patientsrightscouncil.org/site/do-you-need-an-advance-directive/>
- **Other types of euthanasia being introduced in America** Attorney Rita Marker, the Patients Rights Council, provides information on other forms and other types of euthanasia being introduced in America. See <http://www.patientsrightscouncil.org/site/polst/> and <http://www.patientsrightscouncil.org/site/medical-orders-for-life-sustaining-treatments-molst-forms/> including the Medical Order for Life Sustaining Treatment (MOLST), Physicians Order for Life- Sustaining Treatment (POLST), Voluntarily Stopping Eating and Drinking (VSED), and Physician Assisted Dying (PAD).

This is imposed death -- it is assisted suicide in a different form with similar ramifications.

Medical Fact 3:

The National Alliance on Mental Illness has repeatedly said “suicide is almost always the result of untreated or under-treated mental illness”.

In the absence of pain, it would have been reasonable to expect all patients who ask for suicide to be seen by a psychologist or psychiatrist to sort out the cause of their request – whether it is depression, feeling like a burden, isolation from loved ones, being coerced by heirs, or other. Yet, in Oregon this has been the practice except in 4 cases over 4 years. Also, no action has been brought to amend the law to include ‘severe penalties’ for doctors who neglect to properly refer patients for psychological or psychiatric help when they ask for suicide assistance.

Medical Fact 4:

The AMA and leading medical societies oppose physician assisted suicide.

The AMA says, “Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.”

<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.shtml>

In their Position Statement, representing over 600 oncologists, the AMA with the Association of Northern California Oncologists & Medical Oncology Association of Southern California, California Medical Association, and American College of Physicians doctors clearly communicate:

We should not give up on these patients, who have a six-month prognosis to live (called terminal), because we know that physicians are wrong about a given patient's prognosis "more often" than they are right.
[http://dredf.org/assisted_suicide/Oncology%20Statement%20on%20AB%20374%20\(Berg\).pdf](http://dredf.org/assisted_suicide/Oncology%20Statement%20on%20AB%20374%20(Berg).pdf)

Medical Fact 4:

It is clearly stated that a prognosis by two doctors does not protect the patient from a mistake - in the Position Statement, representing over 600 oncologists from six major medical associations.

"A consulting physician who examines the patient and reviews the medical records is prone to the same errors in judgment that the attending physician may make when faced with the same data." See:
[http://dredf.org/assisted_suicide/Oncology%20Statement%20on%20AB%20374%20\(Berg\).pdf](http://dredf.org/assisted_suicide/Oncology%20Statement%20on%20AB%20374%20(Berg).pdf)

Medical Fact 5:

Nurse Eva Cestari, West Haven, shares: "The availability of well-established Hospice care facilities ensures completely humane end of life care, involving the patient and his family, with appropriate pain management and very gratifying outcomes overall, even though a patient is terminally ill and dying. This level of care is readily available throughout Connecticut".

Discussion: Physician assisted suicide does not actively acknowledge the value of other alternatives -- over 600 oncologists from six major medical associations, in their "Position Statement", pointed out that pro-suicide doctors just go through the motions of referring patients. See:
[http://dredf.org/assisted_suicide/Oncology%20Statement%20on%20AB%20374%20\(Berg\).pdf](http://dredf.org/assisted_suicide/Oncology%20Statement%20on%20AB%20374%20(Berg).pdf)

One could see the ignoring of these facts as:

- o derailing other alternatives and
- o "imposing" of their solution on patients.

If this law cannot be managed to respect and co-exist with other medical alternatives, perhaps your committee should just let it die. Were it able to co-exist properly with other alternatives, this would have done, monitored, and enforced in Oregon. It was not.

Physician Assisted Suicide – Laws & Procedures **Ignore Key Legal Facts**

Legal Fact 1:

In response to a law suit by two doctors, in June – 2010, Connecticut, Superior Court Judge Julia Aurigemma, countered their artificial definitions and arguments (that physician assisted suicide is a medical treatment), confirmed that “Assisting a suicide, even for humanitarian reasons, is a crime” and discussed the severe consequences to Connecticut if such a bill is passed.

Legal Fact 2:

Connecticut, Superior Court Judge Julia Aurigemma warned that, “the legislature would have to consider the ramifications of legalizing physician-assisted suicide” including

- how assisted suicide, “threatens the most vulnerable in society;”
- incentivizes physicians and insurers “away from vitally important tasks such as identifying and TREATING DEPRESSION and providing end-of-life pain control and palliative care;”
- compromises “the physician-patient relationship and the integrity of the medical profession;” and
- even may open up the possibility of “involuntary euthanasia,” which has been documented in the Netherlands.

Legal Fact 3:

“The 2010 trial in Connecticut, which was widely publicized, set a powerful precedent that ‘aid in dying’— as defined and advocated by suicide proponents — is, in fact, ‘suicide’ (as the law and the American public understand the term).

- The public here in Connecticut understand it is suicide -- which includes the youth and adults who are suicide prone.
- If PAS becomes law, the perception by the many will be that suicide is now legal/acceptable.

Discussion: How then can we then, under this regime, decrease suicides in Connecticut by decreasing the stigma on mental illness and suicide tendencies, providing easy access, and encouraging people to sign up for treatment if – in the same state -- we call suicide a medical treatment and assist patients to suicide for psychological reasons and quality of life issues and/or for pain that can be more caringly treated through palliative care?

How many people with mental health problems would trust the hospital or their doctors enough to reach out for mental help for themselves? How many would be helped to place a high value on their lives – to avoid suicide?

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf>

We need to ask ourselves what do we want for Connecticut residents and hospitals – real dignity or a poor substitute.

This law cannot be managed to respect life and alternatives, best to let the bill die.

Physician Assisted Suicide -- Opportunities for Patient Coercion/Abuse, Especially Elders

Attorney Thomas E. Dwyer Jr. and James C. King, Massachusetts
Massachusetts Lawyers Weekly

"Participation in the process of assisted suicide should be "entirely voluntary on the part of all participants," the initiative lacks adequate protections against undue pressure or coercion" by physicians, care givers, or family.

While under the provisions of the initiative, a patient's request for lethal medication must be made voluntarily; the patient need not initiate the discussion. Physicians are responsible for presenting treatment options, and **patients typically follow their physicians' recommendations.**

Thus, if a physician presents assisted suicide as an appropriate option, some patients will defer to the physician's judgment.

Pressure may be brought to bear from one who stands to benefit from the patient's death, as, in accordance with the initiative,

- a beneficiary may serve as one of two testamentary witnesses supporting the patient's written request for assisted suicide.
- Moreover, if the beneficiary is a person "familiar with the patient's manner of communicating," then the beneficiary is also qualified to speak for the patient in making an oral request for assisted suicide.
- Such provisions invite abuse, as does the total absence of oversight after the lethal medication is prescribed.
- That is, there is no requirement that a "disinterested person" be present when a patient ingests the fatal medication; that a physician monitor the dying process; and/or that someone ensures that the dose was indeed self-administered, as the initiative requires, and not forced on the unprotected patient.

Attorney Margaret Dore –

Washington State Bar Association - does a good job of pointing out the discrepancies between our understandings, the literature promoting assisted suicide, and the actual laws which have built-in opportunities for abuse of vulnerable patients.

Attorney Dore points out how it is that patients who sign up for assisted suicide do not have the rights to the laws they believe.

For example, she says, "A misleading term is "self administer" – see below for her discussion.

"Self-administer" Does Not Necessarily Mean that a Patient Administers the Lethal Dose to Himself

The Act does not state that "only" the patient may administer the lethal dose.[10]
The Act instead provides that the patient "self-administer" the dose.[11] In an

Orwellian twist, the term "self-administer" does not mean that administration will necessarily be by the patient. "Self-administer" is instead defined as the act of ingesting. The Act states:

"Self-administer" means a qualified patient's act of ingesting medication to end his or her life (Emphasis added). RCW 70.245.010(12).

In other words, someone else putting the lethal dose in the patient's mouth qualifies as "self-administration."[12] Someone else putting the lethal dose in a feeding tube or IV nutrition bag would also qualify.[13] "Self-administer" means that someone else can administer the lethal dose to the patient.

In summary, someone other than the patient is allowed to administer the lethal dose. The Act contains no requirement that the patient be competent or even aware when the lethal dose is administered. There is no requirement that the patient consent when the lethal dose is administered.

Intentionally killing an incompetent person, or intentionally killing some other person without his consent, is homicide.[14] The Act, however, allows this result, as long as the action taken is according to the Act. The Act states:

Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. (Emphasis added). RCW 70.245.180(1).

The Right to Rescind Is Not a Substitute for Requiring Consent

The Act's proponents may counter that consent is actually required because patients have a right to rescind a request for the lethal dose "at any time."[15] A right to rescind is not the same thing as a right to consent when the lethal dose is administered. Consider, for example, an incompetent or unaware patient who obtained the lethal dose on a "just-in-case basis" and has not consented to taking it. He would not have the ability to rescind because he is incompetent, sedated, or simply sleeping. Without the right to consent, someone else would, nonetheless, be free to administer the lethal dose to him. Without the right to consent, the client's control over the "time, place, and manner" of his death is an illusion.

No Witnesses at the Death

If, for the purpose of argument, the Act does not "allow" a patient's death without consent, patients are, nonetheless, unprotected from this result, due to the lack of required witnesses at the death. Without witnesses, the opportunity is created for someone other than the patient to administer the lethal dose to the patient without his consent. Even if he struggled, who would know? The lethal dose request would provide the alibi. This scenario would seem especially significant for patients with money. A California case, *People v. Stuart*, 67 Cal Rptr. 3rd 129, 143 (2007), states: "Financial reasons [are] an all too common motivation for killing someone...."

No Liability for Administration Without Consent

Proponents may counter that the Act protects patients from wrongdoing due to

provisions imposing civil and criminal liability in RCW 70.245.200. None of these provisions purports to prohibit administration of the lethal dose without the patient's consent. These provisions are instead concerned with the lethal dose request and general issues.[16]

Illusory Liability for Undue Influence

In connection with the lethal dose request, the Act purports to impose criminal liability for undue influence.[17] This purported liability is illusory because the concept of undue influence is too vague to be criminally enforced. (See *City of Tacoma v. Luvene*, 118 Wn.2d 826, 844-5, 827 P.2d 1374 (1992) (citizens must be given clear notice of prohibited conduct); and *Mays v. State*, 116 Wn. App. 864, 876, 68 P.3d 1114 (2003) (statute unconstitutionally vague where "reasonably intelligent people must guess as to its meaning").) As noted above, the Act specifically allows conduct that would normally create a presumption of undue influence (allowing an heir to act as a witness on the lethal dose request form). In addition, the Act's prohibition against undue influence is not defined and has no elements of proof.[18] Undue influence is also a traditionally equitable concept, which is "not susceptible of precise definition and must depend heavily on the facts of each case." [19] What elements would a prosecutor be required to prove for the purported "crime" of undue influence? It's hard to say.

Official Cover

In the event anyone questions a patient's death, a meaningful response from law enforcement, generally, seems unlikely. This is because medical examiners, coroners, and prosecuting attorneys are required to treat deaths under the Act as "natural." [20] The death certificate

Hippocratic Oath

WITH NO WAY TO CONFIRM whether patients had actually asked for assisted suicide on their own or whether there were undue influences from family, doctors or a desire "Not be a burden", (which they are unlikely to admit or even recognize if dementia is present), the risk is too high.

"Wait Times" between Time of Ingestion & Time of Death – 4 minutes to 48 hours – Some regain Consciousness

In the position statement representing over 600 oncologists, it says "**Between 1998 and 2005, the time between ingestion and death ranged from four minutes to 48 hours**".

"It is hard not to imagine what those patients who required 48 hours to die might have experienced -- suffering over and above that brought on by the terminal illness".

Indeed, this has been the experience in the Netherlands, with a report from 2000 showing that so called "problems with completion" (a longer than expected time to death, failure to induce coma, or induction of coma followed by awakening of the

patient) occurred in 16% of cases, prompting physician intervention 18% of the time, which of course blurs the line considerably between suicide and euthanasia".

A shame, when stepped palliative care would relieve pain as it grows in a kind way. Physician assisted suicide intrudes on palliative care and tries to replace it with patient death.

By 2012, things had not improved in Oregon. The 2012 Oregon Dept of Health Annual Report says, " A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for 11 deaths during 2012". In 2012, "**Among those those patients, time of ingestion to time of death ranged from 10 minutes to two days**".... The DOH Annual Report reads, " Of the 115 patients for whom Death With Dignity DWDA prescriptions were written during 2012, 67 ingested the medication; 66 died from ingesting the medication, and one patient ingested the medication but regained consciousness before dying of underlying illness and is therefore not counted as a DWDA death. The patient regained consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion."..."Fourteen of these patients died, but follow-up questionnaires indicating ingestion status have not yet been received".
<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf> - page 6

(Can you imagine, the pains of an improperly digesting an overdose of drugs. What would we be subjecting our patients to?)

Attorney Catherine Foster, Litigation Counsel, Alliance Defending Freedom

<http://www.christianpost.com/news/conn-lawmakers-consider-letting-doctors-assist-with-suicide-90318/#vp2LMRjuuyxIVkXJ.99>

Attorney Foster confirms that "Lethal doses administered for suicide are not always sufficient for the task. This has been proven in countries like the Netherlands, where doctor-prescribed death has been allowable for some time. The New York Times lists some of the ways an assisted suicide can "go wrong". Patients...don't take enough pills. They wake up instead of dying. Patients in [a study from the Netherlands] vomited up their medications in 7 percent of cases; in 15 percent of cases, patients either did not die or took a very long time to die – hours, even days; in 18 percent, doctors had to intervene to administer a lethal medication themselves, converting a physician-assisted suicide into euthanasia.

She adds that, "This kind of legislation also lends itself to sloppiness on the part of doctors – after all, a patient whom you help kill is not going to be around to complain about pain, abuse of informed consent, or any of the other steps you took – or didn't take – along the way.

Leading us to a column in the Hartford Courant by **Peter Wolfgang**, that shared, "Contrary to the image of peacefully resting in a chair or bed, surrounded by loved ones, after ingesting drugs prescribed by a trusted physician, the reality of physician-assisted suicides can be grim. Accounts of frantic relatives calling 911, hospitalization, vomiting and choking, panic attacks, terror and drug-induced assaultive behavior during physician prescribed (and unattended) suicides have all been documented in the New England Journal of Medicine and other publications...There are many compassionate alternatives". http://articles.courant.com/2013-01-11/news/hc-op-wolfgang-false-promise-assisted-suicide-1216-20130111_1_lethal-doses-physician-suicides

"To what fate" Attorney Foster asks, "Are we subjecting the weakest of Connecticut citizens when well-intentioned advocates portray drugs as an easy street to ending difficulty and pain?"

The form: "**REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER**" states, "I further understand that most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility". The form does not state that it can take much longer than three hours and even up to two days and that the patient can regain consciousness ("*nondisclosure of information*"). See: <http://public.health.oregon.gov/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ors.aspx> - last page

How will family members hurt from this knowledge? What will this do to hospital/doctor ratings in the community?

Notes:

Allowing physician intervention without an objective witness, would invite opportunity for euthanasia in Connecticut.

To Avoid Completion Problems: In most cases, problems with completion are due to the patient's resistance to the drug used. This is not something that can be controlled, unless PAS doctors were to test the drug beforehand by gradually introducing it to the patient in ever increasing doses, and in doing that they would actually be duplicating what palliative care doctors are already doing.

PAS – Could Jeopardize Hospital Rankings

In relocating from other states, a major consideration for, companies and families is the rankings of hospitals, right along with jobs, housing and living costs, quality of schools and students graduating.

Hospital rankings – are not only about curing or prolong life, they are also about how patients are treated.

In a paper called, "**Physician Assisted Suicide In Oregon – A Physicians' Perspective**", by Sloan Kettering Cancer Center (who won a #2 rating among 900 hospitals by U.S. News Report), with Suicide Prevention International, and NY Medical College oppose a physician assisted suicide in the best interests of patients.

In this paper, doctors say, "The Oregon law seems to require reasonable safeguards regarding the care of patients near the end of life, which include presenting patients with the option for palliative care;

- ensuring that patients are competent to make end of life decisions for themselves;
- limiting the procedure to patients who are terminally ill;
- ensuring the voluntary nature of the request (no coercion);
- obtaining a second opinion on the case,
- requiring the request to be persistent, ie, made a second time after a two week interval;

- encouraging the involvement of the next of kin; and
- requiring physicians to inform OPHEd of all cases in which they have written a prescription for the purpose of assisted suicide.

The evidence strongly suggests that these safeguards are being circumvented in ways that are harmful to patients”

As an example, they say that physicians are required to indicate that palliative care and hospice care are feasible alternatives, but “they are not required however to be knowledgeable about how to relieve physical or emotional suffering in ...without such knowledge, which most physicians do not have, they cannot present or make feasible alternatives available. Nor in the absence of such knowledge are they required to refer the patient to a physician with expertise in palliative care... In the absence of adequate monitoring, the focus shifts away from relieving the distress of dying patients considering a hastened death to meeting the statutory requirements for assisted suicide. Physicians can merely go through the motions of presenting the possibility of palliative care for their patients”.

To be helpful, these doctors point out the “Palliative Care Alternative”: They report, “The difference it makes if a cancer patient is seen by someone who has experience in providing palliative care is suggested by the following excerpt from a letter written by a practicing oncologist in response to the law. As a practicing gynecologic oncologist in Portland Oregon, where physician assisted suicide is legal, I informed patients of my views by having a clear statement, based on the Hippocratic Oath posted in my waiting room. This reassured most patients, however, I had two patients who objected. The first was afraid that I would prolong her life beyond her wishes. This conversation helped me to meet her needs and she had a peaceful, comfortable death at home with her family. The second patient wanted me to prescribe lethal medications in case her cancer pain became unbearable. Prior to this conversation, she had been minimizing her pain. **This conversation allowed us to work together to better control her pain, after which her desire for assisted suicide disappeared.** She died comfortably and naturally two months later”.

They further say, that **“A Study at the Oregon Health & Science Unv indicated that there has been a greater percentage of cases of inadequately treated pain in terminally ill patients since the Oregon law went into effect”**

For more information: <http://www.michiganlawreview.org/assets/pdfs/106/8/hendinfoley.pdf>

Connecticut’s Hospital Rankings – Average without Physician Assisted Suicide Weak Patient Safeguards

U.S. News Report, out of 900 hospitals surveyed in 2012, Yale New Haven is the only Connecticut hospital that ranked nationally in the top 50 with a score of #35

Whereas in Massachusetts, Dana Farber ranked #5, Massachusetts General Hospital ranked #7, and Beth Israel, Bringham & Women’s Center, and Deaconess Medical Center ranked in the top 50.

Other nearby states that also had multiple top 50 ranking hospitals include Pennsylvania and New York which included New York’s well known Sloan Kettering ranking #2, NY Presbyterian University Hospital ranking #17, and NY Langone Medical Center ranking #30. More at: <http://health.usnews.com/best-hospitals/rankings/cancer>

And, though in the top 50, Yale New Haven' s success at "Keeping Patients Safe" scored low:

Preventing deaths from treatable complications = limited
Preventing collapsed lung after surgery = limited
Preventing major bleeding after surgery = moderate
Preventing incisions from reopening after surgery = moderate
Preventing accidental injuries during surgery = limited
<http://health.usnews.com/best-hospitals/area/ct/yale-new-haven-hospital-6160400/cancer>

CT Post reports that a dozen hospitals in Connecticut –

Including Bridgeport Hospital, Milford Hospital and Yale-New Haven Hospital -- received a "C" on safety issues in a ranking system released Wednesday by a patient advocacy group... The nonprofit Leapfrog Group, run by employers and other large purchasers of health benefits, released its Hospital Safety Score, which gives hospitals a letter grade based on their performance on 26 hospital safety measures.

To read more:

<http://www.ctpost.com/local/article/Rankings-give-12-Connecticut-hospitals-C-in-3614838.php#ixzz2LlcWS3An>

To Lower Healthcare Costs, Ignore Assisted Suicide & Plan to Lower Preventable Medical Errors.

American Association of Justice: According to the Department of Health and Human Services, about 100,000 Americans die every year from **preventable errors in hospitals**, at **cost of \$29 billion**.

...Preventing medical errors will lower health care costs, reduce doctors' insurance premiums, and protect the health and well-being of patients, and improve hospital rankings. Even errors that the government and private health insurers have classified as "**never events**," events that should never happen in a hospital, are occurring at alarming rates. Recently the Joint Commission Center on Transforming Healthcare reported that as many as **40 wrong site, wrong side and wrong patient procedures happen every week in the U.S.**⁸

...The Institute of Medicine's (IOM) seminal study of preventable medical errors confirms that an as many as 98,000 people die every year **at a cost of \$29 billion**.¹

If the Centers for Disease Control were to include preventable medical errors as a category, these conclusions would make it the **sixth leading cause of death in America**.²

Further research has confirmed the extent of medical errors. The Congressional Budget Office (CBO) found that there were **181,000 severe injuries** attributable to medical negligence in 2003. The Institute for Healthcare Improvement estimates there are 15 million incidents of medical harm each year.⁴ HealthGrades, the nation's leading healthcare rating organization, found that **Medicare patients who experienced a patient-safety incident had a one-in-five chance of dying as a result**.⁵

In the decade since the IOM first shined a light on the dismal state of patient safety in American hospitals, many proposals for improvement have been discussed and implemented. But recent research indicates that there is still much that needs to be done.

Researchers at the **Harvard School of Medicine** have found that even today, about **18 percent of patients in hospitals are injured** during the course of their care and that many of those injuries are life-threatening, or even fatal.⁶ The Office of the Inspector General of the U.S. Department of Health and Human Services found that one in seven Medicare patients are injured during hospital stays and that **adverse events during the course of care contribute to the deaths of 180,000 patients every year.**⁷

...Much of the discussion surrounding medical negligence revolves around costs, whether it be the cost of physicians' insurance or the cost to health care. While these are the subject of much debate and acrimony, the potential savings from the elimination of medical errors are undeniable.

People have been led to believe that there are hundreds of thousands of medical negligence lawsuits every year and only a handful of genuine medical errors. In reality, the reverse is true. There are very few medical negligence lawsuits, and hundreds of thousands dying from preventable medical errors. As University of Pennsylvania law professor Tom Baker puts it, "We have an epidemic of medical malpractice, not of malpractice lawsuits."¹¹ Dollars better spent on patient safety

The **Center for Medicare & Medicaid Services (CMS)** has, in recent years, recognized the potential for financial savings by reducing medical errors. CMS has stopped paying for hospital and practitioner errors, and thus created a financial incentive for hospitals to embrace patient safety. After evaluating a number of billable hospital-acquired conditions, CMS and the CDC decided on eight expensive but "reasonably preventable" secondary conditions that would not be reimbursed by Medicare, and could not be billed to patients.¹²

Previously, Medicare *rewarded* hospital errors with larger reimbursements, by paying them an extra amount to treat various preventable complications that developed as a result of hospital negligence.

The new rules, which went into effect in 2008, are expected to save taxpayers at least \$21 million annually and will encourage hospitals to take steps to avoid "reasonably preventable" hospital acquired conditions.¹³ Private insurers like Blue Cross/Blue Shield Association and Aetna have also implemented similar policies not to reimburse medical providers for care related to problems or complications that should not occur in the normal course of hospitalization.¹⁴

<http://www.justice.org/cps/rde/justice/hs.xsl/8677.htm>

Discussion: Recommendation for Connecticut Hospitals and Legislators: To Lower Healthcare Costs, Ignore Assisted Suicide & instead Plan to Lower Preventable Medical Errors.

Legal Contradictions/Confusion/Battles -- With Families Caught in the Middle -- Example, Life Insurance

For example, consider life insurance policies.

In Massachusetts, Attorney Dwyer says, "Traditionally, Massachusetts has upheld life insurance provisions that purport to limit the policy payout solely to premiums paid in the event of suicide by the insured within a contractually set period of time. Based on the initiative, an insured with a policy executed before Jan. 1, 2013, who ends his life through the acts allowed by the proposed legislation, would legally be considered to have committed suicide, and his policy beneficiary's benefits would be limited to premiums paid by operation of the suicide clause...."

A very different result occurs for an insured who ends his life through the same acts, but has a policy executed after Jan. 1, 2013. That insured would not, legally, be considered to have committed suicide, and the identical policy suicide clause would be inapplicable, entitling the insured's beneficiaries to full benefits"

"Such drastically different results would lead to confusion and uncertainty for the general population, which likely would be unaware of either the change in the law regarding the definition of suicide or the magnitude of possible implications for the policy benefits".

Discussion: Another consideration -- if a physician assisted suicide law is enacted, whose responsibility is it to arrange of life insurance benefits for the families of patients who die under a doctor's care from physician assisted suicide patients -- the promoters of PAS, state government, private business?????

Will life insurance companies comply and cover such a death, as they cover deaths from palliative care, or will they, deny benefits based on arguments in Connecticut in 2010 by Judge Julia Aurigemma, who rejected artificial definitions and arguments (that physician assisted suicide is a medical treatment), confirmed that "Assisting a suicide, even for humanitarian reasons, is a crime", and discussed the severe consequences to Connecticut if such a bill is passed specifying explicitly "that 'aid in dying'— as defined and advocated by suicide proponents — is, in fact, 'suicide' (as the law and the American public understand the term).?????"

Physician Assisted Suicide – Rejected by Other States 121 Times!

Only two states have legalized assisted suicide. This is not a big enough trial for CT to take a chance with such a law.

If they did not want it why should we??? Our national, medical, and parenting traditions against suicide have served us well. For this reason, attempts to enact physician assisted suicide laws, since 1991, in states other than Oregon and Washington, have failed **121 times**.

For example, there were 6 ballot initiatives or attempts to legalize PAS in California, 6 in New Hampshire and 6 in Rhode Island, 9 in Arizona, 12 in Vermont, 14 in Hawaii, so on up to 121 failed attempts! See <http://www.patientsrightscouncil.org/site/failed-attempts-usa/>

Clearly, this is not a trend as promoters of PAS would have us believe.

This PAS bill is a hot potatoe that other states have rejected. If they don't want it, why should we. Connecticut is not a test bed for bad laws, which would certainly bring unwanted ramifications.

Testimony

Eileen Bianchini, Chair, CT Right to Life Corporation
203 451-0384

Public Health Committee Hearing,
March 20, 2013

Physician Assisted Suicide HB 6445
Legislative Office Building, Rm 1D

Testimony - 4 Pages

In 2010 Superior Court Judge Julia Aurigemma rejected an attempt to legalize physician assisted suicide at that time. She warned that if, at some time in the future, a bill is proposed, "the legislature would have to consider the ramifications of legalized physician-assisted suicide" to patients and to the state. My talk focuses on this.

An attachment provides detail, links to sources of information, and shows associated case studies.

There are concerns regarding the statistics, reports and information coming out of Oregon, which is the model state for this law. The data indicates this is not what we need or should want for Connecticut or our people.

- **Since Oregon implemented assisted suicide, state suicide rates have climbed year after year and as of 2010 were 41% higher than the national levels (not including patients who died through physician assisted suicide). How can a state call suicide a "medical treatment" and effectively lower suicide rates at the same time. **For teens in Oregon, suicide is the second leading cause of death** (not the third as it is for the nation).**
- **Physician assisted suicide doctors and medical consultants, who are aligned with promoters of the law, become involved with patients**, approve suicides for patients, and participate in their deaths, reported as corruption by a reputable Oregon doctor and the Oregonian Newspaper.
- **Palliative care -- is the cornerstone of excellence for managing pain & other distressing symptoms (like nausea)**, but Oregon state agencies fail to successfully ensure it was offered to patients, the disabled & elders.
- **OHSU Study: In Oregon, after 4 years of assisted suicide, there was a decline in end-of-life pain-control** which was improved by local doctors as reported in the Oregonian Newspaper.
- **Dept of Health Reports Show Patients Ask for Suicide for Psychological and Quality of Life Reasons, NOT for pain.**

- **Since 1998, just after the PAS law was enacted, according to the Oregon Dept of Health Annual Reports, patient referrals for counseling (psychological or psychiatric treatments) -- dropped, leaving patients stranded with their mental anguish and in some cases less-treated pain for the duration of their illness.**
 - In 2009 none of the 59 patients were referred
 - In 2010 only one of 65 patients were referred
 - In 2011 only one of 71 patients were referred
 - In 2012 only two of 77 patients were referred

- **A Six Month Prognosis - Is More Often Wrong - 5 Testimonies, 3 Case Studies including Ted Kennedy.** How many patients, who did not know this, have accepted the prognosis, given up medical treatments to cure or prolong life, and opted for suicide...unnecessarily. In a Position Statement representing 600 oncologists -- from key national associations including the American College of Physicians -- doctors who see terminal patients daily say they are "more often" wrong in their prognosis than right. The National Cancer Institute agrees and explains, in a fact sheet, "End of Life Care for People Who Have Cancer", that there are variables such as type of cancer, its location, and whether the patient has other illnesses. They say, doctors can only "estimate" the amount of time a patient has to live. See attachment for details.

- **In Oregon The State's Healthcare Plan Refused Patients Cancer Treatments Based on Costs and Instead Offered Physician assisted suicide** (2 well publicized cases were Barbara Wagner and Randy Stroup - these studies are included in the attachment).

- **Suicide Law & Procedures -- Ignore Pertinent Medical Facts and keep the focus on physician assisted suicide** (For example, that the AMA reports that palliative care successfully protects even end of life patients from pain, which may explain why patients are not asking for suicide for pain. Also, the National Alliance on Mental Illness repeatedly says the desire for "suicide is almost always the results of untreated or under-treated mental illness" In the Position Statement by over 600 oncologists -- from key national associations including the American College of Physicians -- doctors clearly communicate We should not give up on these patients, who have a six-month because prognosis's can be wrong -- they say "more often" than they are right including a prognosis by two doctors. "A consulting physician who examines the patient and reviews the medical records is prone to the same errors in judgment that the attending physician may make when faced with the same data."

- **Physician Assisted Suicide – Laws & Procedures Ignore Key Legal Facts (For example,** In response to a law suit by two doctors, in June – **2010, Connecticut, Superior Court Judge Julia Aurigemma,** countered the artificial definition of physician assisted suicide as a medical treatment, and said "Assisting a suicide, even for humanitarian reasons, is a crime", said that "aid in dying"— **is, in fact, 'suicide'** (as the law and the American public understand the term) and she discussed the severe consequences to Connecticut if such a bill is passed -- to the extent that she warned -- **if a case comes before the legislature,** it would have to consider the ramifications of legalizing physician-assisted suicide" including how assisted suicide, "threatens the most vulnerable in society;" and incentivizes physicians and insurers "away from vitally important tasks such as identifying and TREATING DEPRESSION and providing end-of-life pain control and palliative care"

- **Physician Assisted Suicide Gives Opportunities for Patient Coercion & Abuse, Especially Elders:** Pressure may be brought to bear from one who stands to benefit from the patient's death. A beneficiary may be a witness to the patient's request for suicide, may help the patient shop for a doctor who will approve the suicide, is qualified to speak for the patient, and there is no requirement that a disinterested witness be present when the patient ingests the lethal dose. How do we know the patient consented. [Note: A right to rescind a request for the lethal dose "at any time is not the same thing as a right to consent when the lethal dose is administered."]
- **Wait Times" between Time of Ingestion & Time of Death – In 1998 - 2005, from 4 minutes to 48 hours. In 2012, no improvement. 2 Days – Some regain Consciousness. The DOH reported, "Among those those patients, time of ingestion to time of death ranged from 10 minutes to two days"....** The DOH

For example, the 2012 Annual Dept of Health Report reads, " Of the 115 patients for whom Death With Dignity DWDA prescriptions were written during 2012, 67 ingested the medication; 66 died from ingesting the medication, and one patient ingested the medication but regained consciousness before dying of underlying illness and is therefore not counted as a DWDA death. The patient regained consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion."..."Fourteen of these patients died, but follow-up questionnaires indicating ingestion status have not yet been received".

Attorney Catherine Foster, Litigation Counsel, Alliance Defending Freedom

The New York Times lists some of the ways an assisted suicide can "go wrong". Patients...don't take enough pills. They wake up instead of dying. Patients in [a study from the Netherlands] vomited up their medications in 7 percent of cases; in 15 percent of cases, patients either did not die or took a very long time to die – hours, even days; in 18 percent, doctors had to intervene to administer a lethal medication themselves, converting a physician-assisted suicide into euthanasia.

She adds that, "This kind of legislation also lends itself to sloppiness on the part of doctors – after all, a patient whom you help kill is not going to be around to complain about pain, abuse of informed consent, or any of the other steps you took – or didn't take – along the way.

- **PAS Could Jeopardize Connecticut's Hospital Rankings -- which companies and families look in relocation choices. Connecticut already has a Low "C" Level Ranking** – where rankings are not only about curing or prolong life, they are also about how patients are treated based on inputs from patients and families.

We cannot afford the negative publicity physician assisted suicide will bring as doctors, nurses, and lawyers speak out against it -- as they are doing in Oregon and Washington state.

- **To Lower Healthcare Costs, Ignore Assisted Suicide & Plan to Lower Preventable Medical Errors.** American Association of Justice: According to the Department of Health and Human Services, about 100,000 Americans die every year from **preventable errors in hospitals, at cost of \$29 billion.** Preventing medical errors will lower health care costs, reduce doctors' insurance premiums, and protect the health and well-being of patients, and improve hospital rankings. Even errors that the government and private health insurers have classified as **"never events,"** events that should never happen in a

hospital, are occurring at alarming rates. For example, in 2003 alone, the Congressional Budget Office (CBO) found that there were **181,000 severe injuries** attributable to medical negligence.

- **IN SUMMARY: Only two states have legalized assisted suicide -- Oregon and Washington. Attempts have been made to legalize assisted suicide in all states, multiple times. These attempts failed; states rejected this law. During the last decade, a total of 121 attempts were made and were rejected. For Connecticut's safety, two states is *not a big enough trial*. If other states do not want this law, why should Connecticut. Connecticut should not take a chance with such an unproven -- untested law -- and suspect law.**

It is hoped that you will consider the ramifications to the state and patients, and decide with the other states not to proceed with physician assisted suicide.

Attachment:

"RAMIFICATIONS" -- Physician Assisted Suicide, 30 pages