

Testimony
Public Health Hearing Bill 5326

"An Act Concerning Compassionate Aid in Dying
for Terminally ill Patients"

Eileen Bianchini,
Chair, Connecticut Right to Life Corporation
March 14, 2014

Attachment:
"Medical Statements 4 Life"

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The assisted suicide bill would implement a medical model that is obsolete and out of step with today's progressive medical models. It does not integrate with them. As a result, it impossible to control as we have seen in Oregon. It is like a square peg trying to fit into a round hole. It does not work in our hospitals.

History

In 2000 the AMA started promoting an interdisciplinary teaming model.

In 2007, in a paper Professionalism and the Medical Association 2007, physicians from the **World Medical Association** and the **Canadian Medical College**, expanded on the model to further help physicians to be better doctors and protect the traditional role of physicians. [1]

- Based on A Physician Charter" [2] it demands placing the interests of patients above those of the physician, setting and maintaining standards of competency and integrity, and creating environments that foster strong patient-physician relationships.

"We can accept nothing that threatens this relationship by trying to turn medicine into a mere trade, a dispassionate business venture, an impersonal public utility."

- It also enables hospitals to deal with diminishing health care resources, by having physicians take full advantage of the abilities of each member of the health care team including physician assistants, nurses, nurse practitioners, pharmacists, therapists, psychologists, speech and language pathologists, social workers and dieticians.

It received significant attention in the medical, scientific and lay press for a few years and the AMA and leading organizations endorsed the charter and begun to implement it http://www.wma.net/en/30publications/35whitepapers/White_Paper.pdf

The AMA For Interdisciplinary Teaming and Against Assisted Suicide

They say, "We are a doctor's organization, working for the good of our patients, rather than a pressure group aiming for political power as a way to build organizational predominance, to create personal prestige, or to line our own pockets..."

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." <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.shtml> "Considering the complexity of care for incurable patients, a multidisciplinary approach is a prerequisite to balance curative and palliative intervention options".

Major Disconnects with Hospital Multidisciplinary Models:

Looking at implementations of assisted suicide in Oregon, the flagship state for this, what we see major disconnects:

- where the physician-patient relationship is valued, assisted suicide damages it
- where teaming is promoted, the assisted suicide staff operate in isolation
- where they hold doctors accountable, assisted suicide laws do not have penalties that hold physicians liable

Examples of the Many Unplanned Consequences in Oregon:

- **Referrals for Second Opinions - Ignored**

As a key safeguard, the Oregon law requires a second physician opinion.

According to a survey of 1144 physicians, New England Journal of Medicine, 63% of these physicians believe that it is ethically permissible for physicians to outline their moral beliefs and objections to their patients. Physician assisted suicide doctors who do not agree that a second opinion is necessary, may tell their patients, but they should support the second opinion. However, the WMA states emphatically that "physicians should not obstruct, actively or passively, patients from receiving care from another clinician. Although health professionals may have a right to object, they do not have a right to obstruct".

This legal two-doctor requirement has been ignored according to Oregon doctors who have publicized their complaints, including Dr. William Reichel, MD.
<http://www.nashuatelegraph.com/apps/pbcs.dll/article?AID=/20091015/OPINION02/910159975/-1/opinion>.

- **Referrals for Psychological or Psychiatric Help - Ignored**

Since 1998, just after the assisted suicide law was enacted, according to the Oregon Dept of Health Annual Reports, patient referrals for counseling (psychological or psychiatric treatments) -- dropped, though the law required that patients suspected of having psychological difficulties or depression be referred and patients asked for suicide for mental reasons.

- loss of autonomy
 - decreasing ability to participate in activities that made life enjoyable
 - loss of dignity
 - feeling like a burden
-
- In 2009 none of the 59 patients were referred for psychological help
 - In 2010 only one of 65 patients were referred for psychological help
 - In 2011 only one of 71 patients were referred for psychological help
 - In 2012 only two of 77 patients were referred for psychological help

In summary, out of a total of **272** patients who died from 2009 - 2012, only **4** were referred; the others were left stranded with their mental until they took the lethal dose.

In the Connecticut bill, Section 8 (a) states, "If, in the medical opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological condition, or depression that is causing impaired judgment, either the attending or consulting physician shall refer the patient for counseling to determine whether the patient is competent to request aid in dying.

This is dangerous to the patient, because these doctors are not trained psychologists or psychiatrists and not qualified to make that call. To error on the side of life, all patients should be referred and for more than one visit. Not even qualified doctors can make such a judgment in one visit. In a white paper, called Physician Assisted Suicide in Oregon - A Physician's Perspective, doctors from Sloan Kettering, Suicide Prevention Intl, and NY Medical College, say, **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.**

The bill **should not be trying to shrink medical realities or model**, such as how much time it takes to analyze a patient's competence, to fit an artificial model that is not based on science. For the patient, too much is at stake, and it is not necessary to put the patient

in such jeopardy. Palliative care works very well. This assisted suicide is a poor solution, with a poor bill.

- **Referrals for palliative care and hospice - superficially provided**

In a paper, "Physician Assisted Suicide In Oregon – A Physicians' Perspective" by physicians from Sloan Kettering Cancer Center, Suicide Prevention International, and NY Medical College, the authors disclosed on Page 2 of 28: "The Oregon law *seems* to require reasonable safeguards regarding the care of patients near the end of life, which includes

- obtaining a second opinion on the case,
- 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);
- 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."

Page 2 of 28: "The evidence strongly suggests that these safeguards are being circumvented in ways that are harmful to patients....Physicians are required to indicate that palliative care and hospice care are feasible alternatives. They are not required however to be knowledgeable about how to relieve physical or emotion suffering in ...without such knowledge, which most physicians do not have, they cannot present or make feasible alternatives available. **Nor ...are they required to refer the patient to a physician with expertise in palliative care or hospice.**

What does this mean: In this paper, an oncologist two patients who had requested assisted suicide and were unsettled by his Hippocratic Oath posted in his waiting room statement that he did not practice assisted suicide. When he talked with them and implemented a schedule of palliative care they were both satisfied. They no longer asked for assisted suicide.

Dr. Lisa Honkanen, MD, Geriatrician, Long Island says it clearly: Experience shows that patients do not request physician assisted suicide (PAS) when physical pain and mental suffering are adequately treated. These are legitimate areas of a physician's healing duty, but causing or assisting in death is not.

Summary

In summary, the paper by World Medical Association physicians points out that

With a new model there needs to be some accountability and they recommend self-regulation for the normal reasons -- to encourage physician teaming and referrals but primarily for the general public -- who "need to have confidence that the regulation of physicians is

fair, open and transparent and that physicians are held liable for any clinical or professional transgressions in a significant and meaningful way so that such transgressions will not be repeated in the future. They need to be confident that self-regulation does not mean "self-protection" and is never to be confused with "professional autonomy".....Because, "The profession is always accountable to the public."

In discussions about the Oregon law and that safeguards have been ignored, treated superficially, or circumvented, there is no accountability in the Connecticut bill RB 5326; there is nothing that assures us, the public, that the law's safeguards will not be ignored in Connecticut.

- **There are no penalties that hold physicians liable for transgressions.** Even the most basic contracts, bills, DMC and tax laws have penalties for being late or other forms of non-compliance, and they are not associated with the life or death of a patient.
- **We cannot count on most families** to add a measure of accountability by initiating law suits because families are not required to be informed.
- **Also, section 9, 6b of the bill says the attending physician may sign the qualified patient's death certificate that shall list the underlying terminal illness as the cause of death.** It seems this would make any suit by family weak.

This bill will not work for Connecticut.

It is a model that integrates with hospital interdisciplinary infrastructures. Please reject this bill and the consequences it will bring.

[1] "**Professionalism and the Medical Association** 2007, http://www.wma.net/en/30publications/35whitepapers/White_Paper.pdf

[2] "Medical Professionalism in the New Millennium: A Physician Charter" in the Annals of Internal Medicine, 2002, written by Canadian, European and American physicians.

[3] <http://www.michiganlawreview.org/assets/pdfs/106/8/hendinfoley.pdf>

[4] <http://www.michiganlawreview.org/assets/pdfs/106/8/hendinfoley.pdf>