

Testimony: Re: Public Health hearing on HB 5326 (“Bill”) AN ACT CONCERNING COMPASSIONATE AID IN DYING FOR TERMINALLY ILL PATIENTS Monday, March 17, 2014

To the members of the Public Health Committee State of Connecticut;

I am a retired business executive and my wife is a retired physician, we reside in Connecticut. We are caregiver’s to my 97 year old Mother-In-Law who requires 24/7 care. Our life pursuit was to develop new medicines and/or hold pharmaceutical companies accountable for their safe development, marketing and sales of medicine. It is my testimony that this Bill will establish bad public policy. My Testimony is based on business and personal experience along with the review of published reports from States and Counties that have legalized the taking the life. I have three primary concerns:

- Without clear oversight, controls and review of the assisted suicide process this Bill will lead to abuse and exploitation of terminally ill patients by persons who may have economic or questionable motives.
- It will create mistrust in the patient doctor relationship.
- It will fosters a culture of taking one’s life.

I urge you to vote no on this Bill.

Without clear oversight, controls and review of the assisted suicide process this Bill will lead to abuse and exploitation of terminally ill patients by persons who may have economic or questionable motives.

Death and Dignity Acts (“Acts”) in Oregon (’97) and Washington (’08) authorize physicians to write life-ending prescriptions for their patients. Today we have an abundance of publications that question the wisdom of the law and reveal the unintended consequences. These Acts are much like H.B. 5326 before you that seems to require reasonable safeguards regarding the care of patients near the end of life, however, there is a lack of controls and transparency in the process that shrouds the truth.

This Bill if approved will spawn a cadre marginal doctor’s, those unlicensed or unable to make a living in a practice, to specialize in assisted suicide and become experts in the process however, at the detriment of proper medical care and will foster nefarious acts. We know from other similar public policies that main stream doctors will avoid prescribing medical treatments that contradict their Hippocratic Oath.

The historical evidence arising from Oregon or Washington Acts strongly suggests that without transparency and controls the Bill’s safeguards will be circumvented in ways that are harmful to patients and society:

- The **unintended consequence** of this Bill is that it will enable physicians to assist in suicide without inquiring into documenting sources of the medical, psychological, social, and existential concerns that usually underlie requests for assisted suicide, even though this type of inquiry produces the kind of discussion that often leads to relief for patients and makes assisted suicide seem unnecessary. [1] [2]
- Physicians are required to indicate that palliative and hospice care are feasible alternatives, however they are not required to be knowledgeable nor can they present or make feasible alternatives available. Physicians will merely go through the motions of presenting palliative care.

- In the absence of adequate monitoring, the doctor's focus shifts away from relieving the distress of dying patients considering a hastened death to meeting the statutory requirements for assisted suicide. [4]
- There is no mental standard of consent required at the time of administration nor language requiring the patients consent at the time of administration thus setting the stage for undue influence or abuse. [4]
- Doctor shopping. After the initial decision as to whether the patient is competent or capable is made by the doctor who will be prescribing the lethal dose, this doctor is required to obtain a second opinion from a consulting physician. In practice this requirement is circumvented through "doctor shopping." They will go until they find the second opinion desired. In Oregon the median duration of the patient-physician relationship in 2005 was eight weeks, and for all patients between 1998 and 2004, it was twelve weeks. This means that the attending physician in the majority of cases would have had little more than a passing relationship with the patient and in all likelihood was not the treating oncologist. Furthermore, it strongly implies that "doctor-shopping" is occurring in Oregon. [2]
- The Medically confirmed provision to review or confirm the medical records or letter does not exist.
- Self-administered does not necessarily mean that a patient administers the lethal dose to themselves. In summary, someone other than the patient may be allowed to administer the lethal dose. The Bill contain no requirement that the patient be competent, capable, or even aware when the lethal dose is administered. Statistics for the prescriptions issued compared to the lethal death is 2:1 in Oregon. Obviously people change their minds but who knows? Who would know if a struggle took place?
- Typically persons requesting assisted suicide are seniors with money, which would be the middle class and above, a group disproportionately at risk of financial abuse and exploitation. This Bill is written so as to allow such abuse to occur without anyone knowing. The forms used to collect the statistical information do not ask about abuse. Moreover, not even law enforcement is allowed to access information about a particular case. Alicia Parkman a mortality research analyst at the Center for Health Statistics, Oregon Health Authority, wrote: "We have been contacted by law enforcement and legal representatives in the past, but have not provided identifying information of any type. "[3]
- There is no standard of Competency in the Bill.

In summary without transparency and controls this H.R. 5326 Bill is not safe.

Note: The below articles explain the clear difference between palliative care through all stages of a patient's disease and the dying process, and physician assisted suicide.

<http://www.ama-assn.org/resources/doc/code-medical-ethics/2201a.pdf>

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

[1] Dr. Bentz's patient <http://www.wrtl.org/assistedsuicide/personalstories.aspx>

[2] Kate Cheney <http://www.wrtl.org/assistedsuicide/personalstories.aspx>

[3] Maryanne Clayton: <http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/>

[4] Barbara Wagner <http://www.wrtl.org/assistedsuicide/personalstories.aspx>

[4] Video: <http://www.mofopolitics.com/2009/08/03/video-oregon-says-no-to-chemotherapy-offers-doctor-assisted-suicide/>

Physicians for Compassionate Care http://www.pccef.org/documents/Assisted_Suicide.brochure.pdf

It will create mistrust in the patient doctor relationship.

The vast majority of legitimate physician organizations oppose physician-assisted suicide.

In this debate, it is critical to recognize that, contrary to belief, **most patients requesting physician-assisted suicide or euthanasia do not do so because of physical symptoms such as pain or nausea.** Rather, depression, psychological distress, and fear of loss of control are identified as the key end of life issues. [1]

Legalizing physician-assisted suicide strikes at the heart of what physicians do and adds ambiguity to the physician-patient relationship. The physician's primary directive is to first, do no harm. Physician-assisted suicide destroys the trust between the patient and doctor. Under the pretense of providing compassion, the physician is relieved of his or her primary responsibility to the patient – to safeguard life and to provide comfort to the suffering. It is the **ultimate patient abandonment.** [2]

- The **American Medical Association** states in its code of ethics: Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Suarez-Almazor ME et al. Attitudes of terminally ill cancer patients about euthanasia and assisted suicide: predominance of psychosocial determinants and beliefs over symptom distress and subsequent survival. J Clin Oncol. 2002;20:2134-41.2 Van der Lee ML et al. Euthanasia and depression: A prospective cohort study among terminally ill cancer patients. J Clin Oncol 2005;23:6607-6612.3 Emanuel EJ. Depression, euthanasia, and improving end-of-life care. J Clin Oncol. 2005;23:6456-8.4 Accessed at <http://www.cmanet.org/publicdoc.cfm/2/1/pressection2/384> April 15, 2007. 3 [3]
- **The American College of Physicians**, the nation's largest medical specialty society, states: The profession's most consistent ethical traditions have always emphasized healing and comfort and have demurred at the idea that a physician should intentionally bring about the death of any patient.

Pronouncements against euthanasia and assisted suicide date back to the Hippocratic Oath and have formed the ethical backbone for professional opposition to the practice of physician-assisted suicide. [2]

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

Please share this with your committee and ask them to reject this unnecessary bill. Thank you so much.

[1] <http://www.pregnantpause.org/euth/amagomez.htm>

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

[3] [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)

It will foster a culture of taking one's life.

A major concern for Connecticut is the possibility of increased Connecticut **suicide rates** as happened in Oregon. According to the Oregon Health Authority since assisted suicide became legal, its suicide rates **climbed to 41% above national levels in 2010** (not including patients who died through physician assisted suicide). **For teens, suicides rose from being the third leading cause of death to the second leading cause of**

death. (<http://public.health.oregon.gov/PreventionWellness/SafeLiving/SuicidePrevention/Pages/sdata.aspx>) In Connecticut reducing suicide rates is a top priority. It was proposed that we should seek ways to prevent suicide, not enable it.

In summary, this Bill presents an ethical dilemma partly due to the failings of medicine to adequately provide good care and comfort at the end of life, medicine can and should do better. We must solve the real and pressing problems of inadequate care, not avoid them through solutions such as physician-assisted suicide.

Fredrick Cobb

Stamford, CT