

**Testimony of Linda Anne Hoag, MA, MFT
to the Connecticut General Assembly Public Health Committee**

Testimony in support of HB 5326, An Act Concerning Aid in Dying for the Terminally Ill

If we are to deeply consider the possibility of allowing a terminally ill patient to choose the time of his/her death, we would do well to consider the changes Americans have already made in the birthing process and in the use of advance directives.

In many ways, the process of being born is similar to the process of dying. Both are often lengthy processes, about which much is known medically. Entering and leaving the world may well involve considerable discomfort. Most people view these transitions as highly intimate acts. I think we could agree that most people have very specific wishes about how they will participate in these transitions. With regard to birthing in America, it is now not uncommon for a woman and her doctor to decide to induce a birth, by medication or surgery. The reasons for this decision are as varied as accommodating a schedule, preventing a medical emergency or relieving discomfort. The common impulse in these decisions is the matter of agency, the willingness to allow a human being to act in their own best interest, even if this alters a "natural" process. In no way, however, does the decision to induce a birth interfere with another's decision to give birth at home, without the use of medication. One would wish, in both cases, that the person making the decision could give informed consent, could participate actively in the process, and could be supported in her choice.

In recent years, Americans have increasingly embraced the use of advance directives for end of life care. Thoughtful forms, such as Five Wishes, or the structured conversation, Death Over Dinner, are enabling many to speak directly to loved ones about their plans for a good death. As with birthing, there will be a great variety in the choices people make about their own deaths. Since there is considerable reliable medical information about the process of dying, terminally ill patients have the right to be informed about their prognoses. The patient, in conversation with a doctor, (and, ideally, with friends and family) should be supported in crafting the last days of life in accordance with the patient's beliefs and desires. Hospice, the resources to die at home, good pain management, sufficient companionship---all of these help a patient meet end of life needs. To this list might be added the ability to choose a time of death. Again, the reasons for this choice may be quite varied, including having the opportunity to celebrate this transition with a group of loved ones, being able to die while still capable of speech and cognition, or simply to die when it seems appropriate to do so. The option to induce death at a specified time by self administered medication may be viewed in the larger context of supporting patient agency. This compassionate response can only be provided in a system that safeguards those who cannot give consent or self medicate. It is appropriate to require the supervision of two doctors and to assure that the doctors are protected from liability when providing the needed medication.

As a therapist who has had the privilege to have many conversations with patients and families about the end of life, I strongly support legislation that allows terminally ill patient to determine the time of death, if the patient so desires. I believe that we can compassionately induce death, as we induce birth, while acknowledging the sacredness

of human choice.

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