

Mary T. Nagy, RN, BSN, COHN-S, COHC HB 5326

Vote No Assisted-Suicide H.B.5326 say Doctors and Nurses

To: phc.testimony@cga.ct.us

March 14, 2014

Dear Public Health Committee Members of the CGA,

As a Registered Nurse with experience in palliative care, in opposition and review of House Bill 5326, I urge you to vote 'No' on Connecticut's Assisted Suicide Bill, falsely named 'Aid in Dying'. Please note the following observations and questions:

1. What is the rush to author, introduce and sponsor an assisted-suicide bill, when palliative care and hospice have not been funded, investigated, promoted or exhausted in Connecticut and nationwide?
2. What health care provider(s) have reviewed this bill along with myself?
3. The definition of medication is for preventing and treating injury and disease. It is not rightly used to cause death.
4. The ethics of medical practice and associated disciplines (pharmacy, nursing, dietetics, pastoral care, physical and occupational therapies, social work, community health resources) hold a standard of 'beneficence' and 'do no harm'. To force conflicts of interest on professionals and professional bodies of practice is an injustice and great harm to individuals and societies. Who is the Connecticut General Legislature, to impose standards of murder on professions who espouse to care for and engender an ethic of life?
5. H.B. 5326 statement of purpose reads: 'To allow a physician to prescribe medication at the request of a mentally competent patient that has a terminal illness that such a patient may self-administer to bring about his or her death.' Who are you, as the CGA, to propose to a physician and to the public, to side-step the natural course of death? And be an accomplice to murder and suicide?
6. Mental competency (article 4) is embodied in a will to live. Who are you to change this? You cannot discern that a "qualified patient" (article 17) is both suicidal and mentally competent. 'Suicidal' is not congruent with 'competent', irregardless of co-morbidities and terminal diagnoses. Even when a person finds two physicians (articles 3 and 10) and two non-family members (section 3, {a} and {b}) to attest to competency, this does not 'qualify' the 'patient' for suicide, irregardless of two or more written requests, fifteen days or more apart.
7. Article (7) defines 'health care provider', and leaves OUT the most intrinsic discipline to administering medication, and this is NURSING - albeit the terminology 'but not limited to' does not EXCLUDE nursing. Irregardless this is a major oversight, as the disciplines mentioned, 'physician, psychiatrist, psychologist, pharmacist' are (is) almost NEVER the discipline(s) administering medication. Medication administration is almost always a nursing intervention. In most cases of assisted suicide, the prescribing doctor is not present.
8. Article (9) 'informed decision' cites 'palliative care' at the end of a long paragraph. Any support for early intervention and appropriate referral to palliative care, which is

intensive hospice care, pain assessment and relief, is weakened by the writing of this bill. There is no excuse for subjugation of palliative care in this manner, when no attempt is made to introduce and expand palliative care practice in the legislature, and not only for those with a terminal illness (article 19).

9. A 'patient' means someone who suffers. The genesis of pain is not clear when someone expresses a will to kill themselves. It is unethical to bypass the suffering of a suicidal 'patient', and rather, to enable suicide of a suffering person.

Conclusions:

This bill promotes nothing other than suicide and active euthanasia. The entire notion of passive euthanasia and hospice, intensive palliative care, is weakened by the introduction of this bill by Representative Elizabeth Ritter 38th district and Senator Edward Meyer 12th district. Unfortunately, it is a dismay that the current proposed health care reform known as the affordable care act (Obamacare) has greatly impinged upon hospice and palliative care by removing, abbreviating, and striking funding altogether from the healthcare overhaul for these options, OR making it so difficult that doctors cannot be bothered with getting the little insurance reimbursement that might be available. An appropriate legislative remedy is to introduce a bill to greatly expand both hospice and palliative care and options in Connecticut, which includes care for non-terminal conditions. As Leslie Wolfgang noted in her February 21st opinion editorial comments that Connecticut was the first state to license a palliative care center. She concludes that fact with the suggestion for Connecticut to become progressive in its promotional efforts to further the aim, and reduce both suicide and elder abuse, two statistics that will simply increase with HB 5326. (http://articles.courant.com/2014-02-21/news/hc-op-wolfgang-assisted-suicide-is-wrong-0223-20140221_1_assisted-suicide-lethal-medications-health-care-system).

Personal and professional experience and credentialing:

I have worked in various domains of health care practice including visiting nurses, private duty, hospice and palliative care, and have assisted at numerous bedsides of dying patients and families, including the death of my own mother and grandmother. Death and dying are considered taboo in our culture, and so there is a dearth of personal experience and knowledge of what to expect and how to cope. In no way is it appropriate or compassionate to suggest that a suffering person be offered a lethal agent to hasten death or commit suicide. These acts contribute not only to the general devaluing of suffering and life, but to the decline of medical and nursing professions, and are an obstacle to compassion altogether. It is not an affordable option to pay a doctor or nurse to hasten death which comes naturally and in its time and can be assisted with certain timely medications. One of the biggest concerns and fears we have about death, is that we will be alone, and this is not something anyone wants, to die alone. I remember well, certain patients, who it seems, actually waited until I came into their rooms, to breathe their last breath, and did not die alone. I was with them. This gives testimony to the fact that many people hang on til their journey is shared by another. This sharing gives value to the suffering and experience of doing the last thing each of us will do, which is to die well.

Professional studies on thanatology (death and dying) and palliative care

The SUPPORT project, almost 20 years since its inception, is the largest and most influential longitudinal study of end of life care ever conducted, sponsored by the Robert Wood Johnson foundation. Its objective was to improve the quality of care towards the end of life in patients with serious illness. Perhaps the least significant finding is the most stunning, and speaks loudly to the taboo in our culture against death and dying care expansion. A \$29 million dollar effort has had absolutely no influence on improving the quality of end of life care.

Some of the most important findings of SUPPORT are that while 90% of people in the US prefer to die at home, 80% or more die in the hospital or in some form of extended care facility. Even today, twenty years hence, the majority of patients with terminal illnesses are still not enrolled in hospice until less than two weeks before death. This would change if health care legislation enables earlier referrals and interventions with palliative care options and support. Another significant finding is that medical providers and nurses need more training and a greater knowledge and skills set in the field of death and dying and in pain assessment and intervention.

Positive outcomes from SUPPORT show those getting palliative care from the start, report less depression and live happier lives as measured on scales for pain, nausea, mobility, worry and other problems including socioeconomic AND typically lived almost three months longer than those getting standard care. Doctor R. Sean Morrison, president of the American Academy of Hospice and Palliative Medicine, says it was the "first concrete evidence of what a lot of us have seen in our practices – when you control pain and other symptoms, people not only feel better, they live longer."

Final conclusion

How much harder AND more expensive will it be, if Connecticut legalizes physician assisted suicide? This will enable suicidal people to take their own lives, and continue to ignore an aging population who need end-of-life care. DO NOT make Connecticut the fourth state to legislate 'Dr. Death'! Vote no on Assisted-Suicide H.B. 5326. Legislate to expand end-of-life and palliative care instead.

Signed,

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