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Testimony Against H.B. 5326

Good afternoon members of the committee, Chairwoman Gerratana and Chairwoman Johnson. My name is Peter Wolfgang and I am the President of the Family Institute of Connecticut Action, an organization whose mission is to "encourage and strengthen the family as the foundation of society and to promote sound, ethical and moral values in our culture and government." I am here today to ask you to oppose H.B. 5326, AN ACT CONCERNING COMPASSIONATE AID IN DYING FOR TERMINALLY ILL PATIENTS.

The Family Institute represents a diverse and large group of Connecticut citizens that oppose the "aid in dying" campaign in Connecticut. Many of our members oppose this bill out of religious conviction; but it is dismissive to suggest that is the only reason. It is also a caricature of the people who oppose this bill to suggest that they somehow oppose dying with dignity. Nobody supports keeping a patient alive by extraordinary means against that patient's will. Many of us have friends or family that have endured pain and suffering and would never want that pain to continue for any philosophical or public-policy reason. But "aid in dying" legislation is not a silver bullet to eliminate pain in CT. And because it is not a silver bullet, we should not remove longstanding protections against elderly abuse and discrimination against people with disabilities.

I say it is not a "silver bullet" because after they adopted their law, one study showed reports of pain at the end of life actually increased 18.8 percentage points in Oregon from 1997 to 2002.[1] A separate study supports the finding that pain at the end of life was not decreased by their law.[2]

If the proponents of this bill want our legislature to really tackle pain and

[1] Increased Family Reports of Pain or Distress in Dying Oregonians: 1996 to 2002, Journal of Palliative Medicine, Vol. 7, No. 3 (2004). http://www.dredf.org/assisted_suicide/Oregon_Pall_Care_Study.pdf
[2] Quality of Death and Dying in Patients who Request Physician-Assisted Death, Journal of Palliative Medicine, Vol. 14, No. 4 (2011).
[2] http://www.worldrtd.net/sites/default/files/u22/Smith%20Goy%20and%20Ganzini.pdf.

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comfort at the end of life, we suggest their money and efforts would be better spent introducing uncontroversial measures such as increasing access to palliative care, increasing the number of licensed nursing aids (and also increasing jobs), better access to earlier hospice care, or even something as inexpensive and effective as “comfort carts” for the end of life.[3] These bills would not be “emotional” and would be welcomed by all legislators who want to bring more comfort and dignity to the dying process. And as a result, many, many more people would receive truly compassionate end of life care.

HB 5326 does not guarantee dignity at the end of life. Prescription drugs can cause fearful, messy and undignified moments during a hastened death. Statistics are not kept on “aid-in-dying” failures, but there are news reports of panic stricken relatives calling 911, emergency room visits, hallucinations, vomiting and choking.[4] A study from the Netherlands (which has far more experience than Oregon or Washington with “aid-in-dying”) reports that in at least 18 percent of reported physician-assisted suicides, doctors felt compelled to intervene and administer a lethal injection themselves because of “complications”.[5] To what fate would we really be subjecting the weakest of Connecticut citizens with the false promise of an easy death?

One study from Oregon that may interest this Committee is the annual Suicides in Oregon: Trends and Risk Factors report.[6] According to the 2012 report, after decreasing in the 90s, Oregon’s suicide rate has increased to 41% above the national average.[7] The sociological phenomenon “suicide contagion” has been documented and

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[3] Exchanging a Blanket for a Code Blue, The Atlantic, Aug. 28, 2013. http://www.theatlantic.com/health/archive/2013/08/exchanging-a-blanket-for-a-code-blue/279125/

[4] http://www.patientsrightscouncil.org/site/assisted-suicide-the-continuing-debate/#3 and *NEJM*, 2/24/00, p. 551, 554 and http://www.patientsrightscouncil.org/site/problems-assisted-suicide/

[5] Legalizing Euthanasia or Assisted Suicide, the Illusion of Safeguards and Controls, Current Oncology, Apr. 2011, J. Pereira, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070710/; and http://www.patientsrightscouncil.org/site/euthanasia-assisted-suicide-health-care-decisions/ citing Johanna H. Groenewoud et al, “Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands,” 342 New England Journal of Medicine (Feb. 24, 2000), pp. 553-555.

[6] https://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/NVDRS/Suicide%20in%20Oregon%202012%20report.pdf

[7] Connecticut Office of Legislative Research Report, December 13, 2013. http://www.cga.ct.gov/2013/rpt/2013-R-0450.htm and see footnote 6.

cautioned against by the US Federal Gov't.[8] Laws such as Oregon's Death with Dignity Act portray suicide as a reasonable means to solve a problem and vulnerable people in that state appear to be viewing suicide the same way. We should not be exalting suicide as the ultimate form of expressing one's "choice".

This time last year I cautioned the Committee to consider the extension of "aid in dying" practices in Belgium and The Netherlands to twin brothers who suffered from glaucoma and back pain.[9] Since last year, a person was euthanized because they suffered a botched operation.[10] "Loss of fitness" is now considered an underlying condition for cases worthy of euthanasia.[11] Last month, the Los Angeles Times editorialized that their state should adopt an assisted suicide law and extend it to children.[12] At Compassion & Choices' press conference in February 2013, one of the speakers advocated extending any future Connecticut "aid in dying" law to the mentally incompetent. I try not to use the phrase "slippery slope",[13] I think the term "foot in the door" may be a better example since we don't have to imagine where such laws have led. But I recommend to the Committee that they consider the true long term cost of legalizing assisted suicide for our most vulnerable citizens and the people such law seeks to help.

Thank you for your time.

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[8] **"If suicide is presented as an effective means for accomplishing specific ends, it may be perceived by a potentially suicidal person as an attractive solution." and "Such actions may contribute to suicide contagion by suggesting to susceptible persons that society is honoring the suicidal behavior of the deceased person, rather than mourning the person's death." Suicide Contagion and the Reporting of Suicide: Recommendations from a National Workshop, CDC, April 22, 1994. http://www.cdc.gov/mmwr/preview/mmwrhtml/00031539.htm**

[9] http://www.dailymail.co.uk/news/article-2262630/Brother-deaf-Belgian-twins-killed-euthanasia-describes-final-words-reveals-live-learning-going-blind.html

[10] http://www.telegraph.co.uk/news/worldnews/europe/belgium/10346616/Belgian-killed-by-euthanasia-after-a-botched-sex-change-operation.html

[11] **2014 Position Statement by CMF New Zealand, Euthanasia and Physician Assisted Suicide. http://www.cmf.net.nz/about-us/76-position-statement-euthanasia-and-physician-assisted-suicide**

[12] And a response by American College of Pediatricians. http://www.acpeds.org/physicians-are-healers-not-killers

[13] **Assisted Death and the Slippery Slope, M.J. Shariff, Current Oncology, Jun 2012; 19(3): 143–154. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3364764/**