

TESTIMONY:

March 6, 2014

Dear Chairwoman Gerratana and Chairwoman Johnson and members of the Joint Committee on Public Health.

My name is Dr. Thomas Finn and I am a resident of Southington where I have worked as a CT licensed psychologist in clinical private practice for 29 years. I am writing to ask you to oppose raised bill H.B. 5326, An Act Concerning Compassionate Aid in Dying for Terminally Ill Patients.

Terminal illness is clearly a difficult road and, although I have personally walked this road with my parents, with friends, and with clients who have died after long struggles with terminal illnesses, I do not believe that H.B. 5326 will benefit the citizens of Connecticut.

My primary objection to this bill centers on the concept of a “qualified patient.” The Bill defines a qualified patient as someone who voluntarily seeks their own death and competently makes “informed decisions” regarding the nature, consequences, benefits and disadvantages of this choice to end his or her life.

I share the opinion of many health care providers that it is extremely difficult to determine who can be defined as a qualified patient. To make truly informed decisions, a person needs intact neurological executive functions in order to utilize sound judgment and many persons who are elderly or ill have difficulty processing information and especially medical information. As a result, men and women who are elderly or have a disability greatly rely on their family members to interpret medical information they hear from their health care providers. Many people have had the experience, for example, of attending a medical appointment with an elderly relative who, after listening to a physician explain a medical finding, states to the physician that she understood what had been said and agrees to a treatment plan. When they get in the car, however, the patient asks, “Now what did that Doctor say is wrong with me?” or “What am I supposed to do?” This patient, who may just have appeared to competently make an “informed decision,” and seemed to be a “qualified patient,” must now rely on the relative to interpret the medical information. I am greatly concerned for the potential abuse that can occur when such a discussion would target the patient’s ending his or her own life.

Secondly, the desire to end one’s life and the actions taken to do so are recognized as symptoms of depression<sup>1</sup>, and have been associated with levels of psychological distress in terminally ill patients that impair their decision making ability<sup>2</sup>. Clinically, there is a “negative triad” that reflects depressive views of oneself, one’s present circumstances and one’s future. These cognitive distortions increase feelings of helplessness, guilt and worthlessness resulting in misperceptions that life is meaningless. The hopelessness experienced in the hearts of these patients distorts their understanding of objective information about the quality of their remaining days, the number of which are often underestimated in their medical prognoses, and can limit their ability to perceive benefit from palliative care<sup>3</sup>.

Given the frequent occurrence of depressive symptoms in patients with terminal illness<sup>4</sup>, the frequency with which these depressive symptoms are not diagnosed by general practitioners<sup>5</sup>, the historically low rate of psychiatric evaluations performed with persons seeking physician-assisted suicide in States such as Oregon (only 40 out of 596 patients)<sup>6</sup>, and the questionable practice of competence determination and lethal dosing being provided by the same physician, I am opposed to H.B. 5326 as patients are at risk to be mislabeled as “qualified” and “competent” in making informed decisions when, in fact, they are not.

To be compassionate means to “suffer with” a person who is in need and to “suffer” means to “bear” the burdens one carries. I hope that we can view a terminally ill person’s desire to die as a request for help in bearing their grief and work to improve our ability as a community to compassionately provide terminally ill patients and their families with services that target effective pain management along with emotional and social support. I hope that you will oppose both H.B. 5326 and physician-assisted suicide.

Respectfully Submitted,

Thomas Finn, Ph.D.  
225 Rockwood Dr.  
Southington, CT, 06489  
860-302-1110

1[1] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.), Diagnostic Criteria for Major Depressive Disorder, Washington, DC, 327.

2 Emanuel, EJ, et al., Dept. of Clinical Bioethics, National Institutes of Health, *Annals of Internal Medicine*, 2000, 132(6):451-459.

3 Sullivan, M., Depression and the Refusal of Life-Saving Medical Treatment, in Steinberg, M. and Younger, S., eds., *End of Life Decisions - A Psychological Perspective*, American Psychiatric Press, 1998, 68.

4 Block, S., Assessing and Managing Depression in the Terminally Ill Patient, *FOCUS*, 2005, 3:310-319.

5 National Institute of Mental Health, Older Adults: Depression and Suicide Facts, NIMH pub. no. 4593, 2007.

6 Oregon Public Health Division,

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents>, years 1-15.