



Testimony

Judiciary Committee Hearing Bill 7015

An Act Concerning Aid in Dying for Terminally Ill Patients.
Eileen Bainchini, Chair CT Right to Life - Testifying for Self

+ Attachment:

Integrating Palliative Care with Disease-Modifying Therapy

Dear Judiciary Committee, thank you for the opportunity to present information in opposition to this bill. We do not need it and are doing better without it. It is a handy stop-gap solution that other countries with inferior palliative care offerings are using. It migrated here in the 1980's (in other forms) and 90's and as assisted suicide. For use in America, it is an out of date and inappropriate solution that we do not need, has been rejected by most states multiple times, it does not represent the "American Way" of treating patients with care and love, and as another end of life option it does not team well with palliative care or hospice (their doctors won't refer and if they do - it is too late in the disease to be effective according to Harvard Medical and other doctors). Further, it is in fact harmful to patients.

In America, we have successfully advanced our palliative technology over the last two decades (see the attached article) and bundled it with related hospital and hospice services. Today, the palliative care program includes pain management closely integrated with psychological, social, family, pastoral help and other interventions and treatments required by the patient. It operates to the high AMA multidisciplinary standards and control-measures to ensure pain free and quality care for patients throughout the disease from the time of prognosis through end-of-life. **The AMA states, "There is, in short, compelling evidence of the need to ensure that all patients have access to quality palliative care, but not of any need for physician-assisted suicide"** See <http://www.pregnantpause.org/euth/amagomez.htm>

In fact, American medical schools and societies are against it for the same reasons. Our top medical institutes reject it and are aligned with palliative care. In fact, our medical colleges have stepped out to help train medical professionals in other countries. **The International Program of the Harvard Medical School Center for Palliative Care**, based in the Palliative Care Service at Massachusetts General Hospital offers training and technical assistance in pain relief and palliative care to colleagues in low-income countries. Besides training, they are spreading the word that Palliative Care is the way to go http://www.massgeneral.org/palliativecare/education/international_program.aspx and helping to give guidelines that it must be tightly-integrated with other psycho-social services such as psychological, spiritual and family help; there must be a high level of interactive multidisciplinary teamwork; and it must be initiated early in the disease.

With its palliative care innovations, technology, and integrated procedures, the **United States is not only leading other countries -- it is -**

- reducing the number of patients that will be hospitalized and
- reducing the number that will die in a hospital

which is a good news for both hospitals and insurers as well as fantastic news for patients. This is the type of news that can be advertised by hospitals, will draw out-of-state patients to our hospitals for good reasons, and will create opportunities to promote CT.

(See attached article.)

So, the US is using palliative care to lessen its patient queue and it is training other countries to do similar including under developed countries. One of these countries is the **Ho Chi Minh City Cancer Hospital**, southern Vietnam's largest and busiest cancer centre with approximately 1,700 inpatients on any given day and approximately 9,000 active outpatients. **Its leaders recognised the medical and moral imperative of adding palliation to its mission to prevent, diagnose early, and treat cancer.** The leaders aimed to ultimately offer the full range of palliative care services but focused initially on training.

Note. In doing this research, I am once again in awe of American innovativeness (the ability to raise the bar in whatever we design - from products to enterprise infrastructures). I saw often as a director of global marketing for computer mainframes, workstations, and software - that, other countries, like India, Japan and even Germany, could copy but not invent as innovatively as we do, but they copied well.

On palliative care, other developed countries have not arrived yet. For example, **the UK and Netherlands which were several of the first countries to implement assisted do not have full palliative care solutions or enough palliative care specialists.** In 2013, The UK's Norman Lamb, the Care minister, shared details from an independent review to estimate the number of patients being euthanized. He said "An estimated **350,000 patients with chronic illnesses need palliative care** each year but fewer than half **(170,000) receive it, of whom 130,000 are placed on the pathway (death path)**" As a result, independent investigations or probes were commissioned to determine the use or misuse of the pathway and assisted suicide programs, and recommend how to improve palliative care.

Since the Oregon law was passed, well publicized articles by US doctors and the Dept of Health Annual Records concerned about the slippery slope seen in the UK, Belgium, Netherlands communicate that many of the law's safeguards are regularly ignored by doctors who specialize in assisted death.

David W. Hafer M.D. - in the "Montana Standard" **shares concerns that the two-doctor safeguard is ignored causing** patients to die without first confirming the their terminal prognosis. He says, **"Physicians are fallible human beings and often are wrong"** in their prognosis concerning how long a patient will survive their illness. He also points out that "Often, it is depression that prompts one to think that life if not worth living or gives the feeling that because of their illness they are a burden to their family".

In a paper, "Position Statement on Physician Assisted Suicide...", over 600 doctors of the AMA concur saying the second opinion is imperative and should be enforced because, **Physicians are wrong about a given patient's prognosis "more often" than they are right."**

Sloan Kettering doctors and other doctors share, "The Oregon law *seems to* require reasonable safeguards regarding the care of patients near the end of life, which include presenting patients with the option for palliative care.....**The evidence strongly suggests that these safeguards are being circumvented in ways that are harmful to patients.**"In addition, they may further contribute to patient depression and a weakening of the will to live -- putting patients in harms way by making them more prone to suicide. On our Web site see the page "**Why Oregon Patients Ask for Suicide**" from 2008 on it is not for pain (which proves how far along our palliative care technology and methodologies have come).. See http://connrlc.org/?page_id=245

Additionally, the physician is not required to be present when the patient decides to take the lethal dose, and these laws do not require family to be present (many patients opt not to have their family present for some reason). However, staff of the organization that promotes assisted suicide are present according to an op ed **by Oregon's Dr. Stevens in the Oregonian Newspaper.** Who knows how many patients may have had a last minute change of mind and if those deaths were voluntary. See http://connrlc.org/?page_id=233. See the CT Right to Life Site page, Slippery Slope, for more details on the UK http://connrlc.org/?page_id=940

In summary then, let's wonder with foresight. Why should we put our palliative care offerings in jeopardy of taking a back seat to assisted suicide, which does not team play, will be a distraction to normal hospital operation, put patients in harms way, and will rob monies from funding to continually enhance palliative care as we try to clean up the damage it will inflict on the state - such as increased suicides in Connecticut, decreased referrals to palliative care and psychological help, more hospital patients, longer hospital stays, more hospital preventable medical errors, and more patient deaths in hospitals, more law suits from relatives, numerous complaint letters by good doctors in our newspapers, and the promotion of more cases like Brittany Maynard of patients who travel to CT for death by Compassion & Choices (free speech). Is this something CT wants to become known for. Is our governor aware of all this? In summary:

Ways to Improve Palliative Care in CT: Instead of importing assisted suicide, maybe we should be applying all resources to implement palliative care well in CT. To many, it is still an unknown and the concern is if patients find out about it, they may find out too late for it to have the results wanted.

Pass legislation to enable palliative care to be given as soon as the disease is diagnosed and in parallel with all treatments.

Expand training of

PC specialists - to have a dynamic pool of specialists for every state (not through Dept Aging providers - these agents need special skills and the ability to work flex hours)

Increase patient awareness - they should not have to depend on doctor referrals

Train family doctors, pediatricians (even children need pain and psycho-social management from time to time), and internists - perhaps through orientation classes in "palliative care awareness" so that they can intelligently refer patients and answer questions -- to the good of the patient, doctor, and hospitals (as well as medicare, medicaid and insurers).

Teach doctors how to introduce palliative care to patients.

On this issue, the medical profession and churches can work together. Through churches we can get the word out to parishioners and congregations. Please consider defeating this bill. *Eileen Bianchini*

Notes

An article in the Independent Sunday, "Liverpool Care Pathway: A way of death worth fighting for?" shares that it was originally intended to be a measure to help ease the suffering of the dying. Instead it is alleged to have become a "**backdoor euthanasia**" leading to the early deaths of tens of thousands of patients **in return for millions of pounds in "bribes" for hospitals....The measure, developed over a decade ago by palliative care specialists in Liverpool,** has become embroiled in controversy in recent months, as some doctors, religious leaders and pro-life groups have alleged that patients are being put on the "pathway to death" without their consent or that of their families in response to financial incentives from the NHS".

Disclosures have been well publicized in the UK. "**The Daily Mail has run a campaign claiming hospitals are being bribed with millions of pounds to send patients to an early grave.**"

The **publicity has worried families** and even led to **dying patients refusing hospital admission** because of fears about what would happen to them, experts said today, describing the development as "tragic". *In fact, the UN, informed to the UK's high euthanasia rate, in 2014 threatened to investigate the UK together with Oregon and Netherlands for escalations in euthanasia (involuntary death).

See Attachment