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**Testimony in strong opposition to HB 7015**  
**An Act Concerning Aid in Dying for Terminally Ill Patients**  
**March 18, 2015**

Senator Coleman, Rep. Tong, and members of the Judiciary Committee:

I am a lawyer, writer and a graduate of Harvard Law School. I am also a liberal Democrat, believer in individual rights and a member of Second Thoughts Connecticut. Last and certainly least, I have athetoid cerebral palsy. I mention this because this has caused me to experience first-hand how fallible doctors can be in their judgements and how patient "choice" can be shaped by a doctor's misconceptions.

I deeply regret that again, the Connecticut legislature is considering whether to make it lawful for doctors to write lethal prescriptions for terminally ill people who request them.

Physician assisted suicide is discriminatory. Suicide prevention continues to be a value for the general population. Only persons deemed to have less than six months to live are eligible for lawfully lethal drugs. This sets up an inherently bad dynamic. If it is thought that life is so burdensome for some that it is rational for them to die before death is naturally inevitable, the targeted groups can be increased over time in accord with prevailing opinion. Why not add people over ninety or people with irremediable disfigurements?

Physician assisted death would not exist in a vacuum. It would be an overlay on a medical system where there is an imperative to reduce costs, where many people are unable to access care and where many practitioners still have the prejudices that abound in society.

People with disabilities, for example, are too often seen as individuals with some type of defining, global characteristic that trumps the many other attributes they may have. Yet we tend to be people with an ordinary world view who do ordinary things such as attending symphonies or voting. James McGaughey, former executive of Connecticut's Office of Protection and Advocacy has written in regard to cases where disabled persons faced denial of life sustaining treatment. "physicians...did not understand the prospects of people with disabilities to live good.. lives...and recommendations sometimes reflected confusion concerning the distinction between terminal illness and disability."

People do have the absolute right to refuse procedures they find unacceptable. Yet, the doctor's focus should always be on what more can be done for the patient so he or she will feel physically or emotionally better. Is there enough pain management? Has the full range of palliative care options and complementary therapies been suggested? What resources will allow the person to maintain independence longer? Prescribing drugs with the sole intent of helping a patient kill himself is not medical care. It is simply closing a book.

Act 7105 reverses society's normal expectations of health care. Consider Section 8. Psychologists are usually in the forefront of suicide prevention. However under the act, they could be the ones giving the final green light for a suicide! And how accurate would their assessment be? An ill person's mood and mental status can fluctuate widely based on physical factors such as liver function. A person could have a psychological condition on some days but not on the day he sees the counselor.

If physicians are allowed to enable death or indeed made to feel that they should enable death despite the oath they have taken to do no harm, everything on the treatment continuum will shift. The withdrawal of care, instead of being the endpoint of the spectrum, becomes middle ground. It is this possible change in medical culture akin to what has happened to the Netherlands that will put people with disabilities and other marginalized groups at risk. This is so even if the safeguards placed in the law are technically observed. Quite simply, the traditional medical goal of preservation of life will play second fiddle to a host of other goals, the least of which is patient autonomy.

The act is rife with ambiguity but one reference that personally threatens me has to do with a third party being able to communicate for a patient in some situations (Section 1). My speech can be hard to understand. It takes effort for a listener. Could a doctor use this as an excuse to ask another (including a person speaking without my authorization) to indicate my wishes? No one in this legislature would like to contemplate such a hypothetical situation for himself or herself.

As for Section 9 which prohibits the person signing the death certificate from listing the proximate cause of death as the lethal drug prescription, I can only say that those who do not know history are condemned to repeat it.

A few years ago, Connecticut took a great leap forward by abolishing the death penalty. Let us not go backward by legalizing physician suicide. Please have a second thought..

Senator Edward Kennedy was told he had three months to live after brain tumor diagnosis. He lived for a productive fifteen months. His widow, Victoria Reggie Kennedy, in explaining why she opposed Question 2, a 2012 Massachusetts ballot initiative to legalize assisted suicide, wrote "Senator Kennedy called quality, affordable health care for all the cause of his life. Question 2 turns his vision of health care for all on its head by asking us to endorse patient suicide – not patient care – as our public policy for dealing with pain and the financial burdens of care at the end of life. We're better than that."

Massachusetts, a progressive state, proved her right by defeating the initiative.

Isn't Connecticut is better than that as well?

Sources for quotations:

William J. Peace. "Comfort Care as Denial of Personhood," *Hastings Center Report* 42, no. 4, (2012), p. 15

Victoria Reggie Kennedy. *Cape Cod Times* October 27, 2012