Connecticut General Assembly
Judiciary Committee Public Hearing
HB 7015 Testimony from Father Ted Tumicki
March 18, 2015

Good morning/afternoon/evening. I am Father Ted Tumicki. I am a pastor, moral theologian, canon lawyer, son, brother, and uncle. I live in Jewett City, and I am speaking against House Bill 7015, *An Act Concerning Aid in Dying for Terminally Ill Patients*.

I am opposed to legalizing assisted suicide for several reasons:

1. It would create two classes of people: (1) those who have lives worth living and thus are worth defending and (2) those whose lives are no longer worth living and thus are not worth defending. Once society determines that some people have lives no longer worth living, then it is a very short step to not allowing them to live longer or not allowing them to access life-saving or life-extending treatments. Terminally ill Oregon residents Barbara Wagner and Randy Stroup discovered that their insurances would not pay for them to prolong their lives but would pay for them to end their lives with assisted suicide, and this under a law with (supposed) safeguards. There is nothing in House Bill 7015 that would prevent such a scenario from happening in Connecticut.

2. A patient's choice would not have to be respected and murder would be facilitated. Under such a law a person could request and receive the lethal overdose of medication, then change his/her mind and choose not to take it, but then someone else could mix it with her juice (or other liquid) and give it to the person against his/her choice. No one would know if the person was murdered.

3. The death certificate would be required to be false – it would be required to list the underlying illness as the cause of death even though the overdose of medication is what actually kills the patient. Under this "new" law, are you going to prosecute a physician who writes the truth on a death certificate?

4. There would be no meaningful oversight. Minimal records would be required to be kept, and no records would be required to be checked to ensure compliance. Deliberately lethal overdoses of medication would be easily dispensed with no follow-up or oversight. How is the state going to ensure that unused medication is returned or ensure that deliberately lethal medication dispensed under state sanction is used for its required purpose of suicidal death and not murder? How is the state supposed to enforce a process when there is no public oversight?

Passing House Bill 7015 into law, facilitating murder under the guise of compassionate care, requiring falsification of death certificates to cover up the real cause of death, and allowing the dispensing of deliberately lethal medication with no public oversight creates not only bad public policy but dangerous public policy.

I ask you to vote against this bill.

Additional Points in Reference to House Bill 7015:

- Doctors involved in the process do not have to know the patient. The patient could show up asking for suicide and the doctors can consent if the patient is terminally ill; but then again, if no one is checking the records, who will know if the patient is not terminally ill?
- The required witnesses, who would attest to the competency of the requesting patient, can be total strangers with no knowledge of the patient. After just meeting the patient and reviewing the patient's driver's license, how is a witness really able to adequately determine competency?

Points in Reference to Assisted Suicide in Oregon:

While there is a minimal amount of oversight in Oregon, the latest report of the Oregon Public Health Division reporting on the statistics of assisted suicide in that state indicate that the data is incomplete:

- Out of 155 prescriptions written in 2014, they do not know what has happened with 24 of them - they do not know whether the patient is alive or dead or whether the medication was ingested or not.
- Out of 105 ***known*** cases of "assisted suicide" in 2014, they do not know what the circumstances were from the time of ingestion until death in 85 of those cases; thus, they do not know whether or not the patient was coerced at the last minute or the medication was mixed with a drink and given to the patient against the patient's will.
- Out of 324 ***known*** cases of "assisted suicide" in 2011, 2012, 2013, and 2014, they do not know what the circumstances were from the time of ingestion until death in 274, or 84.5% of those cases. Is it good public policy to dispense deliberately lethal medications and not know what happens with them?

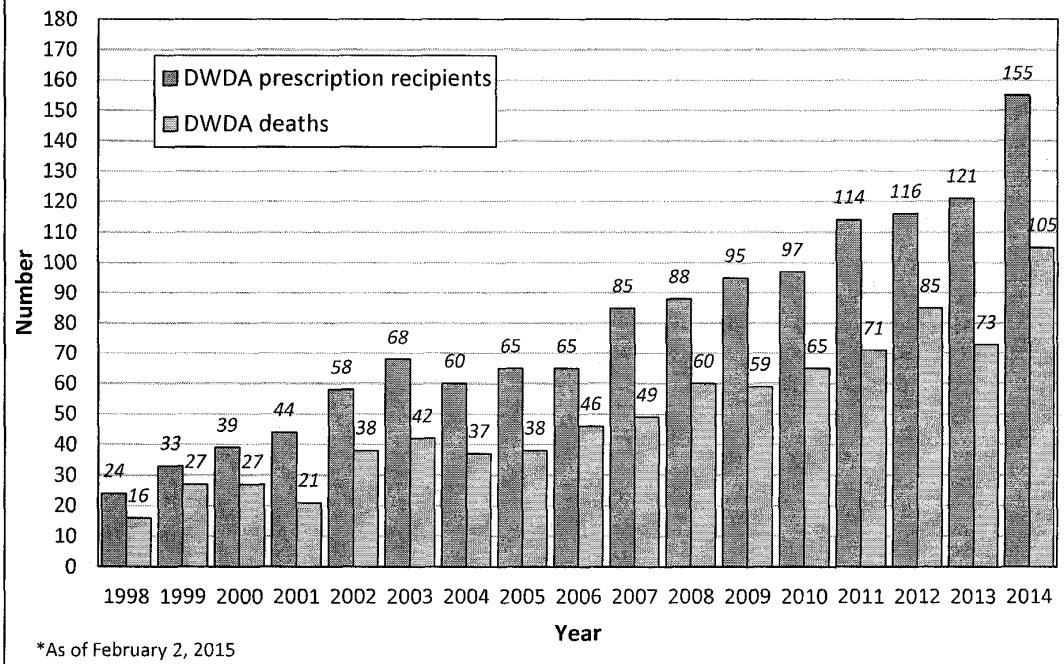
Excerpts from the most recent Oregon *Death With Dignity Act* Annual Report follow.

Oregon Public Health Division

Oregon's Death with Dignity Act--2014

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. The key findings from 2014 are presented below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of prescribed DWDA medications (DWDA deaths) reported in this summary are based on paperwork and death certificates received by the Oregon Public Health Division as of February 2, 2015. For more detail, please view the figures and tables on our web site: http://www.healthoregon.org/dwd.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2014



*As of February 2, 2015

- As of February 2, 2015, prescriptions for lethal medications were written for 155 people during 2014 under the provisions of the DWDA, compared to 121 during 2013 (Figure 1). At the time of this report, 105 people had died from ingesting the medications prescribed during 2014 under DWDA. This corresponds to 31.0 DWDA deaths per 10,000 total deaths.[1]

[1] Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2013 (33,931), the most recent year for which final death data are available.

Characteristics	2014 (N=105)	1998-2013 (N=754)	Total (N=859)
Underlying illness			
Malignant neoplasms (%)	**72 (68.6)**	**596 (79.4)**	**668 (78.0)**
Lung and bronchus (%)	16 (15.2)	139 (18.5)	155 (18.1)
Breast (%)	7 (6.7)	57 (7.6)	64 (7.5)
Colon (%)	5 (4.8)	49 (6.5)	54 (6.3)
Pancreas (%)	9 (8.6)	47 (6.3)	56 (6.5)
Prostate (%)	2 (1.9)	33 (4.4)	35 (4.1)
Ovary (%)	5 (4.8)	28 (3.7)	33 (3.9)
Other (%)	28 (26.7)	243 (32.4)	271 (31.7)
Amyotrophic lateral sclerosis (%)	**17 (16.2)**	**54 (7.2)**	**71 (8.3)**
Chronic lower respiratory disease (%)	**4 (3.8)**	**34 (4.5)**	**38 (4.4)**
Heart Disease (%)	**3 (2.9)**	**14 (1.9)**	**17 (2.0)**
HIV/AIDS (%)	**0 (0.0)**	**9 (1.2)**	**9 (1.1)**
Other illnesses (%)[6]	**9 (8.6)**	**44 (5.9)**	**53 (6.2)**
Unknown	***0***	***3***	***3***
DWDA process			
Referred for psychiatric evaluation (%)	3 (2.9)	44 (5.9)	47 (5.5)
Patient informed family of decision (%)[7]	95 (90.5)	634 (93.6)	729 (93.2)
Patient died at			
Home (patient, family or friend) (%)	94 (89.5)	716 (95.3)	810 (94.6)
Long term care, assisted living or foster care facility (%)	8 (7.6)	29 (3.9)	37 (4.3)
Hospital (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	3 (2.9)	5 (0.7)	8 (0.9)
Unknown	*0*	*3*	*3*
Lethal medication			
Secobarbital (%)	63 (60.0)	403 (53.4)	466 (54.2)
Pentobarbital (%)	41 (39.0)	344 (45.6)	385 (44.8)
Other (%)[8]	1 (1.0)	7 (0.9)	8 (0.9)
End of life concerns[9]	**(N=105)**	**(N=754)**	**(N=859)**
Losing autonomy (%)	96 (91.4)	686 (91.5)	782 (91.5)
Less able to engage in activities making life enjoyable (%)	91 (86.7)	667 (88.9)	758 (88.7)
Loss of dignity (%)[10]	75 (71.4)	504 (80.6)	579 (79.3)
Losing control of bodily functions (%)	52 (49.5)	376 (50.1)	428 (50.1)
Burden on family, friends/caregivers (%)	42 (40.0)	300 (40.0)	342 (40.0)
Inadequate pain control or concern about it (%)	33 (31.4)	178 (23.7)	211 (24.7)
Financial implications of treatment (%)	5 (4.8)	22 (2.9)	27 (3.2)
Health-care provider present[11]	**(N=105)**	**(N=684)**	**(N=789)**
When medication was ingested[12]			
Prescribing physician	14	119	133
Other provider, prescribing physician not present	6	238	244
No provider	4	76	80
Unknown	*81*	*251*	*332*
At time of death			
Prescribing physician (%)	14 (13.9)	107 (15.9)	121 (15.7)
Other provider, prescribing physician not present (%)	6 (5.9)	263 (39.2)	269 (34.8)
No provider (%)	81 (80.2)	301 (44.9)	382 (49.5)
Unknown	*4*	*13*	*17*
Complications[12]	**(N=105)**	**(N=754)**	**(N=859)**
Regurgitated	0	22	22
Seizures	0	0	0
Other	0	1	1
None	20	487	507
Unknown	*85*	*244*	*329*
Other outcomes			
Regained consciousness after ingesting DWDA medications[13]	0	6	6

Characteristics	2014 (N=105)	1998-2013 (N=754)	Total (N=859)
Timing of DWDA event			
Duration (weeks) of patient-physician relationship[14]			
Median	19	12	13
Range	1-1312	0-1905	0-1905
Number of patients with information available	*105*	*752*	*857*
Number of patients with information unknown	*0*	*2*	*2*
Duration (days) between 1st request and death			
Median	43	48	47
Range	15-439	15-1009	15-1009
Number of patients with information available	*105*	*754*	*859*
Number of patients with information unknown	*0*	*0*	*0*
Minutes between ingestion and unconsciousness[11, 12]			
Median	5	5	5
Range	2-15	1-38	1-38
Number of patients with information available	*20*	*487*	*507*
Number of patients with information unknown	*85*	*267*	*352*
Minutes between ingestion and death[11, 12]			
Median	27	25	25
Range (minutes - hours)	11mins-1hr	1min-104hrs	1min-104hrs
Number of patients with information available	*20*	*492*	*512*
Number of patients with information unknown	*85*	*262*	*347*

1 Unknowns are excluded when calculating percentages.

2 Includes Oregon Registered Domestic Partnerships.

3 Clackamas, Multnomah, and Washington counties.

4 Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.

5 Private insurance category includes those with private insurance alone or in combination with other insurance.

6 Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease.

7 First recorded beginning in 2001. Since then, 37 patients (4.7%) have chosen not to inform their families, and 16 patients (2.0%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and 3 in 2013.

8 Other includes combinations of secobarbital, pentobarbital, phenobarbital, and/or morphine.

9 Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

10 First asked in 2003. Data available for all 105 patients in 2014, 625 patients between 1998-2013, and 730 patients for all years.

11 The data shown are for 2001-2014 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001.

12 A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.

13 There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (http://www.healthoregon.org/dwd) for more detail on these deaths.

14 Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.