

**Joint Statement from the Catholic Hospitals
in the State of Connecticut
March, 2015**

Patients nearing the end of life need compassionate, holistic care, not physician-assisted suicide. At its heart, physician-assisted suicide is neither a legal issue nor a political issue. It is not even fundamentally a religious issue. It is a human issue. As such, it transcends political, legal and religious boundaries. Factors that lead to requests for aid in dying such as loss of a sense of control, loss of a sense of meaning and purpose, fear of being a burden on others, and even physical pain or other uncontrolled bodily symptoms are at the heart of human dignity. Healthcare which addresses these fundamental concerns is an obligation we owe to our most vulnerable patients. Proper care for the dying is not the same as assisting them in suicide.

Raised Bill 7015 has a number of terminal flaws, from both a procedural and substantive perspective: it hides the truth behind deceptive nomenclature and allows practitioners and agencies to escape accountability. It violates Catholic teaching on the sacredness and dignity of human life and the *Ethical and Religious Directives for Catholic Health Care Services* as well as fundamental tenets of bioethics and codes of ethics from both the American Medical Association and the American Nurses' Association. Most importantly, it does not accomplish the goals it purports to attain: promotion of patient autonomy, lessening of a sense of burden, loss of self and alleviation of pain and suffering.

The bill goes to great lengths to distance itself from the moniker "physician-assisted suicide", yet this is exactly what it is. If this legislature, and transitively, the people of the state of Connecticut, agrees that assisting in suicide is ethical and should be legal, why are you afraid to call it what it is? You cannot have it both ways. The bill states that "A person is guilty of murder when such person, without authorization of the patient, willfully alters or forges a request for aid in dying . . . or conceals or destroys a rescission of such a request for aid in dying with the intent or effect of causing the patient's death" (Sec. 14). Yet, it also states that "Nothing in sections 1 to 14 inclusive of this act . . . authorizes a physician or any

other person to end another person's life by lethal injection, mercy killing, *assisted suicide*, or any other active euthanasia" (Sec. 15). Directly and intentionally ending another person's life is murder. Directly and intentionally ending one's own life is suicide. The euphemism which the Bill uses to refer to assisted suicide is "participate in the provision of medication" (Sec. 13). This represents an even further attempt beyond previous versions of this Bill to obscure the reality it represents.

This distinction is more than just semantics. It draws attention to one of the fundamental flaws of the Bill. It hides from the truth, and lets doctors and reporting agencies do the same. There is no accountability in this Bill. Section 9 states that "The attending physician may sign the qualified patient's death certificate that shall list the underlying terminal illness as the cause of death" (Sec. 9, 6b). This is a lie. The cause of death is the ingesting of up to 80 pills that are designed to kill the patient in less than three hours. Why are proponents of this bill afraid to call it what it is? In addition, how are we to track deaths that fall under this Act? If we cannot track them and differentiate them from all other deaths, how can we measure either sanctioned use or potential abuses? How can we be held accountable?

This draws attention to another critical flaw in the Bill. It does not differentiate between the foregoing of extraordinary medical treatment, which is recognized as a fundamental legal and ethical right, and assisting in suicide. These are very different things. US Jurisprudence has unequivocally stated that physician-assisted suicide is not a fundamental constitutional right (see USSC rulings in *Washington v Glucksburg* and *Vacco v Quill*). In these rulings, it recognized legitimate state's interest in prohibiting physician-assisted suicide, among which were preservation of the integrity of the medical profession and avoidance of the "slippery slope". What the Supreme Court did call for was a better use of existing resources: appropriate and aggressive palliative care, preservation of patient autonomy through Advance Directives, and the right of patients to refuse treatments that pose little or no medical benefit or undue burden, as well as the recognition of the need to provide better emotional, psychological and spiritual support for the terminally ill. Legislation regarding Palliative Care (Public Act 13-55) and the MOLST pilot program may, if framed within the context of ethical principles and

guidelines, help promote these goals as well. This physician-assisted suicide bill does not. It makes end-of-life another medical treatment. It should be much more than this.

Proponents of this bill will cite the experience of the Death with Dignity Act in Oregon, and will note that the bill has improved overall care for the dying in that state. They will cite a greater willingness on the part of physicians to discuss end of life issues with patients and to effectively pursue pain management. However, discussions regarding goals of care and end of life issues as well as a willingness to provide appropriate palliative care do not de facto flow from a physician assisted suicide bill, but from the desire on the part of health care providers to enter into the experience of the dying patient and accompany them on this journey. In addition, safeguards that are in place to prevent potential abuse are sometimes unmet. For example, in 2014 the state of Oregon reported that only “three of the 105 DWDA patients who died during 2014 were referred for formal psychiatric or psychological evaluation” (2014 Death with Dignity Act Annual Report, 2), and since its inception only 5.9% of all patients who received life-ending medication were referred for psychiatric evaluation even though “Despite its prevalence among patients with serious illness, clinical depression is often unrecognized” (National Cancer Institute), and even though assessment of decision-making capacity, possible depression, and emotional stability is a key component of the Act. The current Bill under consideration has similar provisions regarding psychiatric support and evaluation; however they, like the provisions in the Oregon Bill, will likely go unmet.

Physician-assisted suicide is inherently unethical. It violates codes of ethics and fundamental principles of bioethics. A central tenet of the Hippocratic Oath states “I will not give a lethal drug to anyone if I am asked” (Hippocratic Oath, US National Library of Medicine). The American Medical Association Code of Ethics states:

Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is

impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (AMA Code of Ethics, Opinion 2.211 I, IV).

The American Nurses' Association Statement on Physician-Assisted Suicide states:

The American Nurses Association (ANA) prohibits nurses' participation in assisted suicide and euthanasia because these acts are in direct violation of *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001; herein referred to as *The Code*), the ethical traditions and goals of the profession, and its covenant with society. Nurses have an obligation to provide humane, comprehensive, and compassionate care that respects the rights of patients but upholds the standards of the profession in the presence of chronic, debilitating illness and at end-of-life.

You have heard testimony from physicians and patients about their experiences with terminal illness. Our first response to these patients must be one of empathy and *true* compassion. The most fundamental flaw of this Bill is that it has the potential to short-circuit proper care for the dying. Studies indicate that physical pain is not the most significant factor in requests for physician-assisted suicide. It currently ranks #5 on the list of factors. Indeed, the National Cancer Institute states:

While unrelieved physical suffering may have been widespread in the past, modern medicine now has more knowledge and skills to relieve suffering than ever before. Today, specialists in palliative care believe that if all patients had access to careful assessment and optimal symptom control and supportive care, the suffering of most patients with life-threatening illnesses could be reduced sufficiently to eliminate their desire for hastened death. Even when the desire persists, avenues other than physician-assisted suicide or euthanasia are available to remedy suffering and still avoid prolonging life against the patient's wishes (National Cancer Institute "Education in Palliative and End of Life Care for Oncology" pg 4).

In fact, one study states that “pain alone was a motivator in 3% of requests [for physician-assisted suicide] (Arnold EM. Factors that influence consideration of hastening death among people with life-threatening illnesses. *Health Soc Work.* 2004;29(1):17-26).

If physician-assisted suicide is not the answer, what is?

Dr. Ira Byock, executive director and chief medical officer of Providence Health & Services’ Institute for Human Caring, writes:

If somebody feels they are trapped within a burning room and there is no alternative but to either die in horrible suffering or end their life prematurely, the notion of assisting them in suicide seems reasonable, even progressive. But if we know that there is a fire extinguisher behind a panel in that room and that a fire escape is behind the door if you just know where to push, the idea of giving them a lethal dose of medication or a way to end their life prematurely would seem absurd. I know that those ways of alleviating suffering are readily available. We’re simply not making people aware of them and not building them into the health care environment (Byock, 2015).

Proper care at the end of life involves addressing those factors cited above which can lead to requests for aid in dying: loss of a sense of control, loss of a sense of meaning and purpose, a sense of being a burden on others, and in some cases, physical pain. Conversations around end-of-life are our fire extinguishers; appropriate and fully-integrated palliative care is our fire escape. We preserve patient autonomy and control through effective communication about their goals and values and the use of Advance Directives. We promote human dignity and a sense of meaning and purpose when we recognize that the dying are not expendable or a burden, and when we cherish them in their personhood and accompany them on their journey with true compassion. Advances in pain management have made it possible to virtually eliminate physical pain as a factor in requests for aid in dying. Healthcare providers who specialize in palliative care and/or hospice are expert at not only alleviating physical pain, but also at providing holistic care that addresses these other existential factors. Palliative care is significantly underutilized in the United States, and especially in Connecticut. However, the state’s Palliative Care Advisory Committee provides some hope that

we will be more effective in integrating palliative care into the full continuum of care in the future. Connecticut is the birthplace of the hospice movement in the United States, yet we currently rank in the bottom 2% in the nation regarding timeliness of hospice referrals, which are supposed to occur when a patient has six months or less to live as judged by a physician. On average in Connecticut, patients are referred to hospice with less than *two weeks* to live. This does not allow for adequate time to address the physical, emotional, spiritual and psychological needs of patient and family. Our resources and our votes should be dedicated towards supporting these initiatives. We can and must do better.

Fundamentally, providing “compassionate aid in dying” as this bill is called, means helping the terminally ill to see that they are not disposable. The dying have a lot to teach the living about life, if we choose to listen. We promote compassionate care for the most vulnerable among us when we affirm their existence, listen to and acknowledge their fears, aggressively treat their pain and help them alleviate their spiritual and existential suffering, not by assisting them with suicide.

Respectfully submitted,

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