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Sen. Coleman, Rep. Tong and Distinguished Members of the Judiciary Committee,

Connecticut Right to Life is firmly opposed to HB 7015, which would permit Assisted Suicide in Connecticut. CRLC believes that every moment of life from conception until NATURAL death has meaning and value. We are meant to live and experience our own life, and to learn from others. It is our responsibility to give hope to others – most importantly when our mental, physical and economic health may seem the most bleak. By definition, we are concerned that those who resign themselves to suicide suffer from lack of hope and should be assisted to find that meaning – meaning that sometimes may be difficult to discern.

We believe that assisted suicide – in its current form, as well as ANY potential construct imaginable to end life before its natural conclusion– is contrary to natural law. It also removes the very dignity of an individual who might choose this route particularly as perceived to others. This also promotes a psychological permissiveness among society that may enable others to lose hope as well. If assisted suicide becomes associated with certain specific ailments, we can foresee a culture that reduces its value on research to develop more effective pain medications and cures for ALS, cancers, kidney disease and other ailments. Insurance companies first and government second could at some point in the future decide assisted suicide is a more efficient means of handling a terminal disease than the cost of medication, dialysis, and medication for those who prefer to keep on going. In sum, this bill can cheapen the value of human life.

Even with the so called safeguards proposed – we can see the legislature revisiting this issue year after year just as it had with the death penalty to further reduce the requirements proponents have in mind today. Just as doctor's prognostications of a lifespan are arbitrary, so too are the safeguards:

- For instance, why should a death prognosis be only 6 months? Why not 1, 3, or 12? How is this objectively determined so that a doctor cannot be accused of prematurely writing prescriptions?
- Why not there be a 3 month period? Or one? Or none?
- Why limit the taking of ones' life only be limited to a terminal illness? And why not open the door to changing the definition of terminal illness to simply one of an illness to which there is no cure?
- How is "terminal illness" defined? Aren't all diseases eventually terminal or contributory?
- Why wouldn't the definition begin to apply at some point to a subjective quality of life as perceived either by a patient or their family members or even professional who may or may not have conflicting goals or interests?

In previous versions of the bill, there were provisions protecting healthcare workers, facilities and pharmacists from being required to participate in the suicide. Why have those been removed?

Proponents intend that the patient can only deliver the medication themselves. As a paramedic, I have often responded to calls for assistance from the families of hospice patients at home. Because the signs of death are often unfamiliar to the lay person, we often have to provide support to the family at that time, and sometimes transport them to the hospital. As a lifesaving service, we would have some difficult decisions. Our role is to intervene and help when life may be most bleak. . When emergency care workers – tasked and devoted to HELPING people and GIVING them hope – encounter a patient with this end of life prescription, what then is their role? People are often surprised at what comfort we can provide, especially when perhaps they have been abandoned in a nursing home or even at home.

How do I address my everyday patients who have thoughts of suicide? They certainly may have a similarly bleak outlook on life and wants to take his own life but cannot because he is not yet ‘terminal’, but of course might attempt to seek that diagnosis. We all know that we have a deep recession. Economic and medical costs may lead some to allow their condition to deteriorate. They may ask: “I’m suffering. Why can’t I end my life?”

- What if a family member calls for EMS to intervene with the patient who has this supposed license to end their own life?
- What if the necessary paperwork cannot be found in a timely manner, as is often the case with DNR’s and living wills today? What are the law enforcement implications of this as well, on whether or not to treat the scene as a crime scene?
- If the patient takes a less than lethal dose, would that indicate that the patient has suddenly changed their mind, or is simply incapable of physically completing the suicide?
- Can a bystander assist in this and what if the patient intends to reverse the decision during the administration?
- If this same person was then ‘assisted’ to complete the procedure, would the bystander be an accessory to murder, particularly if they are unable to discern if the patient changed their mind?
- Can a bystander or non-physician healthcare worker or family member override a patient’s nonverbal but clear cues they want to change their mind? This would entirely change the paradigm of consent in healthcare.
- What if a patient administers the medication alone, but is found unconscious by a person who does not know the person intended and was legally allowed to take their own life?

Death is a scary proposition for many people. Family members and friends are often shy and skittish to question or change their course of care after it is begun. Families often believe they are in agreement, but do not talk about sensitive issues. Even today, doctors often attempt to steer family members to believe that a patient’s condition is terminal or of poor condition. On top of that, many families often have a 'take charge' person who sometimes dominates these discussions to the detriment of the patient and others with dissenting views who may stay quiet even in the face of such an intractable decision.

The terms “dignity” and “mercy” are extremely subjective and we implore the legislature to not use them in any bill or in reference to any patient.

Doctors, lawyers and judges’ roles are also questionable. They cannot foresee the lessons we can have in life even when the present seems bleak. These people also only see brief glimpses into our life and

cannot adequately make a value judgment on whether or not someone can learn or be able to further their own life. With the demands of the ACA, the time a doctor spends with a patient is exceedingly brief. They are human beings, and even at their best can be wrong even with the best technology. Medicine is often changing- new treatments for maladies we didn't have yesterday, and more drugs that can make life more tolerable. That is, if we allow the resources to find them.

The answer to all of these questions is clear: Give hope. Encourage others to give hope. Become knowledgeable about alternatives including hospice, palliative care and humane treatment. Understand that there are no obligations among anyone in our society to sustain extraordinary or heroic measures beyond ones financial means except for ordinary means of nutrition, hydration and hygiene while at the same time maintaining dignity. We continuously are making strides in advances for pain and comfort management. Providing spiritual and religious assistance in the end of life is also important.

As a matter of law, Congress and the legislature often looks towards philosophical references for guidance in our position. We believe the legislature would find these helpful as well. I have added the Catholic Church's end of life medical directives as an appendix to my testimony for your reference.

It is our greatest concern that should SB 6645 pass in any form, we could go down the road of pre-war Germany. In the 1930s, seemingly reasonable and compassionate ideas quickly became a slippery slope of prosecution and the murders of millions of people with mental and physical disabilities, people of color, homosexuals, the Jewish population and then non-Germans.

Laughter is the best medicine, and Washington Post humorist Art Buchwald was given a diagnosis where his kidneys were failing him. He checked himself into Hospice where he held what he thought would be the last visits with many friends, and also planned what he believed would be the end of his life, including his funeral and obituary (don't die on the same day as another famous person). After several months though, something surprising occurred. He continued to live and was kicked out of Hospice. He still had one more task in life. He wrote a book entitled "Too Soon to Say Goodbye". And then he did.

Life is full of surprises. Almost two decades after losing contact with my aunt, my grandmother found herself in a nursing home. In the final weeks of her life, my aunt had a chance encounter with my sister and was reunited with my grandmother shortly before she died. That held great meaning for my grandmother and my family. We may never know the blessings that are yet before us.

"Whether it is the best of times or the worst of times, it is the only time we have."

— [Art Buchwald](#)

Ethical and Religious Directives for Catholic Health Care

Part 5: Issues in Care for the Seriously ill and Dying.

Source: <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>

55. Catholic health care institutions offering care to persons in danger of death from illness, accident, advanced age, or similar condition should provide them with appropriate opportunities to prepare for death. Persons in danger of death should be provided with whatever information is necessary to help them understand their condition and have the opportunity to discuss their condition with their family members and care providers. They should also be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them. They should be provided the spiritual support as well as the opportunity to receive the sacraments in order to prepare well for death.

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.³⁹

57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.

58. In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care.⁴⁰ Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed."⁴¹ For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.

59. The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.

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60. Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.⁴²

61. Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person’s life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

62. The determination of death should be made by the physician or competent medical authority in accordance with responsible and commonly accepted scientific criteria.

63. Catholic health care institutions should encourage and provide the means whereby those who wish to do so may arrange for the donation of their organs and bodily tissue, for ethically legitimate purposes, so that they may be used for donation and research after death.

64. Such organs should not be removed until it has been medically determined that the patient has died. In order to prevent any conflict of interest, the physician who determines death should not be a member of the transplant team.

65. The use of tissue or organs from an infant may be permitted after death has been determined and with the informed consent of the parents or guardians.³³

66. Catholic health care institutions should not make use of human tissue obtained by direct abortions even for research and therapeutic purposes.⁴³