**TESTIMONY**

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Before the Judiciary Committee

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**To OPPOSE Raised Bill No. 7015:**
**An Act Concerning Aid in Dying for Terminally Ill Patients**

Senator Coleman, Representative Tong and members of the Judiciary Committee. My name is Dr. Mark Rego and I have practiced psychiatry in Connecticut for 25 years. I am Board Certified in both General Adult and Geriatric Psychiatry, have been a medical consultant to the Connecticut Department of Developmental Services and currently teach psychiatric residents at Yale.

The wish to die is as old as recorded civilization. Most often we associate it with clinical depression. It is also known to occur with traumatic bereavement, severe pain, torture and the prospect of death itself. In each of these situations it is the existence of pain or other forms of severe duress as well as lack of hope for any comfort in the future that seems to underlie the wish to die.

Recently several western countries and some states in our own country have proposed the existence of a right to die that derives from the rational deliberation of a competent person in the throws of a hopeless medical disorder. Furthermore it is proposed that such government entities not only recognize this right but also allow physicians and other qualified clinicians to assist the suicidal person. This raises many questions most of which have been reviewed by other testimony. I wish here to review two other issues that are not often reviewed in this debate.

The first is whether, given the historical context of how the wish to die arises (severe duress and lack of hope for any improvement) and the context of when such a right might be recognized by society (essentially the same conditions), whether or not the emotional effects of such duress and hopelessness can be reasonably separated from a rational process of deliberation.

Second is whether society can guarantee the exercise of such a right without intentionally excluding some from exercising it out of an abundance of caution or, whether in order to guarantee the right to all who supposedly qualify society must necessarily include some who do not qualify.

To take up the first point it is important to recognize the universality with which we as a civilization are familiar with the wish to die. Mental health experts tell us that a majority of clinically depressed individuals experience some form of a wish to die even if their psychological duress is not severe (i.e. he/she may have felt worse on other occasions but not experienced a wish to not live until developing a clinical depression). Although clinical depression is the major risk factor for suicidal thinking and acting, patients with psychotic disorders as well as severe anxiety disorders also are at risk for suicide. Physical pain is also a circumstance in which people are known to develop a wish to die. Consistent

pain whether as part of a medical disease or inflicted by torture can produce a wish to take one's life or be killed. Lastly, lack of hope for any improvement in one's future can be the context of a wish to die.

Complicating this issue is the fact that most people in these circumstances do not develop a wish to die. In addition, research has failed to show a clear correlation between the severity of suffering or disability and the wish to die. For example, some neurologic disorders reliably produce changes in mood and frequently a wish to die (multiple sclerosis) while others with a much worse prognosis usually do not (ALS).

I will mention here two important facts. First, one of the most important, universal and extensively researched topics in modern psychology is that of cognitive bias. This essentially means that it has been shown over and over that even small changes in a person's mood or outlook can significantly bias his/her thinking. Secondly, in Connecticut as in most states the law demands that a psychological evaluation be carried out (usually by a practicing psychiatrist) in order to determine competence to make medical decisions, legal agreements or even to stand trial. Most states have similar statutes.

To return to the topic of this bill, when we look at the conditions named as rationale for the wish to die they are just the circumstances that produce the suicidality we wish to relieve our patients and peers from. How then can we separate the two groups? A reflexive position would be to assess how much the patient's outlook matches the reality of the situation and use this as a basis for discerning how much the individual is affected by his or her emotional status (that in itself will be very much affected by the condition in question). One might assume that a truly terrible situation would bring about a proportionately pessimistic outlook. But both experience and research show us that this is not true. The degree of some one's impairment or the unlikelihood of their survival does not seem to affect one's wish to live. Pain, loneliness, fear, anxiety and depression all affect it though. And these are the very things we can and should offer full treatment for. Sadly, as a society we do not reliably offer these staples of mental and physical well being to the sickest of the sick. If we cannot reliably offer remediation of pain and suffering how can we decide who is "reasonably" afraid of these things and then should avoid them via suicide? And if we ourselves do not know, how can we decide whom among the frightened and grievously ill do?

Furthermore when a long legal tradition demands a psychological exam be carried out by extensively trained experts for most important life decisions when competence is of any question, and all of modern psychological research alerts us of the biases in thinking produced by emotional events, how could anyone accept this legislation not be accompanied by extensive mental health services?

This leads to my second point, which is the role society plays in adjudicating whether or not the person making the wish to die is competent to do so. Most systems will include only experts in medicine to testify that a person meets statutory criteria regarding the right to die. These people will judge whether or not the patient passes certain tests established by the state indicating whether or not the condition the person has meets requirements as reasonable to want to escape from via death and whether or not the person is competent to make this decision.

The key word here is “test.” In the law this usually means meeting certain criteria or passing thresholds. It means the same in science and medicine. In science and medicine however we are aware of the limits of any testing no matter how thorough or precise. These limits are known as the sensitivity and specificity of the test. What these terms mean is that if you wish to make a test that does not exclude anyone who truly qualifies you must accept some results, which will be “false positives.” That is, people who seem to meet criteria but in reality do not. On the other hand if you do not wish to ever have people included who do not meet criteria, your tests must be highly exclusionary and necessarily exclude people who might meet criteria.

Over the past decade society has witnessed the cost of not recognizing these limitations with various projects that use DNA evidence to exculpate prisoners. Some of these individuals have been on death row for crimes, it turns out, they have not committed. And all this after the extensive use of a system with a very high threshold for evidence, “beyond any reasonable doubt” and an adjudicating process many times more thorough than the one proposed by this bill. The serious question this raises is that if the criminal justice system with extensive trials lasting months and including many experts, witnesses, jury members and legal officials cannot reliably conclude who is guilty (and sentences people who are provably not guilty in spite of intensive use of safe guards), can a much smaller system safely, justly and reliably conclude who is able to make a reasonable decision and who is not? The law does endeavor to make this decision in other areas such as wills and the right to make medical decisions. But these are all aimed at benefitting a living patient and in a worse case scenario can be reversed or adjusted. A process that concludes that a person can die cannot be wrong. There is not precedent for such an infallible system.

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