3/18/15

HB 7015

Testimony of Lenore Snowden Opalak MD, Internal Medicine Private Practice in Fairfield County.

During my 25 years in practice, I have had the privilege of providing home based care for many patients in the final stages of life, and patients with debilitating incurable illnesses that can continue for years. Their diagnoses have varied from end-stage heart failure to cancers, to neurologic diseases. In spite of what an outside observer might term "poor quality of life" , none of these spatients, no matter how disabled from their disease, (including those who are unable to even get out of bed and are totally dependent on others for the most basic necessities of life), has ever expressed any desire to terminate their lives. What they desired, and received, was treatment to help them through any pain or distress, and assistance to overcome their limitations, so that they could experience what life they had left. In contrast , the only patients I have encountered who expressed a desire to hasten their death were patients with nonterminal illnesses, clearly suffering from depression, loneliness, or estrangement from family. To suggest that death is a solution to their problems would be an abandonment of these patients to the hopelessness that they already experience, and rather than being "compassionate", actually increases the profound psychological suffering of people who have come to the tragic conclusion that their life is worthless. By complying with a patient's request for assisted suicide, we are thus concurring that the patient's life is indeed not worth living. Is this the message that you want your doctor to be giving? Are we as a society going to promote the idea that there are lives that are worthless?

The medical literature on the reasons behind requests for assisted suicide (studies primarily from oncology and geriatric journals) , show unequivacably that pain is rarely the reason that patients consider assisted suicide (as low as 3% of requests in some studies); the majority of patients cite depression, hopelessness, fear of dependence on others , fear of loss of autonomy, fear of suffering rather than actual suffering. The fears voiced by these patients are often not based in the reality of their illness , are truly distressing symptoms, and are an invitation for the medical professional to come to the patient's aide in clarifying to reason for their fears, to explain what is likely and not likely to occur in the course of a patient's illness, to communicate the variety of options for alleviating the pain, suffering and loss of autonomy that patients fear. This is a multifactorial approach for a multifactorial problem, a team approach to palliative care involving physical, psychological and social support. To simply prescribe a poison to give a person the means to end his or her life is to leave that person alone in their lonliness, hopelessness, and suffering.

HB 7015

There are a number of false assumptions in ~~SB 668~~. The premise that patients can decide to end their lives based on medical prognosis is completely erroneous, given that predictions about desease prognosis is a very inexact science. We have all heard of people who have far outlived their prognosis, and in my own practice I have had at least 4 patients , placed in hospice care with poor prognoses, who have outlived their hospice allotment by years! Another patent falsehood in this bill is the requirement that physicians not list assisted suicide as cause of death on the death certificate. Finally, this bill is essentially a requirement that physicians commit malpractice by simply complying with a patient request for suicide rather than giving that request the thorough evaluation and recourse to treatment that such a presentation deserves.

In this age when doctors are monitored for their adherence to evidence based medicine and Best Practice guidelines, the proponents of SB 668 are asking doctors to adopt a practice that has never been subjected to the kind of rigorous testing that society demands for all other medical treatments, and cannot in fact e considered a medical treatment.

In summary, the medical profession cannot support this bill without betraying our commitment to serve and care for patients. A REQUEST FOR PHYSICIAN ASSISTED SUICIDE INDICATES UNRELIEVED SUFFERING, and we as a profession and as a society can do a much better job at addressing such suffering. SB 668 is not the answer.