

## 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. Bill Zeidler, Medical Director of Middlesex Hospital Hospice and Palliative Care for the last 30 years, and a Founding Member of the American Academy of Hospice and Palliative Medicine.

For years I have struggled with the concept of Physician Assisted Suicide. On one hand, I want to help my patients in any way I can, to comfort them during their dying, and hopefully to help them live their lives to the fullest until they die. I do my best to meet them where they are at - honoring and respecting their autonomy. I want to walk their journey with them, advocating for them, supporting their families and loved ones - to be there when they need me most.

On the other hand, I don't want to do them any harm - I surely don't want to make a difficult journey - perhaps the most difficult journey any of us will ever take - any worse, for the patient or those left behind.

With the above in mind, let's look at an unique group of our Hospice patients - those who are discharged alive, after spending months, and sometimes years, in our Hospice Program. We will have approximately 500 admissions to our Hospice this year - of those, 25-50 (5-10%) will be eventually discharged alive, and - obviously - doing better than expected. Why does this happen? Medicine is an inexact science and physicians are at times not the best prognosticators. Also the support offered through Hospice and Palliative Medicine often enables patients and their families to live not only better, but also longer.

How does all of the above affect Physician Assisted Suicide? Studies in Oregon and Washington have shown that 90% of patients who choose Physician Assisted Suicide are enrolled in Hospice Programs. When patients choose PAS, it is often early in the course of their Hospice stay - at which time it is difficult, if not impossible, to predict whether they will die soon, or eventually live longer than expected, and perhaps be discharged. Once PAS is chosen, and acted upon, we will never know.

A story from our Hospice Program, given only after obtaining her permission, might be helpful. D.N. was admitted to our Hospice Unit in November 2008 with a diagnosis of bulbar ALS - with severe neck, arm and laryngeal spasms. She was diagnosed by experienced and skilled neurologists in Boston and New Haven. Her prognosis was thought to be weeks to months, at best. If available, PAS would have been a reasonable option at that time. With aggressive Hospice care, we were able to get her symptoms slowly under control, eventually using an IV drip of Dilaudid, with many other medications. She spent most of her time at home, although she did require 6 Hospice Unit admissions during her first two years on our Program. The intense psychosocial support she received helped her immensely. As she eventually improved and stabilized, we were able to wean her off her IV Dilaudid and all her other medications, and discharge her from Hospice.

She is now living independently, driving a car, and has more quality in her life than she has had in many years - certainly since I first met her in November of 2008. Clearly, in retrospect, PAS would have not been a good option for her 6 years ago!! Perhaps, when discussing PAS, do no harm is more important than patient autonomy.

For patients like D.N., and perhaps many others, I urge you all to OPPOSE this bill - these patients need you and your support!!

Bill Zeidler MD