

Dear Members of the Judiciary Committee,

I am submitting this testimony in opposition to H.B. 7015. As a citizen and as a Catholic priest, I stand opposed to the legalization of physician-assisted suicide, and I ask that you join in defending the true dignity, the true value of human life. Physician-assisted suicide is an assault on human dignity, and I pray that you will stand in defense of the human person.

I include here for your consideration, ten objections to physician-assisted suicide which are available on the website of the Disability Rights Education and Defense Fund (<http://dredf.org/public-policy/assisted-suicide/key-objections-to-the-legalization-of-assisted-suicide/>):

1. Assisted suicide is a deadly mix with our broken, profit-driven health care system.

Financial pressures already play far too great a role in many, if not most, health care decisions. Direct coercion is not even necessary. If insurers deny, or even merely delay, approval of expensive, life-giving treatments that patients need, patients will, in effect, be steered toward assisted suicide, if it is legal.

For example, patients Barbara Wagner and Randy Stroup, Oregonians with cancer, were both informed by the Oregon Health Plan that the Plan won't pay for their chemotherapy, but will pay for their assisted suicide. Though labeled a free choice, for these patients, assisted suicide is a phony form of freedom.

2. Assisted suicide is dangerous to people with disabilities and many other people in vulnerable circumstances.

As only one example, there is considerable evidence that people with mental illness and depression are given lethal drugs in Oregon, despite the claims of proponents that these conditions disqualify a person. (See [testimony by Dr. Gregory Hamilton](#) focusing on problems posed by assisted suicide in Oregon for people with psychiatric disabilities). Other states' laws and proposals offer no additional protections beyond Oregon's.

3. Available statistics show that pain is rarely the reason why people choose assisted suicide.

Most people do so because they fear burdening their families or becoming disabled or dependent. But anyone dying in discomfort that is not otherwise relievable, may legally today, in all 50 states, receive palliative sedation, wherein the patient is sedated to the point where the discomfort is relieved while the dying process takes place. Thus, today there is a legal solution to any remaining painful and uncomfortable deaths; one that does not raise the very serious difficulties of legalizing assisted suicide.

4. The supposed safeguards included in the Oregon and Washington State laws don't really protect patients for many reasons, including these:

1 If a doctor refuses lethal drugs, the patient or family simply can – and do – find another doctor (“doctor shopping”).

2 “Six months to live” is often wildly misdiagnosed, opening the dangers of assisted suicide to many who are not terminally ill. (See the DREDF statement on [The Fundamental Loophole of Terminal Illness Prognosis](#))

3 Nothing in the Oregon law will protect patients when there are family pressures, whether financial or emotional, which distort patient choice.

4 An article from Michigan Law Review, June 2008, shows how the State of Oregon undermines all the safeguards in the law. *Physician Assisted Suicide: A Medical Perspective* (PDF) by Dr. Herbert Hendin and Dr. Kathleen Foley. Herbert Hendin is Chief Executive Officer and Medical Director, Suicide Prevention International, and Professor of Psychiatry, New York Medical College. Kathleen Foley is Attending Neurologist, Memorial Sloan-Kettering Cancer Center; Professor of Neurology, Neuroscience, and Clinical Pharmacology, Weill Medical College of Cornell University; and Medical Director, International Palliative Care Initiative of the Open Society Institute.

5. Problems with Oregon's data collection and data soundness, and the lack of any investigations of abuse or meaningful oversight, are so significant as to render conclusions based on those data to be critically flawed.

Oregon doctors are not penalized for failing to report assisting in a suicide, and there is no investigation to see if they have done so. The state does not investigate cases of expansion and complications reported in media, and have admitted, “We cannot determine whether physician assisted suicide is being practiced outside the framework of the Death with Dignity Act.”

The state has also acknowledged actually destroying the underlying data after each annual report. (Regarding abuses that have come to light in Oregon, see [handout on Oregon abuses](#) (PDF). Regarding the destruction of data, see testimony of Dr. Katrina Hedberg, 9 December 2004, House of Lords, Select Committee on the Assisted Dying for the Terminally Ill Bill, Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence, (London: The Stationery Office Ltd., 2005), 262.)

6. There is research strongly suggesting Oregon has seen a reduction in the quality of palliative care at the end-of-life since the Oregon law went into effect.

An important study published in 2004 in the Journal of Palliative Medicine showed that dying patients in Oregon are nearly twice as likely to experience moderate or severe pain during the last week of life, as reported by surviving relatives, compared with patients before the Oregon law took effect. An op ed in The Oregonian on July 23, 2004 stated, “The findings call into question the widespread view that pain control at the end of life has improved markedly in Oregon.” (Journal of Palliative Medicine, Volume 7, Number 3, 2004, p. 431)

While it is true that Oregon has shown improvements in some areas of end-of-life care, similar improvements have occurred in other states that have not legalized assisted suicide. As Doctors Kenneth Stevens and William Toffler noted on September 24, 2008 in The Oregonian, many states do better than Oregon. For example, the latest data ranks Oregon 9th (not 1st) in Medicare-age use of hospice; four out of the top five are states that have criminalized assisted suicide.

7. Some 24 states have rejected the legalization of assisted suicide since Oregon passed its law.

[We should heed their significant public policy concerns.](#)

8. Many key organizations oppose the legalization of assisted suicide. Including the AMA and all 50 of its state affiliates; the National Hospice and Palliative Care Organization; many prominent Democrats and liberals including Bill Clinton, Ralph Nader, and noted civil liberties journalist Nat Hentoff; [many disability rights organizations](#); and the League of United Latin American Citizens (LULAC, national level).

9. Suicide requests from people with terminal illness are usually based on fear and depression.

As Herbert Hendin, M.D., Chief Executive Officer and Medical Director, Suicide Prevention International, and Professor of Psychiatry, New York Medical College, stated in Congressional testimony in 1996, "a request for assisted suicide is ... usually made with as much ambivalence as are most suicide attempts. If the doctor does not recognize that ambivalence as well as the anxiety and depression that underlie the patient's request for death, the patient may become trapped by that request and die in a state of unrecognized terror." Most cases of depression among terminally ill people can be successfully treated. Yet primary care physicians are generally not experts in diagnosing depression. Where assisted suicide is legalized, the depression remains undiagnosed, and the only treatment consists of a lethal prescription.

10. International models, particularly the Netherlands, show that assisted suicide cannot be limited to a small, targeted group once Pandora's box is opened.

*(Commentary: The Case Against Physician-Assisted Suicide: For the Right to End-of-Life Care, by Dr. Herbert Hendin)*

I would also like to share the opinion of the American Medical Association on this matter. On their website (<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page>), Opinion 2.211 reads as follows:

“Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. 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. (I, IV)

Issued June 1994 based on the reports "Decisions Near the End of Life , " adopted June 1991, and "Physician-Assisted Suicide , " adopted December 1993 (JAMA. 1992; 267: 2229-33); Updated June 1996.”

I encourage you today to set H.B. 7015 aside. Physician-assisted suicide should never be the solution we seek. Please stand with the many who oppose this bill, with the American Medical Association, and with countless others across the country who value the dignity of human life.

With gratitude for your kind consideration, I am,

Sincerely yours,

Rev. Samuel S. Kachuba, S.T.L.

Director of Vocations - Diocese of Bridgeport

Chaplain - Trinity Catholic High School, Stamford

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