



TESTIMONY

Delivered by Tracy Wodatch, Vice President of Clinical and Regulatory Services
The Connecticut Association for Healthcare at Home

Before the Judiciary Committee

March 18, 2015

**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 Tracy Wodatch, Vice President of Clinical and Regulatory Services at the Connecticut Association for Healthcare at Home. I am also an RN with over 30 years experience in home health, hospice, long term and acute care.

The CT Association for Healthcare at Home is the united voice for 27 of the 30 hospice and palliative care providers in Connecticut. Our membership includes uniquely and highly qualified individuals and provider organizations with perspectives and expertise drawn from direct care experiences with those facing terminal illness.

**The CT Association for Healthcare at Home opposes Bill No. 7015
An Act Concerning Aid in Dying for Terminally Ill Patients**

Connecticut currently ranks last or 51st in the country in hospice median length of stay which translates into “last minute hospice or end-of-life care.” The provider continuum is not doing enough to promote hospice and palliative care services resulting in poorly informed consumers regarding their end-of-life options. Perhaps this is why some feel a bill on Physician-Assisted Suicide is needed as they are not fully informed of the wide array of expert end-of-life services and supports available to them.

Our society’s emphasis on “cure” and the medical emphasis on intervention have sometimes been at the expense of good end-of-life care. We have been slow to embrace the practice and principles of hospice, and dissemination of state-of-the-art palliative care, especially pain control and symptom management techniques. This approach leads people to thinking they have no other choice but to request physician-assisted suicide.

In response to this emphasis, in 2014 several Connecticut provider collaborative efforts have focused on end-of-life care and advanced care planning initiatives:



- Several End-of-Life Educational programs have been offered through the major healthcare provider associations (CT Hospital Association, LeadingAge, CT Association of Health Care Facilities, CT Association for Healthcare at Home and CT State Medical Society) addressing:
 - Advanced Directives: legal implications and current law
 - Updates on MOLST
 - Advanced Care Planning with nationally renowned research ethicist and physician Angelo Volandes
 - Hospice and palliative care indicators and
 - How to have the conversation about end-of-life options.
- Call to Action Event at the Capitol on April 16, 2014 to coincide with National Healthcare Decisions Day
- The DPH MOLST (Medical Orders for Life Sustaining Treatment) pilot to be launched this April 2015 in two communities (Windham and UCONN Health Center/Hartford)
 - Pilot includes education on when and how to have the conversation regarding end-of-life decisions
 - Also, encourages consumers to have the conversation with their physician helping to ensure informed decision-making and choice.
- The DPH appointed Palliative Care Advisory Council has been meeting monthly for just over a year and is nearing formal recommendations to the Commissioner of DPH.
- The Coalition of Primary Care Physicians Annual Meeting included several breakouts addressing EOL care, advanced care planning, when to have the goals-of-care conversation, and timeliness of hospice and palliative care.

These are all efforts to help the consumer understand that there are many options for comfort and quality of life as one approaches the end of life. Instead of considering legalizing Physician-Assisted Suicide, let's instead focus our efforts on the essence of hospice care which is to allow patients to make the most of their remaining time. Hospice values people's lives until their natural end, making their death a true "death with dignity."

Here are some of the things Hospice and Palliative Care providers can do:

- Offer expert, compassionate relief of pain and suffering at end of life enhancing the quality of both living and dying.
- Strive to help patients and families deal with important physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears.
- Promote opportunities for meaningful experiences, and personal and spiritual growth so patients may live life to the fullest and die with dignity.



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- Assist patients and families cope with loss and grief through best-practice bereavement support for up to 13 months following the death, and
- Support the patient's right to participate in all decisions regarding their care, treatment and services based on knowledge and access to all forms of treatment that have been shown to enhance quality of life and reduce suffering.

The CT Association for Healthcare at Home is committed to the hospice philosophy cherishing life until its natural end while reinforcing dignity, quality and comfort. Our Association and its 27 hospice provider members afford the highest regard for person-centered choice and self-determination. We look forward to participating in and guiding the ongoing dialogue and debate to continuously improve upon and promote comfort and dignity in life closure.

We do NOT support the legalization of physician-assisted suicide.

Despite our opposition to this bill, we have grave concern for language within the bill itself which, in our minds, leaves much reasonable doubt. We recognize the attention that this bill has assumed in your committee and in the public. As you continue to debate this issue, we ask that you consider several specific concerns not addressed currently or not defined/outlined in enough detail within the language of the bill.

- Under definitions Section 1.11 "Palliative Care" (A): should read *...throughout the continuum of a patient's serious (not terminal) illness.*
- Under the same section, hospice care is mentioned briefly yet not defined and not encouraged. Please consider adding a definition for "Hospice Care" understanding that Palliative Care is holistic care throughout the serious illness; whereas hospice care is holistic palliative care once the serious illness becomes a terminal illness (with an anticipated prognosis of less than 6 months).
- Determining terminal prognosis is not an exact science as many people outlive a 6 month prognosis and go on to live several months or years beyond their initial prognosis. However, there are accepted standardized tools/scales used to predict prognosis. We strongly recommend that these tools (e.g, Karnofsky or FAST) be mandated as part of determining prognosis as they are in determining hospice eligibility.
- To avoid subjectivity in determining the competency (both cognitive and for s/sx's of depression) of the patient requesting a physician to assist in his/her suicide, we strongly recommend that the physicians determining competency must use a standardized validated tool for both cognitive and depression assessment. And, physicians need to be trained in assessing and evaluating based on these tools. The bill doesn't adequately address this vital issue.
 - Research shows that depression is one of the most underdiagnosed illnesses among the elderly and seriously ill.



- Left untreated, depression increases risk for morbidity, suicide, decreased cognitive and social functioning, self-neglect, and early death. Despite the devastating consequences, clinicians fail to diagnose up to 50% of depressed patients seen in primary care practices. If they are accurately diagnosed, only 22% receive adequate treatment, partly because practitioners fail to recognize depression's red flags - See more at:
<http://www.pharmacytimes.com/publications/issue/2011/January2011/Counseling-0111#sthash.Nhlnsk5H.dpuf>
- In 2010, only 1 of the 65 patients in Oregon who dies as a result of physician-assisted suicide was referred for psychiatric or psychological counseling.
- A glaring hole in this bill is the issue surrounding the physician being asked to provide the lethal drugs.
 - Because many physicians don't (Oregon and Washington) or won't (reported in other states) prescribe lethal drugs to hasten someone's death, patients are forced to physician shop...they are desperate to find a physician willing to prescribe the lethal drugs.
 - In Oregon, some physicians prescribe lethal drugs for patients whom they have only known as little as one week or less.
 - In Washington in 2010, half of the patients had a "relationship" with the physician prescribing the lethal drugs of only 3-24 weeks.
 - This lack of a long-term relationship challenges the physician's ability to truly understand the patient's emotional and psychological state.
 - Most patients who request p
- The cause of the death on the death certificate should never be the underlying disease. The cause of death should be "barbiturate overdose or toxicity. "
 - Putting the underlying disease as the cause is lying and also misinforms state and national statistics that are gathered annually.
 - Given the inexact science of determining a projected prognosis of a disease, a natural death may be for a number of reasons other than the underlying disease itself.
- Finally, any person requesting Physician-Assisted Suicide as outlined in this bill should first be required to have a Hospice and Palliative Care consult.

Thank you for considering our association's testimony. If you have any further questions, please contact me directly at Wodatch@cthealthcareathome.org or 203-774-4940.