

**Testimony to the Public Health Committee**  
**Regarding Raised House Bill 5417 – An Act Concerning End-Of-Life Care**  
**Submitted by David V. Hunter**  
**March 16, 2018**

Representative Jonathan Steinberg, Senator Terry B. Gerrantana, Senator Health B. Somers, and members of the Public Health Committee.

**I am opposed to H.B. 5417 – An Act concerning End-Of-Life Care**, “To allow a physician to dispense or prescribe medication at the request of a mentally competent patient that has a terminal illness that such patient may self-administer to bring about his or her death.”

I have been employed in health service for my entire career, first in the emergency medical response field and for the past 38 years I have worked in the post-acute, long term care and home and community-based services fields. I currently serve as president & chief executive officer for a nonprofit continuum of care organization in New Haven, Connecticut. This organizations provides post-acute and long term care, hospice care, assisted living, adult day health, primary care, outpatient care and transportation. I currently serve as a member of the board of directors of LeadingAge Connecticut, on an ethics committee for a Connecticut hospice care program, and I am past president of the board of directors of the Connecticut Coalition to Improve End of Life Care. I am a recipient of the Humanitarian Award from LeadingAge CT and the Distinguished Service Award for End of Life Care from the CT Coalition to Improve End of Life Care.

The first hospice care center in the United States of America began in Branford, Connecticut. Since inception of hospice care services to the citizens of this State, hospice care services have grown to where these services are provided in all hospitals, many if not most, skilled nursing centers, and home-based hospice care services to individuals in the home setting. The growth of hospice and end of life care services in the health care field has advanced the treatment modalities which directly benefits people with terminal illness and their families. This is a direct benefit to individuals with terminal illness and their families. Most individuals suffering with illness fear the pain that is attributed with these illnesses, and many individuals suffer with depression as they move through the illness and dying process. The advances in palliative care and medicines have alleviated the suffering attributed to end of life illness. The reality is that anyone dying in discomfort that is not otherwise relievable, may legally today, in all 50 states, receive palliative care sedation. Everyone agrees that dying in pain is unacceptable, but nearly all pain is now treatable.

A fact supporting increase in utilization of benefits can be seen in the increase in seniors utilizing the Medicare Hospice Benefit in the USA. According to Kelly Vontran, of the Centers for Medicare and Medicaid (CMS), 20% of all Medicare Beneficiaries who died in 2000 utilized the Hospice Medicare Benefit and that number increased to 45% of all Medicare Beneficiaries in 2013. In addition, of those receiving Medicare Hospice Benefits those with Alzheimer’s disease were the majority of individuals

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receiving the Hospice Benefit, overtaking those with cancer.<sup>1</sup> This is an indication that more individuals are aware of and benefitting from this Hospice Care Benefit.

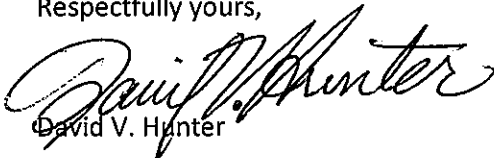
In my years of experience, a larger problem stems from the fact that our culture in America fails to identify with death as part of the life cycle, resulting in the lack of family discussion and the aversion to familiarize oneself with treatments and services afforded to this stage of life. Compounding this problem is the reluctance on the part of healthcare providers, including physicians, to talk about their patient's end of life status. The result is a lack of knowledge and increase of misconceptions.

In addition to advances in medicines and treatments, we have seen the expansion of services to address the psycho-social aspect of the individual, including bereavement services for those left behind. Often, this benefits the individual who fears burdening their families as they become sicker and/or disabled. The wish to die because of depression is also treatable. It would be far more beneficial for the State Legislature and Government to develop methods for educating the public about these services, and from a matter of policy this would be far more effective in population health.

Physician Assisted Suicide legislation has come before the Connecticut Legislature in the past, and to date, no bill has been passed. The major concern I have is the increasing number of seniors in our society. This demographic, coupled with the tightening of financial resources has the potential of individuals dying prematurely in their dying process. This fact and reality might not be done overtly, but it is very possible, that subliminal messages for a senior citizen who is sick to 'do the right thing for the next generation'. It is also true for doctors, what starts as an option soon becomes an expectation. Pressures will grow to make health care providers get involved in assisting suicide directly or by referral. It is for these reasons and others, that I urge members of the Public Health Committee to vote against this Bill to provide Physician Assisted Suicide.

Thank you for the opportunity to testify and for your consideration of this testimony.

Respectfully yours,



David V. Hunter

DVHunter114@gmail.com

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<sup>1</sup> Kelly Vontran of CMS, during presentation at LeadingAge PEAK Leadership Summit, Washington, DC, March 17, 2015