I am submitting feedback to the Public Health Committee regarding Connecticut HB 5417 AN ACT CONCERNING END-OF-LIFE CARE. I am a psychiatrist and a medical ethicist in Baltimore, Maryland, USA on the faculty of Psychiatry at Johns Hopkins, University of Maryland, and the Sheppard Pratt Health Systems who has been engaged in the issue of assisted suicide and euthanasia, particularly in the case of psychiatric patients, in the U.S., Canada, and Europe. I am arguing ***against*** the passing of HB 5417

- An important assumption underlying such assisted dying legislation is that physician-administered death is the only escape from unbearable suffering. This is not consistent with state-of-the-art palliative care, which includes a number of techniques, including but not limited to "terminal sedation," in which consciousness is suppressed to the point where suffering is not experienced. Though there may be an increased risk of death from such a procedure, that is not the *intention* of the procedure. This and many other measures are quite effective at relieving suffering in a dignified and compassionate manner. If we kill patients as a means of relieving suffering, it undermines the entire enterprise of palliative care and will short circuit access, willingness, and even resources available for palliative care. This has happened in Belgium, where palliative care nurses are actually resigning, with the complaint that palliative care facilities are becoming "houses of euthanasia." [https://tinyurl.com/y7kdh9ab , Caldwell, S. "Palliative care nurses quit 'houses of euthanasia'" *Catholic Herald*, 18 Jan 2018]

- The deep and millennia-old value that is "professed" by the profession of Medicine is to not kill in the name of healing. This was the unique feature of the very foundation of Medicine by Hippocrates, who made trainees swear an oath that they would "give no man a poison, nor counsel anyone else to do so." This Hippocratic Oath is so core and fundamental to the ethos of medicine that it is still recited at medical school graduations to this day. Just as the teachings of Jesus were the foundational root out of which the mighty tree of Christianity grew, with all of its core value systems, this Hippocratic ethos was the root out of which the tree of Medicine has grown, and it is intimate to its fundamental substance as a profession. Although there is arguably a continuum between the role of "bringer of comfort" and "bringer of death," society has a vested interest in maintaining the role of physicians as the "bringers of comfort." Maintaining the "sterile field" in which physicians bring comfort, without deliberately killing, is crucial to the doctor - patient relationship. This is vital to how a physician thinks through possible options, the degree of devotion to helping the patient, and the willingness to sustain a field of support for a suffering patient. *Compassion* means "to suffer with." Allowing doctors to kill patients can increase the unconscious temptation for doctors to avoid their venerable, age-old devotion to "suffering with."

- No country that has experimented with medically assisted dying has been able to hold the practice to patients at the end of life. None. That is the intention with which it begins. The living laboratories of The Netherlands and Belgium, which have had over 15 years of experience with this since their law was struck, have seen an inexorable slope. It began with those who are terminally-ill, by the nature of their illness. It progressed to those who produced a terminal condition by refusing chronic life-sustaining treatment (i.e. insulin). Then it slipped to the chronically and non terminally ill; then to the removal of distinctions between mental and physical suffering (thus opening the door to psychiatric conditions and unbearable lifestyles); then to those who are merely "tired of living" or feel they have a "completed life;" then to proxy consent for euthanasia of the incompetent, children, people on life support, and people suffering from dementia — by family members; then to "mercy killing" of those without capacity, by doctors who are unable to find consenting family

members. Now there is the push for over-the-counter suicide pills in the Netherlands. Each of these steps has been widely documented.

- Shifting suicide from a freedom to a right is a profound shift for any society. When suicide is made a right, rather than a freedom, it implies that there is a duty to enable people to fulfill that right. That means setting up a class of human beings who now has a duty to help people fulfill the right to suicide. Whoever has that duty is now vested with the mantel of "compassion," "virtue," and "healing" in the act of killing, however well-intentioned. The now-regretful pioneer of euthanasia in The Netherlands, Doudewijn Chabot M.D., seeing society's inability to constrain euthanasia to its originally legislated applications has noted, "a culture has emerged in which performing euthanasia is considered to be virtuous behavior." This is not only true for doctors, but this sense of virtue is also bestowed on those who choose assisted suicide. They are cast as heroic and noble, while those who continue to suffer are seen as partially responsible for their own continued suffering, because they rejected the death solution. There are widespread anecdotes of this attitude towards the chronically suffering, developing in Belgium, which I discovered in my research.

- There is much evidence for "suicide contagion" as a consequence of ordinary suicide. Several studies in the U.S. and in the Netherlands have shown that the introduction of physician assisted suicide has not only failed to curb the "natural" suicide rate, but has also been associated with an acceleration of that rate. Whether there is a cause and effect relationship is still unknown. Assisted suicide has certainly done nothing to curtail "natural" suicide. However, there is an extraordinary dissonance in a society that engages in public health measures and messages to prevent suicide, while simultaneously designating a "special privilige" to certain groups to not just permit suicide, but to help provide for and abet that goal—by the same professionals (physicians) who are otherwise engaged in thwarting suicide in others.

- Suicidal thinking is a very reliable indicator of a treatable psychiatric condition. Many medical conditions, particularly degenerative ones, are known to be highly associated with clinical depression, as part of the diseases themselves—independent of the degree of impairment (i.e. not just a result of "demoralization"). Research from Oregon shows that clinical depression is commonly missed by physicians who write assisted suicide prescriptions [missed up to 26% of the time: Ganzini, et al, Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey *British Medical Journal* 2008; 337 :a1682]. This is congruent with extensive literature showing that clinical depression is missed in about 1/3 of patients by primary care physicians. There is also literature showing that psychiatric treatment aborts suicidal wishes in a large proportion of people with terminal illness [Liebenluft, et. al "The Suicidal, Terminally Ill Patient with Depression" *Psychosomatics*, 29 (4), 379]. As elsewhere in the world, the proposed New Zealand law makes psychiatric evaluation *optional,* as part of the evaluation for medical ending of life. The evaluating physician personally determines the need for psychiatric evaluation. If such a referral is made, it is largely limited to assessment of *capacity*, and it carries no mandated psychiatric *treatment attempt* to qualify for assisted dying. In addition, even if there is psychiatric evaluation, a patient can refuse to give access to collateral records or informants to enable a fully accurate assessment.

- Reports from the Oregon Health Authority [https://tinyurl.com/ybyh9w63 , "Oregon Death with Dignity Act: Data Summary, Oregon Health Authority, Public Health Division, 2016] demonstrate that the primary reason people request physician assisted suicide is *psychiatric:* fear, hopelessness, despair, anxiety, and inability to conceive of how they will cope as their illness progresses. These are much more commonly motivating factors (90% of the time) for assisted suicide than actual physical pain or current debilitation. It is fear of the future. Often these emotions are in the setting of complex family dynamics, abandonment,

impoverishment, and a wide variety of other psychosocial stresses that affect coping ability. These are common, fundamental *psychiatric* issues, and addressing them lies within the skill set of mental health professionals—independent of any particular psychiatric diagnosis. It is vital to not bypass state-of-the-art means of addressing these concerns with mental health care, rather than providing a civilization-changing shortcut to medically provisioned suicide in the face of these existential distresses. Of all kinds of health care however, mental health care is often the least accessible, due to stigma as well as comparatively underfunded resources. So these factors *facilitate* a path of lesser-resistance, should the assisted suicide option be opened. This puts those who are more emotionally vulnerable and most in need of mental health care at risk of short-circuiting mental health treatment.

I am available to testify before the Parliamentary Committee. Also, see my complete lecture on this issue at:
https://tinyurl.com/yboe394m

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