

Connecticut General Assembly
Public Health Committee Public Hearing
HB 5417 Testimony from Father Ted Tumicki
March 20, 2018

Good morning/afternoon/evening. I am Father Ted Tumicki. I am a pastor, moral theologian, canon lawyer, son, brother, and uncle. I live in Jewett City/Griswold, and I am speaking against House Bill 5417, *An Act Concerning End of Life Care*.

I am opposed to legalizing assisted suicide for a number of reasons:

1. It would create two classes of people: (1) those who have lives worth living and thus are worth defending and (2) those whose lives are no longer worth living and thus are not worth defending. In light of the ongoing opioid and drug overdose epidemic and the use of opioids, barbiturates, benzodiazepines, and other drugs in assisted suicide, the two classes of people created under this bill also include (1) those whose lives are worth saving, and thus using drugs like Narcan, and (2) those whose lives are not worth saving. Once society determines that some people have lives no longer worth living or saving, then it is a very short step to not allowing them to live longer or to access life-saving or life-extending treatments. Terminally ill Oregon residents Barbara Wagner and Randy Stroup discovered that their insurances would not pay for them to prolong their lives but would pay for them to end their lives with assisted suicide, and this under a law with (supposed) safeguards. There is nothing in House Bill 5417 that would prevent such a scenario from happening in Connecticut.
2. A patient's choice would not have to be respected and murder would be facilitated. Under such a law a person could request and receive the lethal overdose of medication, then change his/her mind and choose not to take it, but then someone else could mix it with her juice (or other liquid) and give it to the person against his/her choice. No one would know if the person was murdered.
3. The death certificate would be required to be false – it would be required to list the underlying illness as the cause of death even though the overdose of medication is what actually kills the patient. Under this “new” law, are you going to prosecute a physician who writes the truth on a death certificate?
4. There would be no meaningful oversight. Minimal records would be required to be kept, and no records would be required to be checked to ensure compliance. Prescription drugs and deliberately lethal overdoses of medication would be easily dispensed with no follow-up or oversight. We already know prescription drugs are not disposed of properly, that they are sold or stolen and wind up in circulation in society: Why does the Public Health Committee now want to add more drugs to that mix? How is the State going to ensure that deliberately lethal medication dispensed under state sanction is disposed of properly and is used for its required purpose of suicidal death and not

murder? How is the state supposed to enforce a process when there is no public oversight?

Passing House Bill 5417 into law, facilitating murder under the guise of compassionate care, requiring falsification of death certificates to cover up the real cause of death, and allowing the dispensing of deliberately lethal medication with no public oversight – especially in a climate of epidemic drug and opioid overdoses, creates not only bad public policy but dangerous public policy.

I ask you to vote against this bill.

Additional Points in Reference to House Bill 5417 (numbering continued from above):

5. Doctors involved in the process do not have to know the patient. The patient could show up asking for suicide and the doctors can consent if the patient is terminally ill; but then again, if no one is checking the records, who will know if the patient is not terminally ill?
6. The required witnesses, who would attest to the competency of the requesting patient, can be total strangers with no knowledge of the patient. After just meeting the patient and reviewing the patient's driver's license, how is a witness really able to adequately determine competency?
7. While the bill states the owner of a health care facility cannot be a witness, there is nothing to prevent the owner's spouse or sibling or friend from being a witness. This can very easily become a conflict of interest for the same reasons why a family member or person in the will of the patient cannot be a witness.
8. This bill dictates the process and method by which qualified patients must die in order to enjoy legal safety. Is it the role of a public health committee to dictate how a person must die to enjoy the favor of the law? Is it the role of government to hasten the death of its law abiding citizens? Connecticut got out of the death-dictating business when we repealed the death penalty, why do you want to go back into it?
9. This bill tinkers with the moral, ethical, and linguistic fabric of society and mandates a change. In June of 2013, my mother was dying of a drug-resistant CRE infection in her urinary tract and kidneys. In the hospital, she made the decision to go home under hospice care and told her doctor, who had not yet given a diagnosis. The doctor then walked out of the room to check the latest lab results regarding her kidney function. In a minute the doctor walked back in and said, "There is no improvement with the kidneys or the infection. There is no hope." My mother died on July 20. If my mother wanted assistance to end her life, it would have been "assisted suicide" when the doctor walked out of the room but the same act would have been "compassionate aid in dying" when the doctor walked back into the room. So what

changed to make the bad, illegal act of assisted suicide into the supposedly good act of compassionate aid in dying? The act is the same; the patient's choice is the same; the patient's condition is the same. This bill seeks to redefine and dictate what is good and bad and what language must be used to describe the same act of assisted suicide. This illustrates what ethicists have described as the human capacity to redefine good and evil to justify one's actions. Is it the role of a public health committee to dictate language use to all citizens and religions? How does this protect and promote public health?

10. When assisted suicide proponents assert that losing one's autonomy or becoming a burden on family or having no dignity because of the inability to feed oneself constitutes reasons for committing assisted suicide, people with disabilities remind everyone that such reasons describe the disabled; and if society accepts such reasons as valid for causing death by assisted suicide, the message is sent – intended or not, like it or not – that the disabled would be better off dead as well. The message sounds like, “I would be better off dead than like a disabled person. I would be better off dead than be like THEM.” Legalizing assisted suicide and thus legitimizing the reasons would send the message that “Yes, you would be better of dead than being like one of THEM.” When does the “right to die” become the “duty to die?”
11. There is no timeline for when the qualified patient is supposed to ingest the medication. The patient simply receives the lethal medication and then nothing may happen... but what happens if the patient dies before taking the medication and a young grandchild or nephew or niece finds the medication and ingests it? Who is going to ensure that such a young child is informed of how to dispose of such medication in accordance with the law? And how is such informing supposed to happen if the patient chose not to tell anyone that he or she was going to commit suicide and the existing medication is unknown or its discovery comes as a complete surprise?
12. What happens if the qualified patient takes the medication and it does not work as he or she intends it to: Can the patient sue for malpractice? Can the patient sue their doctor for wrongful life or wrongful living? Will the legal landscape now include lawsuits for both wrongful death and wrongful life? How is that upholding public health?

Points in Reference to Assisted Suicide in Oregon:

While there is a minimal amount of oversight in Oregon, the latest report of the Oregon Public Health Division reporting on the statistics of assisted suicide in that state indicate that the data is incomplete:

- Out of 218 prescriptions written in 2018, they do not know what has happened with 21 of them - they do not know whether the patient is alive or dead or whether the medication was ingested or not.

- In an additional 23 cases, they do not know the ingestion status of the patient.
- Out of 143 *known* cases of “assisted suicide” in 2018, they do not know what the circumstances were from the time of ingestion until death in 103 of those cases; thus, they do not know whether or not the patient was coerced at the last minute or the medication was mixed with a drink and given to the patient against the patient’s will.
- Out of 721 *known* cases of “assisted suicide” in 2011, 2012, 2013, 2014, 2015, 2016, and 2017, they do not know what the circumstances were from the time of ingestion until death in 592, or 82.1%, of those cases: thus, they do not know whether or not the patient was coerced at the last minute or the medication was mixed with a drink and given to the patient against the patient’s will. Is it good public policy to dispense deliberately lethal medications and not know what happens with them?
- According to the report, since the assisted suicide law took effect in Oregon in 1998, prescriptions have been given to 1,967 patients, of which 1,275 patients subsequently ingested the medication and died. While a number of patients chose not to ingest the medication, the status of the remaining 692 prescriptions, (or 35.8% of the total 1,967) of the is not given – Is it unknown?