



Farmington Valley
Visiting Nurse Association

Written Testimony

Submitted by Nancy A. Scheetz, APRN, B.C., Executive Director
Farmington Valley VNA, Inc.
Member: The Connecticut Association for Healthcare at Home

Before the Public Health Committee
March 15, 2019

HB 5898: Aid in Dying

Senator Abrams, Representative Steinberg and members of the Public Health Committee, my name is Nancy A. Scheetz, Executive Director for The Farmington Valley VNA, Inc. I am a board certified APRN with over 36 years of experience in the health care industry. I am writing to you today not only from the perspective of working with those making end of life decisions, but more importantly from the perspective of a clinician that continues to work directly with patients every week. I wear two hats. While I can speak to you as an administrator, I would like for you to hear me as a clinician, one that continues to speak with patients and their families every day that I practice.

As a member of The CT Association for Healthcare at Home, I oppose this bill.

The vital thing that we need to realize is that we agree on one thing: No one should suffer needlessly at the end of a life.

The decision at hand however, is to decide how to get there. There will be testimony given presented to you on the mission and benefits of Hospice and Palliative care. You will be told of the unfortunate situation of our own state

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where the reality remains that people just do not opt for Hospice care until it is too late to even give them benefit. In my agency alone, the number of patients admitted to Hospice care that died within a week is an alarming testimony of how we in the medical field have failed them. The decision should not rest in the hands of lawmakers and politicians. You have been asked to step in because we have not done our job. It is common to be told from my colleagues, physicians, medical providers at large, that they simply do not want to have the conversation with their patients. In their own perception, it is that they are telling patients that they can no longer help them, leaving them to experience this somehow as a failure.

The problem here is that it is not about them. It is not about creating a medical bag of tricks that can successfully prolong life without recognizing that there should be a better look at the quality of that life that they are prolonging. The medical world we live in still does not function as a culture on recognizing that life is finite. We all will die someday, and how we live, up to the very last minute should be at our choice of how we wish that to go. The medical world needs to be accountable for recognizing that there are many decisions that should be made much sooner than they are as to how to make end of life still have quality. There is little to no reason that this should be faced with fear, anxiety, pain and suffering. **The one thing I am certain of is that it is also the wrong time to allow for the answer to be physician assisted suicide.**

My clinical practice has been in psychiatry and behavioral health. I have worked with patients all my career that have believed that suicide is the only way out. While we are not here today to speak about people suffering from depression and other mental illnesses, I understand how the mind can get to contemplating suicide. I know the absolute anguish and suffering that can lead to this decision. It should not be understated that the experiences of people at end of life due to medical issues are not that different. When faced with the potential of suffering, no one is going to refuse a chance to avoid this.

I recently was on-call for one of the Hartford area hospitals. In my clinical role, as an APRN in Psychiatry, I am called upon as a consultant for patients admitted for

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medical crises. Patients are more acutely ill it seems these days, so anyone in an acute care hospital often is not a simple story. At times, it is not even clear to me why a medical team requests a consult, as often, these patients are not currently suffering from a diagnosed mental illness. This one gentleman that I was asked to see was only 72 years old. He had respiratory failure, to the degree that required massive amounts of oxygen to sustain his breathing. The goal of this hospitalization was to help patch him up some, so that he could be transported to a New York hospital where they had approved him for a lung transplant. Unfortunately, in his case, transporting him would mean that he needed to be on full life support and for his case, it was clear that turning him over to this level of artificial breathing was too much of a risk. If you can just imagine for the sake of this example, it was simply impossible to do what was required. The New York hospital then turned him away, and it did not look likely that a CT hospital could take him as well. Here he sat, having a very difficult time breathing, smiling at me, with the unspoken awareness that he was probably about to die. I knew why the team had called me. At times, it is as if I am there for them more than I am the patient as they were all struggling with their own impotence.

We spoke for a while, longer than I would usually spend. He was amazing and calm. He told me his life story, even discovering that we both liked a special dessert from one area restaurant. He had been divorced years back, had no children and no one around him for support other than a neighbor. He didn't want to die but was not afraid of it either. While the medical team somehow wanted me to treat his depression, he and I talked about Hospice. While the medical world can predict many things, even in his condition, they truly would not know when he would die. He could tell me, when given a chance, that there were things he knew he could still experience with pleasure. We chuckled about that one restaurant and how, if only I could sneak away from the hospital, I could bring back that one dessert. The point of his story is this: he knew, even at his stage, that there are ways to make life, even at the end, comfortable and without suffering. He really wanted that transplant, but he knew that it may just be impossible to prolong his life further. He was ok with just being allowed to talk about his life and where he was at that moment. A conversation that really did happen easily, but often simply

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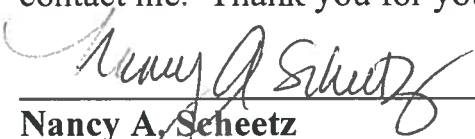


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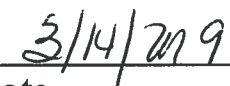
doesn't take place. I left, knowing that I would not see him again, but he touched my life and will not be forgotten. I experienced how end of life, even at this point could be handled with compassion and caring and leave all the team and the patient involved with a sense of peace. Peace that means we did do a good job. Peace that means we met his needs.

I watch the clinical team that works for me helping patients and families make the decision to opt for Hospice care every day. They are not afraid to have the conversation and it is often a relief that they can foster these principles of care. Please, think about this as if you are the one in the room with the patient making the decision. Ending a life is not our jobs. Helping people move away from suffering and fear at the end of life is our mission. Please help us to continue to do that work.

If I can be of further assistance or offer any other information, please feel free to contact me. Thank you for your time and consideration.



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Date