SEN. ABRAMS (13th): Good morning. Good morning everyone. I'm Senator Mary Daugherty Abrams and along with my Co-Chair Public Health Representative Jonathan Steinberg, we welcome you today to our public hearing. I'd like to just state first of all -- it sounded like the microphone just went off -- that we feel that it's extremely important that everyone here feels comfortable in expressing their opinion and that they can come up and say what they need to say without any comments from the public that are here today. Everyone has to feel like they can say want to say to say without feeling in -- in -- in anyway intimidated or overly encouraged. Any of those things that you might think are a good thing may not come across that way, so we ask you to just hold a referendum and respectful environment here so that everyone can come up and say what they would like to share with the committee in a most welcoming way possible.

We will begin -- any comments? Representative?
REP. ARNONE (58TH): It is a tradition in this legislature to allow people to wear stickers or t-shirts. We typically do not allow signs in the public hearing rooms, so I would ask that everybody try to respect that. To the to my co-chairs point, it's important that no one feel intimated. We also tend to avoid expressions of emotion either pro or con. Again, think about what it would be like when you're up here testifying, the regard and respect that you would hope to have as well. We're just going out of our way in the beginning to make sure this is a constructive hearing where all sides can be heard with respect. Thank you.

SEN.ABRAMS (13TH): So, first we have The First Selectman Dan Symen. I know. [Person talking in background]. If you, if you hang long enough, you'll hear us mispronounce everyone's name, so. Thank you. Please, please -- please state your name for the --

DANIEL SYMEN (FIRST SELECTMAN): My name is Daniel Symen. I'm the First Selectman for the Town of Scotland. I'm also in the Scotland Volunteer Fire Department where I'm coming up on my 49th year, 38 years as an EMT. I'm back in as a Deputy Chief with the department. When I was Chief of the department we had 24 EMTs. Our little department in a town of 658 homes could -- could supply 24 hour ambulance, it was -- it was good.

All right, what's happened with the criteria of testing, you have the National Registry EMT System; you have the State EMT Testing System. EMTs were being trained to one or the other standard and then take a test, completely blow the test and fail it, and eventually give up EMT. Like I said, I just
back -- back in as a Deputy at where we had 24, we're down to 8 EMTs. We cannot supply the 24 as my town has had to come up with 145 thousand for day time coverage 7 days a week for 12 hours to cover the day time. And again, that's 658 homes at support.

Senate Bill 1005 that'll finally get the state in one standard for testing and will allow the use continuing education credits to maintain your certification. I'll use myself as an example and my license for 38 years. I took an EMT course in my career department where I retired from, passed it, passed the state test, passed all the test; only to find out three years later when I went to get my license recertified that I had been revoked for three years. Why? Because, I recertified 21 days too early. I'm not throwing all EMS Office of Emergency Medical Services under the bus cause they have their rules and regulations, but this is the -- just one example of the disparity.

EMT coverage and testing is not just the problem in my town, it is state wide. Your volunteer services are struggling to keep emergency medical services alive. By use of the -- the continuing ED credits there's big financial savings. Where I can get 40 hours in, first 20 hours being paramedic protocol training, hospital protocol training, bloodborne pathogen training, training, training the first 20 hours. And then, through the National Registry System I can go online and get -- finish up the additional hours and get certified, done. Right now we're spending 300 bucks per EMT to take a 40 hour course and then another up to 100 dollars for the privilege of taking the test. By the use of continuing education credits that would go to the
wayside. You know, it would put us under same --
same par -- I'm gonna finish up [cross talk].

SEN. ABRAMS (13TH): Excuse me, I was just gonna
say, could you sum up please.

DANIEL SYMEN: Yep.

SEN. ABRAMS (13TH): Thank you.

DANIEL SYMEM: Cause your nurses are recertified
using continuing ED credits and they pay a fee.
Your paramedics are recertified by continuing ED
credits pay a fee. For some reason, for decades
EMTs have had to go through a 40 hour course,
multiple tests, jumping through it, and -- and we've
lost thousands of EMTs across the state. This use
of or -- or approval of Senate Bill 1005 would help
alleviate that problem and strengthen the system.
So, from cost to make an organization a small town,
CCM its members and leadership, we all urge you to
support this bill. Thank you.

SEN. ABRAMS (13TH): Thank you very much. Wait one
moment please. Are there any questions or comments
from committee members?

REP. STEINBURG (136th): Thank you for -- for being
here today and it -- it is important for us to hear
and to support a cost in the CCM and for you here
representing municipal executives from across the
state. We've been very pleased by the process that
we've -- we've engaged over the past year or so
looking at mob -- mobile integrated health more
broadly and we're very pleased at this very specific
direct problem can be resolved. So, again thank you
for your testimony.

SEN. ABRAMS (13TH): Representative Betts.
REP. BETTS (78TH): Thank you Madam Chair and thank you for your testimony. Given the success we've had in the past year of trying to review all of these latencies by different agencies, are you aware of any opposition to what's being requested here?

DANIEL SYMEN: I haven't and I've asked around. I've talked to my -- my fellow -- you know I'm a retired fireman from the University of Connecticut; I've talked to some Union people and what not. It all seems to fit in place where it be conducive for your career departments and in your volunteer departments and more importantly it would put everybody on the same page with the same testing to the same standard including -- and I did meet with a local ambulance vendor provider and I thought he was gonna be here today testifying cause he strongly in support of it too.

REP. BETTS (78TH): Okay, thank you very much.

SEN. ABRAMS (13TH): Representative Arnone.

REP. ARNONE (58TH): Thank you Madam Chair. So, in -- in Enfield we have our own ambulance service also fire departments and I've heard from constituents and that they are in favor of this also because of the National Standards. And, it's important to have national standards in order to make it more stream lined and more cost eff- efficient. Anything else you have to add to the National Standards?

DANIEL SYMEN: It's not easy. I'm having to go through it, I'm taking the National Standard now and I'm impressed with the -- the amount of information we -- we've learned. We're 20, 40 years ago we never thought about nitroglycerin -- nitro and -- and providing Aspirin and medication to patients,
EMTs are now able to do that under outstanding hospital protocol. I think that the EM -- emergency medical services made great strides in this state. We just need to be keep our people interested in it longer.

REP. ARNONE (58TH): Thank you.

SEN. ABRAMS (13TH): Thank you. Any other questions or comments? Thank you very much for your testimony. It's great hear perspective, thanks. Representative Josh Elliott. Is he here? [Person talking in background]. No, I didn't either.

Representative Holly Cheeseman. [Person talking in background]. No. Commissioner Pino. Thank you for being here.

COMM. RAUL PINO: You caught me off guard. [laughing] Good morning. I am here representing The Department of Public Health and to go over three of our bills. You have our testimony. I will just give you an over view and open for any questions.

I think we should at least start by -- with the last -- the prior individual that was testifying, sorry I didn't get a name, but he's a member of EMS services around the state. So, what we are doing with this bill, as he said, is standardizing the way that we examine and test for those licenses. We have a multiplicity of different test exam in the state that are not very conducive to a standard restructure and those services provided by EMS services are getting more complicated. The scope of is increasing, so we think that having a standardized way to provide those examination for knowledge, ability, and skills is the best way to go
for the state and we fully support, of course, our own bill.

There are some (inaudible-00:10:38) in our statues there and on that I think we should also talk about bill 7278. We should look into Mobile Integrated Health Services -- Healthcare. The department supports the concept of Mobile Integrated Healthcare. I think that we need to process a little bit more to be able to fully implement it to the state. The only initiative that would be also conducive to diverse them from the emergency rooms so that we alleviated a lot of work unnecessarily being shifted to the emergency room into all their health care facilities and part of those efforts is partly looking in compensation for transporting not only to the ER, but to all their facilities as well when it's clinically indicated.

And, we also have the Governor Bill 7193 with public health elements in it. In there we are requesting two things for newborn screening. First to integrate three new conditions into our panel that would probably alleviate our panel to about 71 conditions if we -- if you approve these three. And, we also are requesting for you to allow the department to go through the RUSP which is the Nationalized Standard Recommended for Newborn Screening, so that every time that a new condition is added to the National Standards we, by reference, adopt that condition and don't have to go through a process every time. It will allow us to speedily incorporate conditions immediately and serve our public better.

Also, in there you have the primacy for the water drinking fee. You generally ask, last year our
first approach to it this is a way to make it permanent. We have worked with OPM, the water industry and while their stakeholders around the state come up with a primacy fee will enhance our ability to fund a drinking water section at the Department of Public Health and continue to provide a services that we provide for our clients and for the industry as well.

And, that's our bill, if you have any questions for me.

SEN. ABRAMS (13TH): Any questions, comments? Representative.

REP. STEINBERG (136TH): Commissioner, thank you for being here to testify today. Let's start off with the drinking water bill. You made reference to the Legislation we passed last -- last year, which has lead us to this point. Could you comment for a moment on our experience to date with that legislation? What's been DPH experience and what to degree does inform the need for additional staff?

COMMISSIONER RAUL PINO: So, the experience has been great. We have great partners. It has taken us a long time to get to this point. And, we have collected the first year of fee. That process went well. These probably will fund about 14 positions at DPH and last year we added, I believe, two positions clerk our staff for the finance piece that comes with, you know, requesting the funds, making the bills, and pay -- you know getting the money and also following those who may not have paid. There has been some concerns from the water industry that were addressed where in regard to having a cap in the amount of money. And, we also agreed that it will be reflected on the clients bills as -- what is
DPH water -- drinking water section fee, is per connection for larger systems and the smaller system has a flat fee. But, it all opens, you know, we hope that you pass it and it has been great -- it has been a great experience.

REP. STEINBERG (136TH): The reason I'm particularly supportive of this bill is that we did have the State Auditor's report that suggested some opportunity for improvement on the enforcement side, and that's obviously directly related to staffing levels and this will enable you to fulfil your obligation to ensure the equality of drinking water throughout the state, so, I think this is important legislation in that sense.

Shifting over to the Mobile Integrated Health Bill, you make some mention of the need to exam it further in terms of some of its recommendations, could you be a little specific?

COMMISSIONER RAUL PINO: Yes, so, the services were initially designed for large estates sprawling rural areas with difficult access to health care facilities and long distance, so, that EMS could provide essential services. Like everything that DPH does, we may have to go through so much Scope of Services, we are plan to increase the work that some of the licenses may do in these type of approach. Although, we could see a great opportunity we don't think that it is a blanket that we can throw over the state. As our firefighter/EMS person mentioned before, our system is a little bit fragmented. We have more EMS services providers in Connecticut than towns and we have 169 towns. So, we will have to go slowly and carefully so that we don't compromise the quality and the safety of the services that they
already provide to our residences, because this could mean we are dropping additional services, additional requirements, and well though it could be a good opportunity to increase funding to many of those agencies that will not be the primary reason.

REP. STEINBERG (136TH): Well, I gave you on that fragmentation is an issue for us in the state on any number of different levels, but it's most important in the healthcare sphere and we -- we will hopefully partner with you in reviewing the report documented and figuring what the action agenda oughta be going forward with MIH.

One last question if I may with regard to the Governor's Bill. There has been some commentary -- actually I'm gonna come back to that later. Why -- why -- why don't we let Representative Betts go then I'll ask my question.

SEN. ABRAMS (13TH): Representative Betts.

REP. BETTS (78TH): Thank you, thank you Madam Chair and thank you Commissioner. I have a question about the water. You said that there's gonna be a need to hire 14 additional positions to monitor health quality of the water. Can you -- can you let The Committee know how much money that's going to cost and is that going to be covered entirely by this water assessment fee?

COMMISSIONER RAUL PINO: I may have misspoke if I said that. No, it will not be 14 additional positions. These are positions that we currently have at the department and the funding is gonna come from the fee, so, we are not hiring 14 additional individuals. These are funding sources that we thought would be compromised at the Federal level
and that's why we have decided to have local approach to the way that we fund the services that we provide to the water industry and our residences.

REP. BETTS (78TH): That's very helpful, thank you. So, it is -- so, it is from within existing? [people talking in background]

COMMISSIONER RAUL PINO: Yes.

REP. BETTS (78TH): [people speaking in background] The fees for the assessment to put on the water companies, is that passed on to consumers or how is that?

COMMISSIONER RAUL PINO: Yes.

REP. BETTS (78TH): A penny for penny?

COMMISSIONER RAUL PINO: I believe so.

REP. BETTS (78TH): Okay. And, how -- how much -- do you have any recollection or do you know how much, I mean --

COMMISSIONER RAUL PINO: I believe it's 250 per collection. Is that right? Yes, okay.

REP. BETTS (78TH): Okay. Thank you very much.

SEN. ABRAMS (13TH): Representative Arnone.

REP. ARNONE (58TH): Thank you Madam Chair. 7278 on the Ambulance Mobile Integrated Health Care, so, would that also cover -- and I'm looking at D here, which is line 204, non-emergencies for ambulance services, there's two licensures now for ambulance services. One allows non-emergency transportation of patients and one does not. Would this bill allow the one that does not -- licensure does not allow them to transport non-emergencies?
COMMISSIONER RAUL PINO: No I -- no I don't believe so.

REP. ARNONE (58TH): That was quick one. Thanks [laughing].

SEN. ABRAMS (13TH): Representative Comey.

REP. COMEY (102ND): Thank you Commissioner for being here. Good to meet you. [throat clearing]
Regarding the -- the newborn screening program, what is the role of -- I noticed here in -- the changes that affect -- it's the approval of the Secretary of the Office of Policy and Management. Can you tell me the role that that office will play in -- in this?

COMMISSIONER RAUL PINO: OPM?

REP. COMEY (102ND): Yeah, and, I mean is this a change to the, this is an addition the --

COMMISSIONER RAUL PINO: So, currently the way that it is structured every time that we want to add a new condition to the panel, we have to come in front of you, go through a try -- entirely legislative process, which can take six months if we have long session. It can be shorter when it's a shorter session. Then we have to calibrate the equipment, get with (inaudible-00:20:54), certify the lab, so, it's an entire complicated process. What we are trying to do with this -- with that portion of the bill is that by reference we are in any conditions that are recommended in a national level so that we don't have to go through this process. You have been so generous to us; we have never got any condition disapproved. Of course, you are working in the best interest of our residents, so, adding
condition for us is more of a speedy process to have it place as soon as those conditions come.

REP. COMEY (102ND): Okay, thank you.

SEN. ABRAMS (13TH): Representative Steinberg.

REP. STEINBERG (136TH): I finally remembered my other question Commissioner. With regard to the Governor's Bill, I made note in sections two and three that it includes a reduction in funding for local departments of health, which is always a little distressing. But, you and I have had conversations over the years about the opportunity perhaps for consolidation, and of course when we use the word consolidation around here it is often very controversial. Are you concerned at all about further reduction in health district funding in terms of the ability to meet the needs of their local communities?

COMMISSIONER RAUL PINO: So, that's a -- that's a -- that's a very hot topic as you mentioned it. So, I -- I should say first that -- that account -- that line at DPH is about 4 million dollars. And, that is now the only way that DPH help and funds local health departments that’s one of the lines, that's only 4 million dollars. We at any year give out about 78 million dollars to local health department through different programs on funding and structures that we have.

So, what I'm trying to say that -- is that that's not the funding for local health at DPH. Now with that account what happens is that it is one of the few accounts that DPH has of line items that we can adjust our budget to have it balanced, and that's always a tricky task because no matter where you
reduce to balance your budget, it's gonna have impact. And, no matter how you do it someone's going to be unhappy, that is -- that's the reality.

So, funding for local health -- and I say all of that to get to these -- is I think we need to look at the way that we use that per capita money, that's the name of that funding line, and we may have to restructure that in a way that is more equitable to all the towns and their needs. And, if it's gonna have an impact, yes it will have an impact. How big the impact is gonna be, that's hard to determine based each town use the funds different ways. They have a whole menu of activities that the funds can be used from -- for and it goes from, in some cases paying for the salary of the health directors for that municipality. In some cases pay for epidemiology services and in the older cases it is used to incentivize some activities at the local level. So, the impact depends of, first how much of a reduction that being and second how that municipality specifically used those funds.

REP. STEINBERG (136TH): Well, thank you for that answer and perhaps in your time here you will help us think it more probably about a better structure for how we not really dispense funds but how our districts function to the point you mentioned with the focus on providing the services the community needs. I agree with you. It needs further reform. I think that we need a robust conversation about what that means.

COMMISSIONER Raul Pino: We are more than open and willing to engage in that.

REP. STEINBERG (136TH): Thank you Commissioner. Thank you Madam Chair.
SEN. ABRAMS (13TH): Thank you. Any other questions or comments? Yes, Representative McCarty.

REP. MCCARTY (38TH): Thank you Madam Chair and just very quickly. Good morning Commissioner, good to see you. On the Governor's Bill, again, when -- if I may go back to Representative Comey, we're talking about the newborn screening panel, but the conditions that are listed that's not limited to just those right? Because, --

COMMISSIONER RAUL PINO: No, those are the only three we have on our 69 conditions.

REP. McCarty (38TH): Right, that's what I thought cause I remembered a few from here and I didn't see them, thank you.

And, then on the Integrated Mobile Care, you're in favor moving forward but will keep an eye on just to make sure that all of the requirement -- that they don't go out of their scope practice?

COMMISSIONER RAUL PINO: We are favorable of the concept. I think we need to work it out, restructuring in a way that it doesn't compromise the quality and the safety of the services that -- that they're going to provide. So, what I'm trying to say is, we don't want this to be Chinese auction that everyone moves towards without taking into consideration what other services they currently provide.

REP. McCARTY (38TH): So, it needs to be all integrated?

COMMISSIONER RAUL PINO: Yeah, it's a very interesting concept. For example, let's look at the opioid crisis. Let's say that they transported
someone yesterday who have OD’d and the person was released by the hospital. Will this be an adequate service to provide to the individual, to double check on the individual that they have received information what needs to be done next, that they know what services are available for them. Do they need to be transported to a detox facility? So, there -- there's specific areas and conditions that we think is more critical than others, but again our state isn't a small state. It's hard to find someone who lives more than 30 miles away from any healthcare facility, for the majority of the population. So, how we structure those services I think is critical to maintain safety and quality.

REP. McCARTY (38TH): Okay, thank you. Thank you Madam Chair.

SEN. ABRAMS (13TH): Any other questions or comments? Thank you very much Commissioner for your testimony.

COMMISSIONER RAUL PINO: Thank you.

SEN. ABRAMS (13TH): Representative Cheeseman. Welcome.

REP. CHEESEMAN (37TH): Good morning. Good morning to you Madam Chair, Representative Steinberg -- Chair Steinberg, and distinguished members of the Public Health Committee. Thank you for the opportunity this morning to submit testimony on House Bill 5898.

There are many reasons to oppose this proposed legislation. For a start, let’s call it by its correct name, physician assisted suicide. The American Medical Association, the body who would be responsible for -- whose members would be responsible for carrying this out continues to
oppose this practice. It reiterates its opposition and says, "assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks."

They recently convened their ethics on -- Counsel on Ethical and Judicial Affairs that did a two year study and again reached the same conclusion that this was a path down which they as an association did not want to see their members go. Their review of European experience showed that since it began as physician assisted suicide and it soon morphed into not only allowing this to happen with terminally ill patients, but then patients who were suffering from depression, mental illness, elderly couples, and people who feared abandonment.

In Belgium, children of the age of 12 are now permitted to request assisted suicide. Close to 25 percent of all the deaths in the Netherlands in 2017 were results of physician assisted suicide. Do we want to send a message that your life is not worth it? In Belgium and the Netherlands, organs are harvested post physician assisted suicide.

What about the pressure the availability of assisted suicide places on people who are worried about the effect on their families.

And, I know my time is up. I just wanna sum up there many reasons to oppose it; the unpredictability of the length of life, the fear that there will be coercion, and the need for the real access to palliative care which can address so many of these fears and concerns.
So, again I thank you so much for allowing me to testify today and I would be happy to answer any questions.

SEN. ABRAMS (13TH): Any questions or comments? Representative Steinberg.

REP. STEINBERG (136TH): Thank you Madam Chair. Thank you, Representative for testifying today. I--I agree with you. I--I would hope that the vast majority of people who are in distress end of life would find a hospice or palliative care, would be the right solution for them, and we have wonderful programs in the state, and people should be aware of those options and hopefully it'll be sufficient access to them.

What we're talking about here is different and I will contend with your statement that this is a kin to a suicide. Suicide is often involving people who are depressed. If you read the bill carefully as we've intended it, certainly they are protections in place to make sure that is not the reason. I take your point no one knows for certain length of life, but there are also issues of quality of life. But, let me address one of the--the comments you made with regard to the medical community. Are you aware of the fact that the Connecticut State Medical Society is now neutral on this subject recognized there's lack unanimity on the part of physicians in this state?

REP. CHEESEMAN (37TH): Yes I am but I don't figure--I don't feel it alters the essential nature of what's happening here. Being neutral to me is like maybe you're a little bit pregnant. You're not gonna take a stand. To me this is something--as I say I find it hard to accept that you can be truly
neutral on an issue like this and maybe we would differ there Representative.

REP. STEINBERG (136TH): I think the challenges with any society you have a variety of viewpoints and I think what they've -- changing their positions reflective of the fact that there's a change in general opinion among the physician community. So, when you make a statement that the physician community is against it, I find it perhaps misleading at least here in the State of Connecticut and the State of Massachusetts and the many other states the medical community is now viewing it somewhat differently. So, I just wanna make sure that everybody's aware that it's a challenge for medical societies of any nature to express a firm opinion in this becoming even more so in this context.

REP. CHEESEMAN (37TH): Well, I -- I do appreciate that and I'm sure there are different views, but people decline the slippery slope argument. And, I think if anything the slippery slope argument applies here. In Canada they're no long conscious preventions. You are required to provide these services. And, again I am not saying this is going to happen in Connecticut and I just wanna -- so in -- in the UK, which is a very different healthcare system. In large hospital settings, they found there was not physician access to true palliative care at end of life; so, they instituted something called The Liver Pool of Care Pathway. Well, for a variety of reasons this care pathway, which was meant to be a really integrated end of life experience for patients in hospitals, morphed out of all recognition to what it was intended. They were seeing increasing use of continues sedation for end
of care in life, lack of consultation not only with the patients but with the patient's families and having instituted it into 2003 it was ended.

And, I just wanna sum up a -- a research paper. This is the most important lesson that can be learned from this, is not about the dangers of scaling up clinical interventions rather it is about the need for greater assessment of the wider risks involved; and, more careful consideration of the unintended consequences that might result from a given course of action especially in the politically and morally charged arena of end of life care interventions. And, I supposed that's what I'm asking here.

Please let us be absolutely sure that we know what opening this Pandora's Box will be to. I mean, looking at the Legislation and its section 19, line 76 through 79. Terminal illness means the final stage of an incurable and irreversible medical condition that an attending physician anticipates within reasonable medical judgement will produce a patient's death within six months.

Well, what if you're a type I diabetic? What if you were my husband who spent four years waiting for a kidney transplant, fighting off dialysis, and then discovered that unlike the parts of the country in New England, you don't start qualifying for a kidney transplant until you actively start dialysis? He discovered he had wasted four years of his life. What if had then said, "That's it, I know I'm going blind, I am losing my kidneys, I'm a type I diabetic, I'm not gonna take my insulin." Now I am terminally ill and I go to my doctor. Is he given a prescription? What about someone with a
theoretically treatable, but when not treated incurable disease says, I can't do this anymore. I am tired of taking the antirejection drug or whatever. Are we to say to them go ahead and do it and then miss out on what may turn out to be a quality of life. In my husband's case, he did go on. He was able to see my younger son married. He was able reconcile with his youngest daughter from whom he had been estranged. I fear had this been available -- and he would have said, "No I am not depressed. I'm of sound mind. I just can't do this anymore." That he would have taken that way out, and I don't want any other family member to have to go through something like that.

We must be able to embrace the people we love. Assure them that we'll be there for them and be with them and it's a terrible, terrible situation. No one wants to see a parent suffer, a husband suffer, a child suffer, but that's where our humanity must come forward as we embrace them and let them know they will not be left alone.

REP. STEINBERG (136TH): Well, thank you for that and I think you made a number of valid points. First of all, the support from family members is very important and -- and the concept of embracing them is something I think we -- we all endorse as well, but this is about their choice. And, I think the example you give of your husband is such that with the conditions we put on in this legislation, I got a physician would have agreed to this given the fact that your husband chose -- might have chosen to forgo treatment if there were options within our -- our medical knowledge that would have forwarded him the ability to -- to keep going. I -- I -- I would agree that he would not eligible for this because he
had treatment options and his choice to forgo them would be an indication perhaps that he's not appropriately eligible.

And, also, I appreciate you bringing up the experiences in Europe and in Canada because those are not this bill. And, their experiences actually help us inform -- trying to come up with a bill that -- that is more protective as good as we can get. I agree they are no absolutes in medicine. We like to believe so. We like to believe it's a pure science. But, they are individual differences and it is an art.

What we are talking about here is simply a matter of providing choice to the individual to make that choice on the basis of good medical input, counseling from somebody with psycho -- psychological background, and really as well as we can determine with the lack of absolutes that this person is at the very end of life and this is their choice.

SEN. ABRAMS (13TH): Thank you. I would just like to add to that, that we -- the slippery slope idea, I think is always something that concerns us with any legislation. You know that, Representative. But, Oregon has had this in place for many, many years and The Journal of Medical Ethics reported that Oregon Death with Dignity Act and I quote, "rates of assist dying in Oregon show no evidence of heighten risks for the elderly, woman, the uninsured, people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnical minorities compared with background population." So, we do
have an example of good writing legislation that will keep us from going down that slippery slope and that's what our intention is, so, -- but, I -- I think that's always something that we have to look out for.

REP. CHEESEMAN (37TH): Oh, I appreciate that and I have read the legislation and it does look very carefully crafted. It just -- I think it gets back to my initial point, I do think we have aware and beware of that potential danger because it is to -- this is a power -- the power over life and death that I think is -- could be easily misused to the detriment of us all.

SEN. ABRAMS (13TH): Thank you, are there other questions? Representative Candelora.

REP. CANDELORA (86TH): Thank Representative Cheeseman for your testimony. I think your adding an important perspective noting that the AMA is still currently against assisted suicide even though Connecticut Medical Society has chosen to be neutral. Having served in this Committee with the debate, I think it's unfortunate they're not here to provide their expertise. I agree with you taking a neutral position makes this much more difficult for us to make the best decision that we can for the public if they're not gonna give their important input on medical procedures.

In Oregon, you know getting to the slippery slope point, I think -- are you familiar at all with the changes at Oregon have thought out and looked at in terms in redefining a healthcare provider so that maybe the medical profession would not be aiding --
REP. CHEESEMAN (37TH): I have read a little bit about that but I would welcome your input on that.

REP. CANDELORA (86TH): Yeah, I mean I guess we could flush this out today, but -- but it seems that in Oregon there's so many doctors that don't want to perform or -- or I guess provide this procedure that they're seeking to expand this out so that non-doctors could prescribe for -- for assisted suicide.

REP. CHEESEMAN (37TH): I would find that extraordinarily worrying and I worry that as the legislation goes forward well, you know if I only have a few weeks left to live it's gonna be too hard for me that what is here, what are the very well intentions, road block preps; not road blocks perhaps speed bumps along the way to ensure that this is not misused. To ensure that only those people who actively know what they're doing and who actively seek it that -- well now this is taking too long and my mom wanted to it and it took three months and I now saw her suffer that -- that what stands as good legislation today will be watered down.

REP. CANDELORA (86TH): Are you familiar at all in Oregon where the insurance companies are potential denying procedures --

REP. CHEESEMAN (37TH): I had heard of one instances in which a woman in late stage cancer was not given treatment but told she had the right to physician assisted suicide.

REP. CANDELORA (86TH): And, you also spoke to the -- the mental health views to this legislation, you know currently right now it provides the attending physician to determine whether or not mental health
should be incorporated into the decision making. And, you know over the years I -- we -- I know we have heard from our, you know from psychiatrists and different social workers who have talked about how people who are choosing to go down this path, almost always should have some sort of mental health counseling because the decision not only is -- is so grave and final but it almost necessarily predisposes the fact that there could be depression or other factors that are driving that decision because it's not natural inclination to want to end your life.

So, you know in Section 8 though we have this in the opposite way in which the doctor gets to determine whether or not you should have some sort of mental health review. Do -- do you believe if this legislation was to go forward it maybe more important to require that every individual that's seeking assisted suicide should have to have some sort of evaluation and a conversation with medical experts that are in that field? Or counseling?

REP. CHEESEMAN (37TH): I would hope so because again -- and again, you know what it is hard cases make bad law. I have a dear friend whose husband was diagnosed with a very advanced stage of kidney cancer, underwent numerous treatments, surgeries at one stage because of a, you know a wound that wouldn't heal. Basically they had given up hope on him, and he admitted if he had had the opportunity he would've taken his own life and it would have been clinically, you know on the card. Well, fast forward three or four years and they -- he's recovered, they've made numerous trips you know all over the world, welcomed new grandchildren.
I guess that is again one of my, you know biggest concerns about this. That people in times of despair and again, with a clinical diagnosis yes this person generally in our best clinical opinion this person is going to be, you know dead two months, three months, four months that they improve. There are -- well I'll call them miracles but because of medicine and because of the unknown nature of the life span that we all have that they will be foregoing that wonderful experience, that life, that time with their loved ones. That time of high quality because at a very low point at a time when on the surface yes I looks like that, you know we've -- we've written you off and you can't go back from that. That's it, that's done, and that's what I fear.

REP. CANDELORA (86TH): Thank you. I wanna thank you for your testimony, for your personal experiences because I think that is important to hear. There is so much hope that we hear and so much positive that we hear out of people's endurance and perseverance, and it's part of the equation I think that we should always be considering. And, I get concerned when I do see, you know a state like Oregon you know continuing down that slippery slope to make this more and more accessible and, so, thank you for -- for your testimony today.

REP. CHEESEMAN (37TH): Thank you Representative.

SEN. ABRAMS (13TH): Representative Arnone.

REP. ARNONE (58TH): Thank you Madam Chair. Thank you for testimony. Do you believe there is any circumstances for aid and dying?

REP. CHEESEMAN (37TH): Me personally?
REP. ARNONE (58TH): Yes, would accept any circumstances? Do -- do you know of any that you would agree with?

REP. CHEESEMAN (37TH): I -- I personally, no. I think our -- we have done so much with the hospice movement and so much with knowing how to best care for people at the end of the lives. I accept that other people may differ. That's why we're here. That's why you're having this public hearing.

SEN. ABRAMS (13TH): Any other questions or comments from the Committee Members? Representative McCarty.

REP. McCARTY (38TH): Good morning Representative Cheeseman, it's good to see you here today. And I -- just mine is more or less a comment. I just want to thank you for taking the time to come here this morning and to doing -- I actually printed off your testimony because it's very comprehensive and it shows a lot research that you really put into this. And, in your opinion -- because I think the ultimate goal for all of us is that the end of life that we want compassion, comfort, and care. And, in your research through hospice and the other centers do you believe that everyone in their last stages of life that they're receiving that care and that they're comforted? And, then finally the other piece in your research, and you mentioned Canada and some other places, do -- has there been an increase in assisted term -- helping terminally ill people end life?

REP. CHEESEMAN (37TH): Yes -- yes. Well, touching on the hospice, yes I -- I think that prob -- only problem with hospice is people don't access it soon
enough. I think that the average stay or the median stay was 24 days. I think you need to -- if you -- once you receive that diagnosis you need to reach out to hospice because they can do so much both in terms of emotional and spiritual support, but physical support true palliative care easing the symptoms. Really good pain control. I know with some of the legislation that's been passed here to deal with the opioid crisis, there have been concerns that for that end of stage the -- the true pain, we don't want to put up road blocks that prevent people from getting that care. But, I think they do such a wonderful job at -- it -- at such a very hard and painful part of life but they do it in a way so that they help the family and the dying person reach that wanted conclusion in a -- in a -- in an embraced and sheltered way.

And, with a regard to an increase, yes and as I -- as I sited legis -- the research in 2017, 25 percent of all deaths in the Netherlands were as a result of physician assisted suicide. And, there're have been cases in which it -- in certainly in Belgium and the Netherlands if you receive a diagnosis of dementia you can request assisted suicide once your condition worsens.

Well, there was a horrific case recently. A woman had requested assisted suicide upon receiving a diagnosis of Alzheimer's. Her doctor and her family determined her dementia was becoming too far gone. She had no quality of life left. They had to actively subdue her to administer the fatal dose. And, I realize we're not talking active euthanasia here, and I believe this Committee has no desire to see us to go down that road. But, I worry that -- so -- you know, I worry. I worry and I'm sure we
all worry and we wanna do what's best for our citizens at all stages of their life, and particularly at that incredibly difficult end of life.

REP. McCARTY (38TH): Again, thank you so much for your testimony.

REP. CHEESEMAN (37TH): Thank you.

SEN. ABRAMS (13TH): Representative Klarides-Ditria.

REP. KLARIDES-DITRIA (105TH): Thank you Madam Chair. Thank you Representative for your testimony. I think it's important for us as a Committee to see all sides and -- and there may be an -- an option or a side of it that never you've never seen before.

But, one of my questions is for me personally I have a living will, so, that seems to take care of that aspect of it. Meaning I -- I'm not gonna be kept alive by any artificial means. So, if I'm suffering and I'm -- I'm at that point then my living will will take care of that for me.

REP. CHEESEMAN (37TH): I -- I think it does in terms, you know if you get to the point you don't wanna be put on a ventilator. You don't want, you know forcing nutrition or something like that. But, I accept that if you're, you know the reason you're choosing this is because you don't wanna lose control over your functions, you don't wanna be in terrible pain. I'm not sure -- a living -- a living will necessarily addresses all of that, but I agree everybody should have a living will. Everybody durable power of attorney, a health care power of attorney, so, all of you listening there if you haven't done it go do it. [laughing] But, I mean there're many things that we have to think about as
we think about not only the end of our lives but our parent's lives. Make sure you know your loved ones pass words and any safe combinations; believe me it will make your life much similar later on.

But, getting back to your point, I think certainly the way this legislation is contemplated it would not necessarily address everything that you would outline in a living will.

REP. KLARIDES-DITRIA (105TH): Okay, thank you very much for your testimony. Thank you Madam Chair.

SEN. ABRAMS (13TH): Any other questions or comments from Committee Members? Thank you so much Representative for your testimony.

REP. CHEESEMAN (37TH): Well, thank you so much for your time and your very good questions today.


REP. ELLIOTT (88TH): Thank you Chairman Abrams, Chairman Steinberg, and other members of the Public Health Committee. I'm here to speak on behalf of House Bill 5898. I have been opponent of this bill since I was elected a couple of years ago.

And, one of the books that I read that really changed my mind was written by Atul Gawande a book called Being Mortal. He was also an author of another book The Checklist Manifesto. He led the WHO for a number of years and is responsible for tens of thousands of lives being saved through systematic use of -- of checklist. As to say, someone whose thoughtful in terms of thinking about how do we provide somebody with both access to good healthcare but then also looking at what does it
mean to be living a good life and -- and that is what Being Mortal was really about, was it touched on his end of life decisions cause it used to be for a long time that these end of life decisions was it simply do you live or do you die. But, I think that there's been more nuance to the conversation over the last 20 or so years.

So, we have about 40 or so years' worth of aid and dying regulations on the books in eight different jurisdictions. And, we have seen that there is no abuse and there's no coercion and there are a couple of different groups that are opposing this bill.

First, there is the moral and religious beliefs that because life is sacred that we should have no way for people to take end of life care because it would basically insulting to whatever the holy -- your holy beliefs, and I understand that. I -- I get that. The problem is that we should not be here basing realization off subgroups sense of morality. It's really gonna be if people who are religious belief that we should not any sort of end of life care then they should be able to make their decisions. And, for those who don't have those same beliefs, are in terrible pain, have less than six months to live, have undergone these diagnoses, have talked to multiple doctors, have multiple witnesses, they opted and be able to make those decisions for themselves.

And, then there's the medical community which has basically historically undergone Hippocratic Oath and said that we need to make sure we are preserving life and because of this we cannot be allowing this end of life care, about 30 more seconds. And, we have also seen a shift in the culture from the
medical profession saying that we are firmly against this to now being neutral, to letting it be on behalf of the states on making decisions. And lastly there are folk with this ability were considered about the abuse of the system and people who might consider themselves having poor qualities of life or doctors who consider some folk with disabilities as having poor qualities of life. And, you know that's a very subjective determination but this bill as crafted would not be allowing people purely with disabilities to be undergoing this treatment. It is specifically for people who are in terrible pain with diagnoses with less than six months to live.

And, what we found in the 40 or so years of these rights being on the books is that the vast majority of people have cancers -- it's about 65 percent have cancers and about 15 percent have some sort of neurological disorders. And, then also the vast majority people who take these medications are 65 plus and with that I hand the reins over to you.

SEN. ABRAMS (13TH): Representative Steinberg.

REP. STEINBERG (136TH): Thank you for being here to testify today Representative. I appreciate the fact that as you expressed it, there are significant philosophical differences in the two sides. I think both sides to some degree based upon conjecture and assumption which is very hard to prove the slippery slope argument. In reading this testimony, so who oppose from religious grounds that make mention the fact that God doesn't give people more than they can, that suffering is good. Why can't we enter the context of hospice or palliative care just drug people who are in pain sufficiently so that they
can, can live out however many day they in that condition? Why is that not a good solution?

REP. ELLIOT (88TH): We find that people who are taking these drugs are still suffering terrible pain, there is no amount of drug that they can take that can ease this pain, it is a small subset of the people but it exists. We also find that over 90 percent of people who are in hospice care end up dying at home and it’s actually not antithetical to be both in hospice and to have good quality of life for as long as you can but then at a certain point make the determination that you also then want to take these end-of-life drugs.

REP. STEINBERG (136TH): Thank you, so you are supportive of palliative care and hospice care for those when it’s appropriate?

REP. ELLIOTT (88TH): I am.

REP. STEINBERG (136TH): And it’s just the small percentage of the folks who might not be suitable for that you’re focused on with this Bill?

REP. ELLIOTT (88TH): That’s correct.

REP. STEINBERG (136TH): Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Senator Arnone.

REP. ARNONE (58TH): Thank you, Madam Chair. You brought up some good points especially with the end-of-life decisions, so today an end-of-life decision in my will, I have a living will, I can say no feeding tube, I can say, you know, no ventilator what happens beyond that happens to the family. So my personal case was my mother, she was terminally ill, she was full-blown dementia, broken hip, she couldn’t eat, she never wanted to be on a ventilator
or feeding tube. Now goes that next checkbox, that as a family for seven days as we watched my mother starve to death and said why. Why couldn’t she have that check box also. She was willing, she knew exactly how she wanted to leave this earth but she couldn’t leave this earth without that stretch of time that the family have to just suffer also through that emotional horrible, emotional feeling of watching your mother starve to death. So I thank you for coming up and speaking in favor of this. There are circumstances, circumstances that belong in that checkbox and that whole part of hospice there needs to be that hard end also. So thank you Josh, appreciate it and I know we’ve had discussion on this in the past. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Madam Chair. Representative Elliott thank you so much for coming in and speaking. I just want to share something one of my friends mentioned to me. I don’t know many other people may know Peter Kelly. Now the State of Connecticut is the first state in the entire United States to have hospice. So hospice was not even known in the rest.

REP. ELLIOTT (88TH): It was in Branford, I think, correct?

SENATOR ANWAR (3RD): Yeah, yeah, it started in Connecticut and when Peter Kelly who was a lawyer, an activist, he was actually proposing that hospice should be something to talk about. He said the room filled up with people with so much anger and so much challenging each and every aspect because nobody had thought of hospice in the past and right now hospice is the safety net for people who are anticipated to
die. But think about many years ago as a society we were not even ready for having that conversation and thankfully people had that conversation that allowed individuals to be able to, it’s not even a question anymore in anybody’s mind. As the hospice care strengthens, as the palliative care strengthens and our trainings improve the number of people who will need this kind of service is minimizing but not eliminating and I think that’s the part it’s worthy of a further conversation for us collectively that if things are done well and they are being done well the overwhelming majority of the patient’s needs will be met, but not everyone’s needs will be met and I think that’s the conversation for us today. So I wanted to put this perspective because people are saying let’s do hospice and absolutely no doubt about it, but hospice will not eliminate everyone, so that’s hopefully we will keep our conversation around that. So, thank you, Madam Chair and Mr. Chair.

SENATOR ABRAMS (13TH): Thank you, Representative. Representative Klarides-Ditria.

REP. KLARIDES-DITRIA (105TH): Thank you, Madam Chair. Thank you, Representative for your testimony. I have a question under Lines 273-274, “the person signing the qualified patient’s death certificate shall list the underlying terminal illness as the cause of death” so do, is falsifying a death certificate, is that an issue with you?

REP. ELLIOTT (88TH): Yea, I think that would also be a felony as well.

REP. KLARIDES-DITRIA (105TH): Right, so I mean per this Bill you would be falsifying a death certificate the way it’s written?
REP. ELLIOTT (88TH): Perhaps I’m not understanding you.

REP. KLARIDES-DITRIA (105TH): So under line terminal illness that is what you are putting down as your cause of death not the assisted suicide?

REP. ELLIOTT (88TH): I understand your point. The whole purpose of this legislation would be to allow doctors to provide that medication so if we don’t have it written as it is then we are basically allowing liability against the doctor in which case we wouldn’t have the law. So I understand your point but I don’t know any other way to write this in a way that protects the doctors.

REP. KLARIDES-DITRIA (105TH): Okay thank you for your testimony. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Any other questions or comments? Representative McCarty.

REP. Mc CARTY (38TH): Thank you, Madam Chair. Welcome, Representative good to see you. You did make a few comments that I would question but I know as the day goes on we’re gonna hear more from hospice and the others, so I just want to ask you do you think there could be any economic pressure put on individuals that may choose this pathway and that’s the part that really is upsetting to me that, I’m just worried that some people may be coerced into ending their life quicker, the elderly particularly who are frail and I know there have been cases as we were told there has been no abuse or anything else but there are cases cited in Oregon and Washington so I just wonder what your thoughts are in that regard.
REP. ELLIOTT (88TH): My first thought would be that if it were found that there were coercion there again be felony charges against any and all people whether it was insurance or family that would be participating in that endeavor. The second aspect is from what I’ve read that is there is actually very little incentive on behalf of insurance companies to be coercing either by pulling insurance funding or by trying to eliminate services, I think that by the time somebody gets to hospice they are by and large not using their insurance because it’s longer term care is my understanding, I could be wrong about that, so I think there are enough protections in place. I share the same concerns. My goal would be to make sure that we’re crafting the language to ensure that there’s penalties for those who are conducting themselves this way and that there are protections on behalf of the person looking for this medication so that it doesn’t come to pass that is by having a doctor to insure that person is in the right frame of mind so that when they are making those decisions it is less likely that they are being coerced because they are in the right frame of mind but then also having witnesses as well so to have as many people involved in the process so it’s not just that one person making decisions it’s a group of at least basically five people between the witnesses and the doctors and the patient themselves. So I think there is enough protection in place that alleviates some of that fear but I understand the fear.

REP. MC CARTY (38TH): Thank you.

SENATOR ABRAMS (13TH): Senator Anwar.
SENATOR ANWAR (3RD): Thank you. I just wanted to clarify line of questions that you had earlier. Just again this is an opportunity for everybody to learn about some of these aspects. So, if let’s say somebody had lung cancer and they were dying and they were on a ventilator when they die the cause is still going to be the lung cancer it would not be asphyxiation from, I mean an inability to breathe or anything like that? And the same way if somebody has pancreatic cancer, God forbid, and they actually are passing from that and they are not able to eat anymore the cause of death would not be considered as starvation it would be considered as pancreatic cancer. I mean that’s how you are trained to write some of those things, just so that it’s clear from anybody who’s listening to this, thank you.

SENATOR ABRAMS (13TH): Thank you, Senator. I was just wondering, Representative Elliott is you, in your reading or looking into this issue have you thought about the aspect of people having some kind of control at the end of their life and how many people might pursue this but then not actually follow through but just knowing that that is an available choice to them give them a better quality of life perhaps during the time that they are alive?

REP. ELLIOTT (88TH): So of the people that actually get the medication, about 60 percent use it. But of the people that look into getting the medication and don’t actually get the script it is less than one percent. So a large aspect of this is not just the dignity side to make sure that you are not basically dying in your bed with a week of starvation. It is about determining for yourself what does it mean to have a full life and if that is getting cut short both by time and the dignity aspect of getting cut
short by the fact that you are in terrible pain and you are suffering a large component of this is just feeling you have control over your own destiny.

SENATOR ABRAMS (13TH): And over your own suffering?

REP. ELLIOTT (88TH): Correct.

SENATOR ABRAMS (13TH): That you don’t have to fear that?

REP. ELLIOTT (88TH): Correct.

SENATOR ABRAMS (13TH): Okay. Thank you very much. Any other questions or comments? Thank you very much, Representative. Up next we have Sharon Hines. Welcome.

SHARON HINES: Committee Chairs, Committee Members my name is Sharon Hines and I live in Middletown.

This issue could not be more personal. I have stage IV lung cancer. I have undergone multiple chemotherapy treatments and been enrolled in two different clinical trials. In January, I was told the cancer in my brain has started to grow yet again. Unfortunately, I am running out of acceptable treatment options. What you also need to know about me is, I am an oncology nurse practitioner. I have spent my entire nursing career, more than 30 years, caring for people with cancer and that includes many years in hospice.

The pain and suffering that often accompanies an advanced cancer diagnosis, is frequently unavoidable. I have been at the bedside of enough dying patients including members of my own family, to know that despite the best hospice care, not all pain can be controlled, nor will every patient have a peaceful end to their life. There is so much fear
and worry that comes with a terminal illness. It's not only about how will I die or when will I die but, how much suffering will I have to endure. Having Medical Aid In Dying as an option would bring me the peace of mind I so deserve. And with less worry there is more time to enjoy life.

And it's not just pain and other symptoms that we deal with at the end of life. Loss of autonomy, loss of control, and loss of cognitive abilities, are all very real in my situation and will negatively impact my quality of life. It's important to note that no one can define another person’s quality of life.

When I was given a prognosis of six to nine months, I knew exactly what I wanted. I already had an advanced directive. My focus has always been on quality of life, not quantity. My experience working with cancer patients and having thoughtful discussions with my family, medical team, and more recently, my palliative care team, continue to validate my belief that Medical Aid in Dying (MAID) should be an option for those of us with terminal illness.

At some point in my future, this disease will consume every aspect of my life and there is no doubt that it will kill me. I want to die in my own home and on my own terms. I want access to medical aid in dying here in Connecticut the state that I have called home my entire life, I should not, at the end of my life, be forced to become a medical refugee, to move out of state to gain access to an option that 70% of the American people support and I encourage you to support this Bill as well. Thank you.
SENATOR ABRAMS (13TH): Thank you very much for your testimony. Thank you for being here today.
Representative Cook.

REP. COOK (65TH): Thank you, Madam Chairman. Thank you for being here and the courage that you have to sit in front of us dealing with the disease that you are dealing with right now. I lost my step-mom in August to lung cancer. On the day that she died, two hours after her birthday ended, she called that morning and she said, “I’m done.” She says, “I can’t deal with this pain.” She was a God-fearing, church going woman that believed that life was supposed to happen the way it was supposed to happen. On her last 24 hours her request was undaunting, “I can’t take the pain, this is not how it’s supposed to be” and the doctor said to her we are not that kind of hospital, we’ll give you morphine. So after the first dose of morphine the extensive dose of morphine, I might add, her last words were spoken about three hours after that and she took her last breath an hour and 55 minutes after her birthday had ended at 1:55 in the morning. Those hours between that dose of morphine, the first heavy dose, and that last breath were more painful for us to watch sitting by her side with the squirming and the moaning than anybody should ever have to endure. So I’m sorry for what you’re going through but I think we need to have an understanding and you might be the person to answer that, so that’s why I’m asking you’re a touch question. What is the difference between what we are trying to do and the extensive amount of morphine we give people and all it hospice care since you’ve been on both sides?

SHARON HINES: Could you repeat your question?
REP. COOK (65TH): We give them enough morphine at what we consider to be our appropriated regulated dose, we might call it hospice, we might call it vtox, we might call it whatever we want and quite frankly a lot of cancer patients are sitting with a prescription of morphine in their home that could, if they chose to take it and end their life anyway. And we’re sent them home with that. So what we’re asking for today and what we approve because we call it hospice, what is the difference?

SHARON HINES: Hospice does not support medical aid in dying or offer it. The difference is those last days of life can be the most difficult for the patient, for family. No having to endure those kinds of last days, weeks, whatever it is, is so critical for me. It’s about quality of life, it’s about how I want to die. I see medical aid in dying as a much more peaceful and gentle way to go and the possibilities I know I could be facing.

REP. COOK (65TH): So if we’re approving an increased dose of morphine or whatever you might be, lets get rid of the word hospice because I think hospice offers so much more than just this conversation which I believe fears our elderly population. So lets take away the conversation of hospice and let’s talk about those end of days. We give enough morphine to end your life. We in essence have already approve the ability for a medical professional to give you morphine and increase the dose so the family is able to ask for an increased dose as the hours progress.

SHARON HINES: It’s not Medical Aid In Dying brings on death in a shorter period of time.
REP. COOK (65TH): So in years past we’ve discussed this Bill and stated that you would have to take upwards of 90 pills to be able to end your life. Have we solved that problem because with those 90 pills which I could not even imagine is no guarantee that you can consume all 90. What happens if you don’t? What reverses the effects if you don’t? Where’s the guarantee lie?

SHARON HINES: It certainly does lie in science as to how to compound the drugs and there is a second option that is currently being used in Vermont that doesn’t require the extent of, you know, it’s not 90 pills. So we do have options out there, not a lot, but they are carefully thought out and planned and I know that there will be other people, other experts who can speak more to the specifics about the drugs itself.

REP. COOK (65TH): So if your were an advocate. So you are advocating for the opportunity to do what you chose as your right to do?

SHARON HINES: Yes.

REP. COOK (65TH): What would that option look like? I’m not familiar with the Vermont options. Can you please explain just a tad of that if you have information.?

SHARON HINES: What I envision is taking frequently what is given prior to taking the medication is an antiemetic, and then shortly thereafter takin a lethal dose of medication. I take it myself, no one hands it to me, you know, administers it to me. This is something entirely myself.
REP. COOK (65TH): And is this lethal dose a liquid form or a pill form or are there options in that regard?

SHARON HINES: There from that I understand there are options now, not a lot but there are options available and again I can’t speak to the specifics of that.

REP. COOK (65TH): Thank you and I’m sorry to ask you some tough questions and I am so very sorry that you are dealing with what you’re dealing with.

SHARON HINES: And I am very sorry for your loss.

REP. COOK (65TH): And I hope you find some resolve and may you have through the rest of this battle.

SENATOR ABRAMS (13TH): And I just want to clarify just one thing. Hospice and the Bill that we’re looking at right now are mutually exclusive so to make that clear. So even though I understand your line of questioning I want to make sure people understand that you can be in hospice are and still choose this.

SHARON HINES: Exactly it’s not an either or it’s an and.

SENATOR ABRAMS (13TH): Representative Steinberg.

REP. STEINBERG (136TH): Thank you, Madam Chair and thank you for being here to testify. We are all sort of focused in on you because you bring frankly a unique perspective on it as a healthcare practitioner yourself. I am obviously very sorry for your diagnosis and your prognosis. I imagine that given your background and given the prognosis you’ve been given, you’ve looked at alternatives in
terms of how you might want to manage your remaining days?

SHARON HINES: Do you mean? Oh, yes. I’m sorry and one of them would be to move out of state to, you know, to take on the burden of moving out of state to a state that does offer Medical Aid In Dying, that’s how strongly I feel about it.

REP. STEINBERG (136TH): How do you answer the question about the uncertainty of how long you might actually live?

SHARON HINES: I think that when someone is dying with advance lung cancer and many other cancers and if we look at the statistics of the duration patients are on hospice, 24 days I think was mentioned earlier, I don’t know if that is exactly right, I think we can do it and as people get closer to dying you actually start to see signs of the dying process where things start to shut down, they don’t eat, they sleep more and more. In my case struggling to breathe could be a real issue. So there are signs that we can assess and how we used to do it in hospice when we were trying to keep our families informed was talk about prognosis in hours to days, days to weeks, weeks to months because yes it is unpredictable but there are things we can look at.

REP. STEINBERG (136TH): And since I’m not the first, I’m gonna ask you it, a brutal seemingly insensitive question, I hope you can take in context, have you considered what some people have said, which is, you know, you seem pretty okay right now, why can’t you just tough it out to ease the guilt of family members and provide them with peace of mind? Why isn’t that just the right answer?
SHARON HINES: I actually, my family, you know being a nurse for more than 30 years, spending a lot of that working in hospice and oncology but I know nurses everywhere deal with life and death situations from working with patients and families. We’ve had these discussions for many, many years at my house. My husband fully supports my decision. My son is 32 he fully supports my decision. I have friends here today, my 19-year-old niece is here with me today. They are here because they support my decision. Ultimately it is my decision. I am fortunate that I have their support.

REP. STEINBERG (136TH): thank you for your testimony. I believe it takes a special kind of bravery to be candid about this particular option and I really appreciate your testimony. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Senator Anwar.

SENATOR ANWAR (3RD): Thank you. Ms. Hines, I want to thank you for being here. I know just to be physically here it’s a lot of pain and discomfort and respiratory symptoms that you have to overcome and there is an emotional barriers as well to come in front of everyone to speak about your health. So, I just want you to know that you are a hero. No matter where anybody’s positions may be in this room or beyond, you are a hero for being here so I want to thank you for that and your testimony is very powerful for us to sit here who are not in pain or suffering or have a terminal illness it is easy to make judgements either way but when somebody who is experiencing the realities of what the decision would entail and how that may affect them, that is what we have to look at. Sometimes we have to put
ourselves in the shoes on the individual who is asking for some of this. So thank you for that.

SHARON HINES: Thank you.

SENATOR ANWAR (3RD): The question I have for you is as an oncology nurse do you recall patients asking you for help and aid in dying?

SHARON HINES: Yes, I do. We’ve had conversations maybe not as early as when hospice first started here in Connecticut and I was part of that group, as a nurse we are active listeners. We show empathy and compassion and that is how I responded to those conversations, validate people’s feelings.

SENATOR ANWAR (3RD): And there are family members you’ve already had the conversations with and okay. I just want to thank you again. Thank you so much.

SENATOR ABRAMS (13TH): Any other questions or comments from the Committee? Thank you so much for being here today. You really are a hero.

SHARON HINES: Thank you, everyone.

SENATOR ABRAMS (13TH): Cathy Ludlum. There is a second microphone there that can move that might be easier, I mean easier for her to get to. I’m not sure that will reach if we can hear her on that microphone but if you use the other one press the button and turn the other one off please so that you. Then turn that one on and move it up and you can pick it up and put it right in front of here. Thank you Ms. Ludlum we just want to make sure that we can hear you. That’s excellent, thank you so much for being here. Welcome.

CATHY LUDLUM: Thank you and I want to thank the Committee for making this a comfortable place so I
can talk. I know that passions run right on this issue to all of us on both sides. And as you said it is really important that we all need to feel comfortable so thank you for that.

Senator Abrams, Rep. Steinberg, and members of the Committee, my name is Cathy Ludlum, and I am one of the leaders of Second Thoughts Connecticut, a group of disabled people and allies who are working to prevent the legalization of assisted suicide. I am here to oppose HB 5898.

And I have a lot of comments I’d like to read my testimony is not up yet but it will be. In the meantime I would very much like to look at the comments by my colleague Diane Coleman, I’m not dead yet, because some of what I’m saying is overlapping with some of what she has put in also.

Many of us with serer disabilities tend to be though of prematurely by medical practitioners as having reached our final stage where death might be expected in the near future and if we go to the hospital we bring friends, because we have to. This will be even more true now that the Connecticut State Medical Society has dropped its opposition to assisted suicide. The last thing we need is for practitioners to have in the back of their minds, “I don’t know how you live the way you live, maybe it’s time for ‘Aid in Dying.’” If the CSMS will not advocate for us and good medical practice, who will?

Now referring to the Bill itself, we can spend a lot of time picking about the problems with it but I would like to focus on a couple of things.

One is under Line 76, Section 1-19, I would qualify for this Bill under this law because nowhere in part
of that the definition of terminal but nowhere in there does it say, with or without treatment. With treatment, my feeding tube that I’ve had for 20 years, respiratory support I can live a long time. Without treatment I would not live very long. So that’s a clinical difference. Can you turn this over please?

One other thing, people like to say that there are no problems reported in the Washington one, it is very important to know, we will never know if there are problems because even Dr. Kartina Hedberg from the Oregon Department of Human Service said, this is a quote, “We are not given the resources to investigate [assisted-suicide cases] and not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves.” I am not saying there is wrongdoing going on but if there is, and particularly there might be, there is no way of are knowing that covering that suggestion, there is just no mechanism. So thank you for your time and attention and I will have that testimony up there real soon. Thank you.

SENATOR ABRAMS (13TH): Thank you so much for your testimony. Are there questions or comment? Representative Steinberg.

REP. STEINBERG (136TH): Cathy, thank you for being here. Anybody who has been in this building any period of years know what a fierce advocate you’ve been on behalf of those with disabilities. I don’t think you could have a better Representative and I’ve always enjoyed your testimony when we talk in the Long-term Planning Council and many other contacts so thank you for bring you advocacy and expertise to us today. One of your comments alarmed
me considerably is that the members of the medical community view those with disabilities as effectively being terminal. Why would any person with disabilities continue to go to a doctor who viewed them in that fashion is rather surprising.

CATHY LUDLUM: Oh, I’m not suggesting that every doctor does that, I’m not saying that. But what I am saying when you go to a doctor looking at our health for whatever the situation is, there are those that are in my population who do receive comments like, “Boy I don’t know how you do it, if I were you I wouldn’t want to continue.” That has been said to people I know. And if I could just give a very quick anecdote in answer to your question, my colleague Bill Peace who is a paraplegic in New York State, he was hospitalized for a very, very bad pressure sore and in the middle of the night, a doctor in the hospital came in and said to him, you know things are really looking bad here. You know, we can try to treat this, you’ll lose your job, you’ll become bankrupt, you’re gonna be bedridden for a long, long, long time probably a year or more while this heals and end up in a nursing home. But we can fix that, I can make you comfortable and you won’t have to go through any of that, what do you think? Bill Peace wrote this in an article called “Comfort Care a Denial of Personhood.” And it went everywhere. The doctor really said that to him, you know, we can make you comfortable, you won’t have any problems anymore. And that was not a doctor he elected to go to, but it was the doctor he had in the hospital. So in some places, or what doctors say, you don’t choices all the time. I’m not saying all doctors would do that but some do.
REP. STEINBERG (136TH): I think that raises some interesting concerns that I know you’ve expressed previously with regard to legislation of this sort. I think also the example you gave, given what this Bill requires would not be anywhere near sufficient or even the appropriate sending in that we would not necessarily be deemed the attending physician. But I also want to address some of the other things you brought up as concerns and we shouldn’t dismiss the prospect of unattended consequences is often the case with legislation but you made reference to the with or without treatment language which again we’re here today not only to hear testimony that if there are ways to improve the Bill so it addresses some of the issues you raise, we are very open to do such things. If we were able to address that and also to your point address the need for monitoring mechanism, that hasn’t existed, would you be supportive of the Bill?

CATHY LUDLUM: I’m not sure I could support it but I believe you will continue working on it and try to address people’s concerns and I appreciate that. That doesn’t necessarily mean I’m gonna support it though. Will they end up agreeing to disagree but, you know, I’m bringing forward life perceptions, issues, problems with it and so you and so others on all side so this is why we’re having a dialogue about it. I’m not promising to support it. I don’t think I can because of the concept doesn’t work for me that we’re gonna be providing suicide prevention to our society and agree that we should try to discourage people from taking their own lives and then we’re gonna create a program that not only, I’m not saying that encourages, but facilities that
process to get the results, that’s a real difficult paradox in my mind.

REP. STEINBERG (136TH): Well I agree with you and certainly there is significant concern about the widespread depression among many people which could often lead to suicidal thoughts and that is really not what we’re talking about here but I want to thank you for your testimony and I hope you’ll stay engaged because it is our desire to see if we can put all the protections in this Bill that we can. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Thank you. Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Madam Chair. Just wanted to thank you for your testimony, very thoughtful and useful and I think you bring about a good point about going through line by line and making sure there are protections in place because so of the illnesses that may be deemed terminal may have some options with the new treatments so we need to cover that aspect as well and then make sure that those protections are in place, so thank you for that.

SENATOR ABRAMS (13TH): Any other questions or comments? I would add that I spent my career as a special educator and so making sure that nothing that I do would in anyway impact the community of disabled people in a negative way is very important to me. So I thank you so very much for your testimony and for bringing to our attention any of your concerns at any time. And you are a fierce advocate, it is a pleasure to meet you.

CATHY LUDLUM: Thank you, Senator.
SENATOR ABRAMS (13TH): Thank you. Next is Mary-Ann Langton.

KAICIE WARE: My name Kaicie Ware. Hello Co-Chair Abrams, Co-Chair Steinberg and Members of the Public Health Committee.

My name is Mary-Ann Langton and I live in East Hartford. I asked my personal assistant Kaicie Ware to read by testimony that I wrote about AN ACT CONCERNING AID AND DYING FOR THE TERMINALLY ILL PATIENTS. I oppose this Bill 5895 because of the risks that people with disabilities and other vulnerable populations would be pushed towards asking for self-administering drug in order to end their life. I have also emailed this testimony to the Committee.

This Bill is not moral. Often times the medical professionals do not recognize the many abilities of people with disabilities rather they see us as a burden upon our families and friends. I luckily went to see my friend Pete, a man with a severe physical disability who only communicated with a speech machine and he was in the hospital with pneumonia. While I was visiting Pete’s doctor came to see him and I learned that the medical team was going to stop all liquids and food because they thought that Pete was too disabled to live. The medical profession did not take the time to learn about Pete’s accomplishments such as graduating from high school and serving on a Governor’s Appointed Council. There are many, many more stories like his.

Please oppose this Bill because it would do great harm to the disability community and other vulnerable populations. Thank you.
SENATOR ABRAMS (13TH): thank you for your testimony. Are there any questions or comments? Thank you very much for being here today. Appreciate it. Elaine Kolb. Can you press the button please, it will turn it on. Thank you very much.

ELAINE KOLB: It’s no now [Laughter]. Well, we’re here again. Another time trying desperately to convince mostly nondisabled people that assisted suicide is a horrible thing, a terrible dangerous thing for people with disabilities. And once again we patted on the head by some saying, oh you don’t understand this isn’t about disability as if we don’t know what our lives are about and what affects us. So what I want to explain to people is that the reason this is about disability is because of something that is very powerful in our society and it’s called “disabiliaphobia”, the fear of disability.

Now the fear of disability goes a long with something called ableism. Ableism is like racism, sexism and all those kinds of things, the assumption that you’re automatically better if you do not a disability and that if you have a disability you are automatically less than. And disabiliphobia is like homophobic, there’s fear and the fear of disability, the anxiousness about what might happen, what kind of suffering might occur is part of the driving force of this.

And I want you to know that, do I look like, do I project being a helpless person? Really? And yet people come up to me thinking they’re giving me a compliment and say, “Oh I just think it’s amazing all that you do, but if I was like you I’d rather be
dead.” Excuse me! I’ve been told that many times and I have been the person who has gone to the hospital that does not often provide medical care in the medical industry and there you are. And you do have to have a friend there to protect you if you have a significant severe disability and I’ve been one of the people that’s been there and I was just there last week with a friend who had a seizure disorder that was brought on by beats. Try to get the medical system to cooperate. I’ve been present at the moment of death of three people in my family and I call them my family because two were my partners. I’ve been there. I’ve provided trach care for my partner who we would go to the hospital and at some point while she was fighting for her life somebody would say, “Don’t you think it’s time to let her go?” And I would say she is fighting for her life, she values her life, I value her life and maybe I would like someone else to help her and being designated health care agent I could do that. But there is a lot of people who don’t have an advocate like that and their lives are not considered to be worth living by nondisabled people and they are dying or they are not receiving services.

So before you provide poison pills please provide real healthcare. I mean concise, extensive healthcare with home services so people can live in freedom cause what a lot of people what they are really afraid of is they don’t want to end up dying in a nursing home and who would want to go there anyway. There is no reason for it. I know I have to stop and I’m sorry.

SENATOR ABRAMS (13TH): Thank you, I need you to sum up. Thank you.
ELAINE KOLB: That’s it. [Laughter] That’s it. Nobody wants to go to a nursing home and everybody wants to live with dignity, everybody is gonna die but you want to live with dignity.

SENATOR ABRAMS (13TH): Thank you. Representative Steinberg.

REP. STEINBERG (136TH): Thank you for your testimony today and you’ve also been there for the disability community on many occasions and we appreciate that. And I agree with you I think there is ableism bias out there. I think people aren’t comfortable and that is often an expressed in most inappropriate ways and I think you make some good points that we really have to put every possible protection in place so that the pressure on those with disabilities would never be a factor in this and certainly you have my condolences on the loss of your partners in the past but I have one simple question. If, and this is hypothetical, and one you can chose not to answer, if your partner had said, you know I’m done fighting for my life, this is the end for me, would you deny that person the ability to make that choice?

ELAINE KOLB: See this is the thing about my partner, Patty, she could have died almost anytime. Essentially when people are as significantly disabled as she was, all you have to do to die is give-up. The only reasons she stayed alive was her fighting and in further response to that, I would like everyone here to look up the name Carrie Ann Lucas. Carrie Ann Lucas was not only a severely multiply disabled person on multiple things that many of you have listed that you don’t want to live with, okay. She wanted to live, she lived with
them. She became a lawyer, she adopted children with disabilities, died because her insurance company would not pay for the medication that would possibly have saved her life. So as far as I’m concerned the medical industry killed her and yes she was a proud member of “Not Dead Yet.”

REP. STEINBERG (136TH): Thank you for that. I think you also raised a very important point which is medical technology is advanced to the point where we can keep people going for a long, long time and this is actually intended to provide an option for those who the medical community may not be serving well. Thank you.

SENATOR ABRAMS (13TH): Just a minute please. I just wondering if there are any other questions. Representative Candelora.

REP. CANDELORA (86TH): Thank you. I want to thank you for your advocacy all these years, you’ve returned again and again on this issue. And I think what I hear is one of the concerns about this Bill is making sure that the Bill would no impact the community with disability their abilities to get appropriate health care and I think you just spoke to that issue and I was going to ask that question of, do you have experiences where you feel that healthcare services are potentially denied?

ELAINE KOLB: Absolutely. All the time. I am 41 years past a spinal cord injury. I’ve made it the business of my life because I did survive, I almost died. I’ve made it the business of my life to try to find out as much as I can about all different kinds of people with all different kinds of disabilities and disadvantages and the system as it exists right now is designed to limit or prevent
services for low income people. People get denied constantly. Like I said, I moved into senior disabled housing in 1992 every day I see people in my building that are seniors and people with disabilities that are not receiving the kinds of services that would make their lives really best, that are denied frequently. People that need equipment that get it denied frequently. Please that have treatments that could be helpful but they can’t afford it, that’s not on their insurance. So yes, so all of these things make is so our lives are extremely difficult. So please before you offer poison pills which are very cheap by the way, please provide real, real healthcare and the real services, and home care and also there’s just a place to live. Most people with low incomes, we can’t afford to live anywhere except in public housing and they’re falling apart.

REP. CANDELORA (86TH): And I appreciate that point because I think one of the interesting struggles in Connecticut that we do deal with and I think what the taxes we see on healthcare right now and our hospitals, it seems as if the private insurance companies are paid, you know, pay out more and more and more. If you’re on Medicaid you may get a different level of service because the payments aren’t necessarily there so when you have private insurance you’re potentially getting a different level of healthcare than if you are on Medicaid and so many of our populations with disabilities are on Medicaid.

ELAINE KOLB: And I’m dual eligible so you so are you gonna mess around with us again. You know, it looks like there is the possibility of, I’m on Medicare with the sort of some Medicaid and am I
gonna get pushed into one of these, you know, privatized things and stuff, I don’t want it.

REP. CANDELORA (86TH): I appreciate your passion.

ELAINE KOLB: Okay, thank you.

SENATOR ABRAMS (13TH): Senator Anwar.

SENATOR ANWAR (3RD): Thank you for your testimony, very thoughtful. I wanted to ask you, I think the current Bill is not talking about disabilities at all, I just looked at it again but I think what you alluding to is that this is a slippery slope of risk where, and I think, is that what you’re suggesting is that if a law is passed and the healthcare industry which as you perceive has failed providing appropriate and fair treatment to people with disabilities would use this as an opportunity to make bad choice again?

ELAINE KOLB: Well this is the thing, let me explain. This once again expresses that certain kids of lives really are not as valuable as others, certain kids of life, so people are concerned about suffering. I have many, many friends that have chronic pain all the time. This is just the way of life. So this Bill specifically does not provide any mental health care. If somebody. Let me switch this around a little bit, it will help try to explain this to you. One of my partner’s with her physical disabilities had some very severe anger issues. She wanted to go and sign herself in and get treatment but because she had a physical disability the psych ward place would not provide the personal assistance that she needed in order to be there and you know what, in this day and age, that’s still a problem. If you have psychiatric
issues and physical disabilities it is hard to get the assistance that you need so then if suicide is not a good thing then let’s not support it. If, I don’t know. I’m sorry I’m getting emotional here because I’ve just watched too many of my friends die because they were not respected and they did not receive the assistance that they needed and then they got depressed and then they gave up. So don’t devalue our lives, please.

REP. CANDELORA (86TH): Thank you so much. Thank you.

SENATOR ABRAMS (13TH): Are there any other questions, comments? Thank you so much for your testimony. Thank you for being here today. Let’s see, we’re going to move to 1005. Welcome.

MICHAEL ZACCHERA: Good morning, Senator Abrams, and Representative Steinberg and Ladies and Gentlemen of the Committee. My name is Mike Zacchera, and I am the Chairperson of the State of Connecticut EMS Education and Training Committee and I am here in support of Raised Bill 1005.

This bill, specifically pages 19 through 25, actually represents a little over two years of my committees time in researching the recertification process for EMS providers here in the State of Connecticut. We had some lengthy debates about, you know, now to best go about this, what opportunities there were and after a great deal of discussion we came down to the National Registry of EMT’s offers the very robust program and that was our recommendation to use that process.

After having made our recommendation back to the Office of EMS we presented this recommendation
throughout the state, to the EMS Advisory Board, the North Central Connecticut EMS Council, to the State Fire Commission to the Tolland and Windham County Mutual Aid, Southeast Connecticut Fire Chief’s Association, and a variety of other bodies. And all of them together have pretty much concluded that this is the direction we should go and that this is a solid recommendation.

In our discussions with the National Registry they have been very flexible as far as meeting the needs of the EMS providers here in Connecticut as far as being able to get them into the National Registry system if they are currently not in the system. The National Registry of EMTs is a recognized national body. Their entire purpose is to certify providers and provide educational standards for continuing medical education and they are the standard for EMS certification throughout the country.

Thank you for your consideration and I appreciate your time today.

REP. STEINBERG (136TH): Thank you for your testimony. I just want to say I really appreciate the effort you and others put in over these past two years to get us to this point. I was amazed at really that hard work of so many stakeholders obviously so heavily invested in getting this right and we are pleased that at least this one little piece of legislation is a step in the right direction to facilitating timely response and quality care. I really don’t have a question but again I just wanted to thank you for the work you’ve done and for helping us get to this point.

MICHAEL ZACCHERA: Thank you, sir.
REP. STEINBERG (136TH): Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Thank you, Mr. Zacchera for the dozens of pages, it’s lengthy pages 24-25 of the Bill. The CME that is required for recertification, how many hours is that?

MICHAEL ZACCHERA: So that will verify depending on the level of providers. So it will, give me one second here, [rusting paper] at the Emergency Responder level that would be 16 hours, and that will vary going upwards so at the EMT level the next level up that would be 40 hours, at the advanced EMT it would be 50 and at the paramedic level it would be 60 hours and that would be over a two year timeframe.

REP. PETIT (22ND): So the max is 60 over two years?

MICHAEL ZACCHERA: Correct.

REP. PETIT (22ND): And that’s specified by DPH or specified by National EMS organizations.

MICHAEL ZACCHERA: That would be specified by the National Registry of EMTs.

REP. PETIT (22ND): As a general philosophy is your field happy with the CME that’s specified or is it constantly tweaked to add and subtract things depending on what’s happening in the field?

MICHAEL ZACCHERA: It actually varies quite a bit so, I can have that available for you, but the way they have set up their CME program is if you think of it as three broad categories. There is a national category. Let’s use the paramedic as an example. At the paramedic level the national category is work 30 hours of that 60 hours. And the
National Registry actually for lack of a better term stipulates what you should be taking to cover that information. Okay, so that’s a broad topic is you will. Then there are two other categories that would make up the remainder of that 60 hours. So the remaining 30 hours, so 15 of those are actually left up the individual states. So for example DPH here could say, okay of the 15 hours that are allotted to us we want you to also address these topics as well. And then the last 15 hours is actually left to the individual provider so that way they can adjust their CME to either local needs or their own specific interests if you will. The national component does vary, it usually varies every three to four years or so. I would actually have to go back and lookup the last date that actually happened but it was, there was a rather lengthy process where this was rolled out to the individual states if you will.

REP. PETIT (22ND): And finally someone opts out to do something else is it three years where someone can be away and be recertified without having to completely certify again?

MICHAEL ZACHERA: So not quite right but sort of. So let’s say for example I decide today that I no longer wish to be a paramedic. I want to take a leave of absence for lack of a better term. What I can do I can actually request nonactive status or inactive status with the National Registry and that would be fine. And let’s say three years, five years from now I decide that I wish to come back. So what I would need to do is I would actually need to go back, meet those recertification requirements as if I had been practicing. So if for example if now I have to do my 60 hours work of CME, bring that
back to the National Registry to show I’ve met all of the training requirements, I would like to come back in as an active member.

REP. PETIT (22ND): I’m sorry, and if you, so you’re out for five years, would you pay the licensing fee for all five years or not pay it until you first came back?

MICHAEL ZACCHERA: Not. Well I can’t speak DPH I feel fairly certain they are going to tell me I have to pay every year, happy birthday [Laughs].

REP. PETIT (22ND): Thank you. Thank you, Mr. Chair.

REP. STEINBERG (136TH): Thank you. Other questions or comments? Yes, Senator.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. I wanted to clarify something, when you are talking on page 19 about the National Organizations and learning online for them. I look at the skills as well as intellectual and educational component but for your industry you needs skill. You need to be able to intubate the person, get IV lines in. I don’t want to, I don’t want people to be able to have those skills be practiced.

MICHAEL ZACCHERA: You are 100 percent correct, sir. And actually the online portion that you are referring to is actually a database, it is the way to record the continuing education that you’ve done. So it is not necessarily, while some of the education can be done online, not all of it can be. As a matter of fact the amount you can do online is limited for just the purpose that you spoke to. So I still would have to do, just like you described, physical skills that actually we require that of our
paramedics in most regions here in the State on a yearly basis where we demonstrate not only intubation but backup airway skills, vascular access just like you were describing.

SENATOR ANWAR (3RD): So the National Organization when they are looking at the databases they will have to require those individuals to show that they have had the skills practice again.

MICHAEL ZACCHERA: That is correct.

SENATOR ANWAR (3RD): Okay, thank you so much.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony.

MICHAEL ZACCHERA: Thank you for your time.

SENATOR ABRAMS (13TH): I’m gonna move on now to Bill 7278, Bruce Baxter please. Welcome.

BRUCE BAXTER: Good afternoon, folks. My name is my name is Bruce Baxter. I am the Immediate Past President of the Connecticut EMS Chiefs Association. I am also the CEO of New Britain EMS which is the primary 9-1-1 EMS responder for the City of New Britain. I am here today to reiterate what I have already pledged in writing with my testimony.

The Connecticut EMS Chiefs Association is firmly in support of the further passage of Raised Bill 7278 to create the infrastructure allowing Mobile Integrated Health to come to live in Connecticut.

We believe that there are three minor changes which is really what I would call homogenization between the Bill language and really the recommendations that came out of the MIH legislative study committee. I believe that occurred largely because
the Bill came up and then the study came out and I don’t see the challenges being overburdensome not to get it done in a timely manner.

But today I really want to put a local face MIH. MIH is not something new. It has been around since 1997 and as Dr. Pino cited initially started in very rural areas of the United States that had a true defined lack of access to local healthcare. It actually started in Red River, New Mexico, population 500 where the closest medical facility was about 50 miles away. There were a couple of other attempts that went on over the last three or four years ensuing in 1997 predominately rural areas. Urban areas began to explore this as an option to enhance the tripling of, enhancing the outcomes of patient, enhancing patient experience in developing valued care base models that EMS could buy into.

Currently, there are 129 active EMS MIH Programs operating in 33 States inclusive of New York State and Massachusetts. There are another 200 programs that are in the process of development. There are well over 55 scholarly articles that have been published in various journals that have lauded the positive impact MIH programs have had on patients, on patient satisfaction and on cost savings.

Most recently some of you may be aware that Medicare came out in support of one aspect of MIH that would permit the treatment and release of patients in 9-1-1 system as well as utilizing nurse triage and funding project study committees to further this.

I know my time’s up, I would simply ask that this Committee revise the language to meet the criteria that will answer a lot of people’s questions that
was included in the report. The infrastructure to support this exists and the one thing that needs to be corrected, while Dr. Pino was correct in saying there’s fragmentation in EMS in the State, there is fragmentation in EMS across the country. There are 200 ambulance services in the State, MIH is identified in that report, only will be practiced by the 41 paramedic services that provide border-to-border coverage of our resident with advance life support. Thank you for your time.

SENATOR ABRAMS (13TH): Thank you. Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Madam Chair. Good afternoon. This is my first time to serve on this Committee but on other Committees I have served on there have been taskforces created which this legislative body has quite often done, and then the taskforce comes back sometime and hopefully they get put into place and comes back with recommendations. I’ve seen where the recommendations have not been taken and sometimes where they have been and you mentioned this, so I am curious. So there was a taskforce put together regarding this?


REP. ZUPKUS (89TH): Okay and the recommendations that came out of that taskforce, are they in this language or do you think some of them are?

BRUCE BAXTER: The language from my perspective took 100,000 foot level to get a Bill raised understanding that the final report was being corrected. The final report is very specific in terms of the areas of multiple integrated healthcare that the taskforce sought added benefit to the State
of Connecticut. It also clearly outlined the process of which service interested in providing multiple integrated healthcare services, paramedic services, services that have the primary service area designation to provide an advanced life support paramedic level care needed to follow in order to assure that the program had the quality and had the oversight and the partnership infrastructure in place in order to assure that program was not only successful as evidenced by supporting the triple aim but also sustainable over the long-term.

REP. ZUPKUS (89TH): And those all listed in your testimony?

BRUCE BAXTER: Those are not in my testimony because it would have taken more than two pages, there is a 78-page report that was released to the Public Health Committee on March 1st and it is within that document.

REP. ZUPKUS (89TH): Great. Thank you.

SENATOR ABRAMS (13TH): Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Madam Chair. Thank you, Mr. Baxter for your presentation. I want to suggest a couple of things. If I’m not mistaken the basis of some of this is from the work that’s happening in Massachusetts is that?

BRUCE BAXTER: The basis of this really is work that is going on across the United States. Massachusetts has two programs that have been highly successful that are operating that is correct.

SENATOR ANWAR (3RD): And I know they have been very effective and have provided reasonably good care to the patients and has reduced the cost. The name
Mobile Integrated Health Care is a misnomer in this situation at least when I see this, because it is a triage process. From what I understand somebody calls EMS and rather than taking them to the emergency room people are there to assess and see what are the things that can be addressed right there for the most part, right?

BRUCE BAXTER: I would say that is incorrect.

SENIATOR ANWAR (3RD): Explain to me then.

BRUCE BAXTER: It depends on what aspect you are looking at. There is certain cases where there are low priority 9-1-1 calls, can be a transferred to a triage nurse. The triage nurse goes through a defined protocol, offers the patient, while the patient is still connected to the 9-1-1 Center, the opportunity for them to maybe get them an appointment at a federally qualified healthcare clinic within a defined period of time, provide them with transportation vouchers so they have the opportunity to go there. There are other aspects of this however where Mobile Integrated Health Care paramedics actually respond to this part of the 9-1-1 system and have the ability to utilize telemedicine to bring an emergency department physician into the conversation they have with the patient to make a determination as to whether the patient can be treated on the scene within the scope of practice of the paramedics, whether the patient is better service going to a healthcare clinic or a doctor’s office. Bu the same token they have the ability to turn around and allow the paramedic to turn around and treat the patient and discharged the patient right there avoiding hospitalization altogether.
SENATOR ANWAR (3RD): So, I was accurate what I was saying actually. So in other words this is triage system. This is bring the triage early on in the call?

BRUCE BAXTER: In some formats, yes.

SENATOR ANWAR (3RD): So when we use the term integrated the primary care physicians in the healthcare system for the past many years have been talking about integrated health care system and when somebody looks at the name right now it actually gives the impression this is going to provide healthcare in the primary care settings and both of those are inaccurate because it is not integrated and it is not healthcare because this is triage process.

BRUCE BAXTER: I would disagree again. Again if you go back to the document that’s released there is also integration with home health, primary healthcare physician, cardiology practices depending on the segment of mobile integrated healthcare which is a nationally coined term, it is not one that the Committee came up with, there are various requirements that we have collaborative integrated working relationships so this is not just the paramedics working with the ED doc in a vacuum or in a silo. It has to be a collaborative integrated approach. Let me give you an example Doctor that may tie it together.

In my amount of years I have lost family members and one of the issues that occurs that is very sensitive to me is that when somebody is heading towards the end of life, they have an admission let’s say for congestive heart failure as an example. They get discharged from the hospital, you know as well as I
do, that when you reach a certain point in life you just want to hear one work, you’re discharged and you have your freedom and you can go home. They go home with a referral for home healthcare, a referral to follow up with a doctor’s office. A bunch of numbers and a bunch of prescriptions. The only think those patients hear is, “I’m free to go home.” There are times where the patient feels fine for a couple of days. They turn around and suddenly a day or two before home health arrives or they follow up with a primary care physician don’t feel well. They turn around and call the number, maybe to the home healthcare service, I don’t feel well. Okay we’ll try to get somebody there. They call back, home health is busy, why don’t you call the doctor’s office and it it’s an emergency dial 9-1-1. If you turn around and call the doctor’s office frequently there is no room in the schedule, call 9-1-1. There is a vicious vortex of the patient going back into the emergency department. The integration component is that with MIH there is an opportunity to sit there and say, Mary Jones lives in New Britton, oh, New Britton has a community mobile healthcare program. We turn around and maybe we send the paramedic out there who then has the opportunity to talk with you as the primary practitioner and maybe the reality of it is she needs to adjust her medications.

SENATOR ANWAR (3RD): I know the concept. I’ve seen the data, it actually works. I would be very supportive of this idea. I just don’t want people to be confused that this is how they are going to get their primary care. People are already getting their primary care in the emergency rooms now they will be calling this mobile unit to come over and
describe whatever and coordinate things. So there is a little slippery component in there but we need to be conscious of it and that’s why the name should be, it is a glorified triage system at the patient’s house or close to their place. But I support the idea because the data shows that it reduces the number of emergency room visits and without putting patients at risk. Thank you so much.

REP. STEINBERG (136TH): Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Thank you Chief Baxter for all your hard work in this area over time. One things, I’d like your observation and it may not be totally germane to the nuts and the bolts but I was just in judiciary testifying about a Bill and being asked about the physician supply. From your perception and from your guys and gals perception on the ground, do we have an adequate workforce of primary care providers to care for these patients?

BRUCE BAXTER: I think access is problematic in urban areas for the underprivileged. I think it’s, there is a lock of it, doctor.

REP. PETIT (22ND): Thank you and nuts and bolts when forms of this have done in other parts of the country are folks able in terms of the day-to-day operation, are people able to use current ICD-10 codes for billing or do they have to develop new codes to bill and be reimbursed so that this can continue to be self-sufficient it you will involving peoples coverage if they have it?

BRUCE BAXTER: Sure, it depends upon who the payer is and that depends on the State. The Medicare program is allowing you to bill under, I believe AO-
428, Blue Cross/Blue Shield, Anthem Blue Cross/Blue Shield which came out January first in support of reimbursing 70 percent of the average transport rate is billing I believe under the AO-428 code as well. A number of community programs is supported through downstream cost savings and relationships that are cut between ACOs, different health insurance companies for specific populations on a per member, per month type basis.

REP. PETIT (22ND): Maybe I should have asked the broader question has the experience been around the country that the insurance companies, the third party payers have been helpful to support this concept that you can turn $5000 dollar ER visit into a $250 dollar, you know, office visit.

BRUCE BAXTER: My assumption is Anthem Blue Cross/Blue Shield was on the cutting edge of that when they made the announcement in January the fact that CMS came out actually the day that we were meeting with you folks at the end of February and announced that they were doing a five year study in which they will be enrolling service to do it. I’ve heard that Aetna is interested, CIGNA and United Health Care have this under serious consideration.

REP. PETIT (22ND): I appreciate that and appreciate your suggestions for revisions once again. Thank you for your hard work in this area. Thank you, Mr. Chair.

BRUCE BAXTER: Thank you, doctor.

SENATOR ABRAMS (13TH): Are there any other questions or comments? Thank you very much for your testimony. David Lowell.
DAVID LOWELL: Good afternoon, Senator Abrams, Representative Steinberg and members of the Committee. My name is David Lowell and I thank you for the opportunity to testify today in support of HB Raised 7278 Mobile Integrated Health Care. I have provided written testimony and I would hope to just highlight some of the comments based on some of the previous testimony that has come out today.

It was a pleasure to be one of the 24 members on the Mobile Integrated Health Care workgroup. It was a collaborative of healthcare and emergency service stakeholders from across the State of Connecticut that worked the better part of year plus to come up with a comprehensive report that Chief Baxter just referred to. There is a lot of data attached to that report that gets to many of the questions and so in encourage you to read it.

As part of my testimony one of the things that I would like to clear up, hopefully provide clarity to, I provided a chart attached to my testimony, if you have it. What the chart does is shows the integrated relationship of these paramedic practitioners working for a licensed or certified ambulance service, working under the regulatory and statutory structure of the State of Connecticut and that existed for a lot of years. It also shows from a clinical oversight perspective is that mandatory requirement of these paramedics through their service to have a sponsor hospital agreement. We’ve had paramedics in this state for 40 years working very comprehensively in the field under physician medical oversight and I would daresay there have not been any clinical issues that have come to bear.
Mobile Integrated Health Care doesn’t change the clinical practices of the paramedic. What it does is create an environment for those clinic service to be provided differently in the community. What it does is stop the access as was said of using the 9-1-1 system to go the highest cost center of care, an emergency department for primary care service. What it does is stop the revocation of hospice for the uninformed patient’s family who are dealing with an end of life that we’ve heard compelling testimony in the home environment. They don’t know what else to do other than call 9-1-1 in that crisis at the end of life. It provides protocols for that. It provides the paramedics who have the clinical background and the ability to determine whether a patient needs to go acutely to an emergency department for the testing and possible inpatient admission or whether they could be medically managed through some alternative means. There is certainly not enough time in these three minutes to get into any more depth. I’m supportive of this legislation, I hope that you are. I think it does need to incorporate elements of the report that came out from the workforce that came out with a 100 percent consensus from all parties and I sit here ready to answer questions.

SENATOR ABRAMS (13TH): Thank you, are there any questions or comments from Members of the Committee? I would just say that I would very much appreciate working together with you to make sure we get this right. Senator Anwar did you have a question?

SENATOR ANWAR (3RD): Yes, I wanted to clarify something. What were the mechanism to communicate with the primary care physician and the specialist involved in the care of that patient because in the
emergency rooms you get a full note of detailed intervention that were made.

DAVID LOWELL: Yeah, so communication is probably one of the biggest needs across this healthcare spectrum and not just with the introduction of Mobile Integrated Health Care one of our normal communication standards is, you know, radio communication from a scene to an emergency department and that is the standard of care for a person who is in a, much of what we do and this came up earlier, is not part of the 9-1-1 system, it’s not an emergency response it is the movement of a patient within the healthcare system not as the result of a 9-1-1 call. I can tell you the majority of the patients that go in the back of one of my ambulances with my paramedics is not a 9-1-1 call, it is from a facility to a higher level of care facility, and so radio communication or phone communication, back to your original question, if it the home or residence of a patient it would be phone communication to their primary care or their specialty care and it’s the integration of the communication between homecare, hospice care, primary or specialty and the ER. Right now its call 9-1-1, transport to the hospital and talk to the doctor at the hospital who has no clue often times of that patient’s medical history and there is where our system is broken. We probably provide the bridge between all care providers. There are days where my paramedics will touch two or three care providers with one patient in the back of that ambulance.

SENATOR ANWAR (3RD): Let me rephrase it. End of that service call management is there going to be a
written report that is going to be sent to the family care and the specialist?

DAVID LOWELL: Yes. So thank you and I’m sorry that I misunderstood, but yeah. As a function of our services now across the state we create electronic patient care records that in many models are being integrated with the patients primary medical care file, if you will, through the EPIC system or whatever health system. Some models have developed a hybrid where you as a primary care physician could peek in on that patient and see what that call was about and what the referral was and transport to an non-ED as could the emergency room physician as could the specialist. And those notations would come out of a narrative presumably that the paramedic would create.

SENATOR ANWAR (3RD): Thank you so much.

SENATOR ABRAMS (13TH): Any other questions or comments? Representative Steinberg.

REP. STEINBERG (136TH): Yes, I just wanted to thank you for all the work you’ve put in to get us to this point. You have been very helpful to this Committee on all related to EMS, so thank you for your help.

SENATOR ABRAMS (13TH): Representative Petit.

REP. PETIT (22ND): A little sort of envy to envy sidebar here and do any providers in the field have access to electronic medical records?

DAVID LOWELL: Yes.

REP. PETIT (22ND): And is it 10 percent of the state, 20 percent, half?
DAVID LOWELL: I couldn’t give you an informed percentage. I know that our service who is largely Hartford Health Care provider has an HDE interface now where all our patient care records going into one of their facilities are uploaded in the EPIC system which then allows the technicians that had the interactions with those patients to view that particular medical record.

REP. PETIT (22ND): So in response to Senator Anwar’s question, so can you enter in the system in which case I assume the primary care provider would have access to that and get the ping saying there was an entry into one of their patients care records.

DAVID LOWELL: Yeah, that’s my understanding. As soon as our technicians are done in the mobile environment filling out their patient care record and they save that record. It goes up to the cloud, reads a barcode, populates that patient’s primary medical record, you know, in the institution.

REP. PETIT (22ND): Thank you. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony. Nice to see you today.

DAVID LOWELL: You as well.


JOSHUA BEAULIEU: Good afternoon to the Committee leadership and Committee members, my name is Josh Beaulieu and I am a Battalion Chief with the Town of Manchester Fire Department and I operate as their EMS Office. I’ve been a licensed paramedic in the State of Connecticut for 20 some odd years now. In
addition I am the Chair of the Connecticut EMS Advisory Board, it’s Mobile Integrated Health Care committee and I also served on the legislative workgroup on MIH that recently reported to you.

I am here to speak in support of Raised Bill Number 7278 AN ACT CONCERNING MOBILE INTEGRATED HEALTH CARE. I have the benefit of following two very, very bright and squared away folks on this topic so I’m not going to get too, too redundant with what they said, I’ll just say that I do support the comments from Mr. Lowell and Mr. Baxter on this. I support the fact that the Bill looks to do what I believe is in the best interest of this state with the few changes that have been suggested.

Generally speaking as they said, Mobile Integrated Health Care has been shown to be very beneficial in other states. We believe that it can also be very beneficial here. Of note, this particular Bill does provide the benefit of defining MIH as the function of the EMS system which is a hurdle for paramedics working outside of a 9-1-1 call and in addition it allows for rate setting for reimbursement which makes the programs potentially sustainable. Those two elements I think are big takeaways from this Bill and two items that we are looking for.

Additionally I’ll just say that MIH is an umbrella concept that talks about a lot of different programs all of which become tools in the toolbox for communities to do their own community gap analysis in healthcare and address problems at a local level. MIH is not meant or intended at all to be a catch-all to be state program. It is intended to give local communities the ability to look within themselves be it rural or urban, identify what
services are in place and what services are lacking and then look to see whether or not a paramedic might fill-in some of those gaps. In some cases this might be a great thing and in some cases communities may decide that it is not for them. But this is not a blanket one-size-fits-all, great for everyone program. I think that is important to note. I really encourages communities to utilize the resources that they already have in a different way to that end. So, my time is up. I thank you folks for hearing me out and I’m happy to answer any questions you may have.

REP. STEINBERG (136TH): Thank you for your testimony and for your hard work. We really heard from a lot of people very intimately involved with this and we are very pleased with the output and we will look at the changes that you’ve recommended. Any questions or comments? If not, thank you for your testimony today. We appreciate it.

JOSHUA BEAULIEU: Thank you very much.

REP. STEINBERG (136TH): We are going to move on now to House Bill 7193 and first up is Laurie Vitagliano, I believe. [Conversation off microphone] Thank you Susan for your patience, I make one mistake at every hearing, so this is the one hopefully. [Laughter]

SUSAN KELLEY: Good afternoon Committee Members, Members of the Public Health Committee, thank you for the opportunity to testify. My name is Susan Kelley, and I am the Director of Advocacy and Policy for NAMI Connecticut, the National Alliance on Mental Illness.
NAMI Connecticut provides mental health support, education, and advocacy for all Connecticut children, youth, and adults impacted by mental health conditions.

I am testifying today in support of HB 7278, and then also to raise a question about whether or not this Bill includes behavioral healthcare and the way I read it, it doesn’t. And when you look a Mobile Integrated Health Care’s definition is says, “clinically appropriate medical evaluations, treatment, transport or referrals to other health providers by a paramedic.” So I have to say that I was not part or I have not read the report by the taskforce so I am kind of in the dark about a number of the particulars but I think that I would agree with Senator Anwar that this integrated label is a bit of a misnomer especially when you come from the behavioral health role which I do. When I think of integrated care I think of behavioral health integrated into medical care and so we believe that behavioral health should be added to the definition or at least be considered. I haven’t heard one thing since I sat here about it yet one of the reasons why I am sitting here today is because I look at issues about kids going to the ER with behavioral health issues and that they, many of them shouldn’t be going to the ER and it is causing a great increase in costs, kids getting stuck in the ER and so forth. And so, as we look for solutions to that problem one of them has been well, maybe kids could be able to go to a like a urgent care center to be able to be evaluated and that those that aren’t true emergencies but of course currently you are not allowed, transports are not allowed to do that. They have to take them directly, they have to
go to the ER is my understanding. I’ve spoken with doctors, ER doctors and psychiatrists about this. So I think that and I just to summarize there currently isn’t, urgent care centers for example, don’t provide psychiatric care. Now if this Bill were passed and included behavioral healthcare the potentially then there could be transport to other locations to be able to address behavioral health needs of children and keep them out of the ER. So, I wanted to bring this issue to your attention and I’d be happy to answer any questions that are related to behavioral health, I’m not sure I can answer related to details of the taskforce.

REP. STEINBERG (136TH): Thank you for your testimony particularly on this point and we seem to be coming back over and over it to the issue of behavioral health and making sure we received equal and adequate attention when we’re talking about a lot of these issues and to your point, perhaps it hasn’t been given the focus and I think we’d all hear anything you have to offer with how we might strengthen this Bill or if it requires further analysis we might do on the behavioral health side going forward. Representative Arnone followed by Representative Petit.

REP. ARNONE (58TH): Thank you, Mr. Chairman. So your bring up a good point especially I would assume you’re talking like protective custody. So when a child is moved out of a school to a hospital for protective custody you could use a local, it would probably cut down on the trauma of these transportation we have issues with in school systems now, is that what you were touching on there?
SUSAN KELLEY: Yeah, I’m not sure I would use, I’m not sure what protective custody you’re using in that instance but yes, certainly schools are a major referral to sending kids to the ER when they have not been yet evaluated and may not be an emergency but there’s been an issue that the school hasn’t been able to handle.

REP. ARNONE (58TH): Yeah, what I mean by protective custody is a child that was endanger of himself and this happens quite often with, in high schools today and sometimes picked up by ambulance and moved to the hospitals which is traumatic also because the kids are actually witnessing this is school the kid being loaded up and moved to the hospital. It would be a really great idea for that to happen on a local basis so it would be easier on the child’s family and everything else, you know, to be local in an emergency care in the town, so, throw a little thought around right there and maybe start something, but thank you very much.

REP. STEINBERG (136TH): Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Thank you Mr. Kelley that’s, you raise a great point and it maybe that it causes us to reassess the system because when you are in your office and you get that phone call as the person is there or they are offsite, in that relationship with mental health providers you can try to get someone in their organization, it there is not the emergency department becomes the court of last resort because you don’t have a place for someone you know though they may go and sit for six hours, there is a crisis intervention person, a social worker who’s gonna sort through, not very efficient or a great use of
resources but there is often that resource in the community that you can, on a Monday at 1:15 when someone is having an issue and someone’s schedule is completely booked, there is usually not a place to put ‘em so, I guess that’s more of a statement than a question but I think you raised a great point and may cause us to reevaluate what are the resources we need in the community so that people can get some acute mental health care health care cause you said that urgent care centers and most of them are not staffed to handle mental health issues and their response would be to give them a heads-up ahead of time, they are going to say, don’t send ‘em here, we don’t do that, send ‘em to the emergency room, or if it’s a child and they don’t feel comfortable with a child who’s got an issue, say, well, you know we’ll do sprained ankles and otitis media and fractures but psychiatric issues are beyond our expertise so sent them to the ER. So I think it’s a great point and it may mean that we need more resources so that people don’t have to always hit the ER to be triaged if you all decide what level of care they need going forward. I wonder if you have any thoughts on that.

SUSAN KELLEY: Yeah, I definitely want to reiterate that previous testimony is talking about how this is benefited, been a good thing nationally. I don’t know whether or not behavioral health, how if it has been integrated the way I’m suggesting in other states, but when I took a look at this, you know, it just seemed like a real oversight because there is an opportunity there, an amazing opportunity really and I think it could be dealt with pretty easily in terms of the language of this by just inserting the word, you know, medical and behavioral health evaluations. In addition there could be some other
things that would be necessary but I think that there is no, I can’t think of a reason why you wouldn’t want to include both because you certainly have paramedics who are taking people in emergency situations who have behavioral health or psychiatric needs, so yeah, and I’d be happy to be a part of any discussions about it. I would like to just point out that I’ve been to the ER to at CTMC as part of this issue in trying to reduce the number of children who with behavioral health issue in the ER and it was interesting to see that they are not setup for kids with behavioral health issues. In fact they continue even though, you know, rates of kids coming in has been increasing over the years, they do not consider themselves a psychiatric facility and so I would image there are other ERs in the state who are similar, not all, I don’t think that Yale necessarily would fall into that category but when you consider that when all the discussions about the ER and the rural areas and so forth, I mean if you have some other facilities that can handle these kids or even adults, I think that should be, you know, available.

REP. PETIT (22ND): Thank you, you made great points. Thank you, Mr. Chairman.


SENATOR ANWAR (3RD): Thank you, Mr. Chair. So I just walked over and asked Mr. Beaulieau and he assures me that behavioral health is a part of that plan. So that is good that they feel it is front and center of the plan, itself so what I think it is maybe worthwhile that along with the testimony if it’s a plan can be made public as well so that everyone can look at it, so that other people who
may have questions would be clarified and thank you for your testimony, Ms. Kelley and I think you guys should exchange cards.

SUSAN KELLEY: Okay, I will. When you said plan, what do you, what are you referring to that it is part of the plan.

SENATOR ANWAR (3RD): Supporting that it is actually part of the Mobile Integrated Health Care to actually address the acute behavioral issues that may need to be addressed as a part of the mobile unit or as part of the.

SUSAN KELLEY: Okay, so it was contemplated but it somehow.

SENATOR ANWAR (3RD): It is part of it and I’ve not seen the report but that’s what I was saying if we make that report public then we can all start to feel more comfortable with this.

SUSAN KELLEY: Okay.

SENATOR ANWAR (3RD): And then we can hopefully make that public as well.

REP. STEINBERG (136TH): We will arrange that the report document is made available on the Public Health Committee website.

SENATOR ANWAR (3RD): Thank you. Thank you so much.

REP. STEINBERG (136TH): Thank you again. Okay now we’re going to move on to House Bill 7193 and Laurie Vitagliano.

LORI VITAGLIANO: Good afternoon Chairman Steinberg and Representatives and Members of the Public Health Committee. My name is Lori Vitagliano am I am here South Central Connecticut Regional Water Authority.
We are a public corporation and political subdivision of the State. We provide approximately 45 million gallons of water per day to some 430,000 consumers in the Greater New Haven region. Thank you for the opportunity to comment on House Bill 7193 3AN ACT IMPLEMENTING THE GOVERNOR’S BUDGET RECOMMENDATIONS REGARDING PUBLIC HEALTH. And I am here specifically about Section 4 of the Bill.

So the RWA understands and supports the Drinking Water Section’s responsibility to ensure the adequacy and purity of Connecticut’s public drinking water. We supported the initial legislation establishing the drinking water primacy assessment fee and we have been active stakeholder in the conversations to assist the Drinking Water Section in their efforts to maintain primacy. However we have specific concerns outlined in detail testimony but I will touch on a few of them this afternoon.

First of all, Service Connections. We are requesting that this should be defined by metered accounts. By utilizing metered accounts as the customer, that most accurately reflecting our billing system. Also the proposed language calls for a cap on the fee of $5.00 dollars per service connection, that is almost double of what the current fee is set now. Also we request that the DPH Commissioner set a gross amount that a cap be collected and whether that shouldn’t set annually and not greater than the consumer price index or some type of justification for any future increases.

We need to know also the timing of the fee. So we receive the current assessment fees in October and that is really not compatible with our billing system. We would need to how the per-connection fee
and number of connections on or before July 1 in order to raise the necessary funds. In addition we are getting the fee and the amount set in October, however the due dates would be due just quickly March and May. That timing does not allow us to adequately collect the necessary funds, there is only two months between those two billing periods. So with that, I will just have you refer back to my testimony unless you have further questions. But overall we really demonstrated our commitment and we really feel there should be a sunset clause as well on this. We’ve been at the table, all of the water companies have been at the table and we would like to continue the conversations and with that I’’ stop.

REP. STEINBERG (136TH): Lori thank you for your testimony and your involvement to this point. I don’t see your testimony on the list, was it submitted recently?

LORI VITAGLIANO: It was submitted this morning and I did see it online actually as well, I looked.

REP. STEINBERG (136TH): Maybe I’m just not looking at the right place. I’m just saying that all your comments are important for us, as you say its within the context of the other water companies. But my one question for you is, what kind of interactions have you had with DPH with regard to your concerns?

LORI VITAGLIANO: On behalf of the Water Works Association and as a member of that association we’ve been involved with the conversations back in September there were roundtable stakeholder meetings. We continue to have conversations as well as last month there were public comment periods.
also submitted at that time as well. So there is ongoing conversations.

REP. STEINBERG (136TH): And they have responded to you in some fashion?

LORI VITAGLIANO: I think, yeah for the sake of conversations but we can’t talk to the details if you don’t mind.

REP. STEINBERG (136TH): Sorry, Lori didn’t mean to put you on the spot.

LORI VITAGLIANO: No, that’s quite all right. No, no we’ve had conversations.

REP. STEINBERG (136TH): thank you for your referral, we’ll make sure Betsy answers those questions. [Laughs] Are there questions or comments. If not, thank you for your testimony. Next up is John Herlihy.

JOHN HERLIHY: Good afternoon Chairman Steinberg and other Members of the Committee. I am John Herlihy, Vice President of Water Quality for Aquarion Water Company, a large public utility, privately owned and we supply drinking water in 72 different cities to approximately 600,000 people in Connecticut.

I am here today to opposed Subsection 4 of House Bill 7193 AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS REGARDING PUBLIC HEALTH.

We fully support the drinking water section of the Public Health Department has having the lead responsibility for assuring an adequate supply of safe drinking water to the public and we consider them to be a valued partners in accomplishing that goal. We have the same goal as public water supplier.
Our concern with Section 4, or my primary concern, is the cap at five dollars is excessive. As a public water supplier in addition to having the mission of providing an adequate supply of safe public drinking water we do that to the best of our abilities at a reasonable cost for all of our customers. So, we are concerned that by moving the cap to five dollars from the currently the assessment is at $2.57 cents and a cap of five dollars would almost double that fee and we are very concerned about having that possibility looming our customers. I also think, so I consider myself to be an optimistic realist. I think that our economy is going to turn around and that’s way it may be necessary at this point for the water customers to support the State Health Department and at some point in the future I am hoping that we can return to the previous way of doing things. So I also think it is important to have a sunset provision in this Bill so that it is not just, it just doesn’t extend out in time forever that our customers will be paying to support the health department.

The last point I wanted to make is that we believe that the bills for large water systems like our 72 different public water systems the health department should submit one bill to us, this would reflect a matter of efficiency on the part of the health department, it’s less work for them and it will save the water companies also, will save them time. So it would reflect an eye towards efficiency on the part of the State Health Department. Thank you very much for your consideration.

REP. STEINBERG (136TH): Thank you for your testimony. A couple of points. We have discussed with DPH the five dollar cap and the point that they
have made is that rather than having to change the statute too frequently since you desire to have the cap, that they set it higher than they thought they would need and to your point they did point out the current assessment being roughly half that and suggested that perhaps the future assessment might even be lower than that. Their argument is they wanted to set a cap high enough so that they would not need to come back to the legislature and see that cap increased one more time. It’s maybe a clunky approach to statutory language but that was their explanation to us. Is that your understanding?

JOHN HERLIHY: I’m not sure what the reasoning is, but I’m concerned about seeing the cap going up from four dollars one year ago to five dollars a year later.

REP. STEINBERG (136TH): As you pointed out even though it was at four dollars the assessment was recently $2.50 and they are hoping to lower it still further, so I am hoping they are correct and they are just doing it to provide an arbitrary cap that you don’t have to worry about going above but their intention is not to go anywhere near that.

But getting on to your second point, actually again I forgot where I was going, this is twice.

JOHN HERLIHY: Sunsetting?

REP. STEINBERG (136TH): No, it wasn’t the sunsetting. No it wasn’t one bill either. But thanks for trying. [Laughter] Maybe it’ll come to me again. I have to write these things down. Senator Anwar.
SENATOR ANWAR (3RD): Thank you, Mr. Chair. On this single bill that you’ve talked about. Have you had a conversation with the Department of Public Health about it. It almost doesn’t look like it is a legislative issue.

JOHN HERLIHY: Yes, yes we did have conversations with the Department of Public Health Drinking Water Section about that.

SENATOR ANWAR (3RD): And what was their?

JOHN HERLIHY: The language was not changed unfortunately.

SENATOR ANWAR (3RD): Okay, so you think it is a legislative issue?

JOHN HERLIHY: We would like to see it in the Bill, yeah.

SENATOR ANWAR (3RD): Okay, thank you.

REP. STEINBERG (136TH): I do recall, it was more of an editorial actually. You describe yourself as a bit of an optimist. Eight years of this place has made me a bit of a pessimist. Even though I would like to believe that the economy is going to be turning around, we’re making efforts to make it so, the major reason why we have continued to cut DPH funding is because of the unfunded pension liabilities which are not going away in the near future. Therefore I think the current framework is likely to stay in place for a good number of years going forward. So I look forward to the day in which we can have a conversation about changing the framework when this state is on good fiscal footing but that looks to me to be some years away and I
guess I would leave it at that. Any other questions or comments? Again thank you for your testimony.

JOHN HERLIHY: Thank you very much.

REP. STEINBERG (136TH): next up is Betsy Gara.

BETSY GARA: Good afternoon, my name is Betsy Gara and I am the Executive Director of the Connecticut Waterworks Association which represents municipal, private and regional water companies throughout Connecticut. You have already heard some testimony on this so I will summarize.

One of the reasons that our members are so concerned about this proposal is that as public water suppliers we have an obligation to provide high quality, safe drinking water supplied to customers at a reasonable cost. And that is getting harder and harder to do as the consumption of drinking water goes down because of the efficiencies, etc. additional requirements in terms of complying with safe drinking water on the state and federal levels. So we are constantly water needing to upgrade water infrastructure and so forth and there are other fees that unfortunately have to added to the customers’ bills and you heard in MVCs testimony they are hearing a lot of concern from customers that they just simply can’t afford water. So we want to make sure this primacy assessment fee is limited in a way that will insure that we are not imposing a greater burden on our customers and so we’ve talked about the need so sunset it. This was intended, in my opinion, to be a stop-gap measure to insurance that there was funding available to support the State Department of Public Health’s Drinking Water Section their primacy role over drinking water we do agree with that and we work with them to do that but we
also think that there needs to be some opportunity to cap the fee, I think five dollars is too high. We also feel that the cost should be equitably borne by all water uses and the fee as proposed for transit systems is only $150 dollars every five years and a lot of time when you hear the Department of Public Health talk about all the time they have to spend with those small water system, they are not referring to the community water systems they are referring to these transit, noncommunity water systems like the Dunkin’ Donuts, gas stations, 7-11’s that our water systems for the purposes of law but really don’t understand all the requirements they need to do in order to ensure this safe provision of drinking water.

We also agree that there needs to be greater focus on accountability and efficiency, there are some other technical issues that we would like to see addressed that I have referenced in my testimony.

To your question, Representative Steinberg I think one of the reasons we are so frustrated is that there was a public comment period as part of the enabling legislation and we had a number of utilities submit comments by February eighth of this year and despite all the comments raised in these concerns there wasn’t one sentence in that proposal that has changed. However, I will say that I did have an encouraging discussion with the Office of Policy and Management this morning were are always taking with Lori Matthew at the State Department of Public Health so we are hopeful that we can sit down and work on some of these issues.

REP. STEINBERG (136TH): Thank you, Betsy. There’s certain irony in public testimony having an impact
or not on final legislation, just couldn’t help but note that. I won’t go into that any further.
Suffice it to say we really do appreciate your input on this. The one question I have for you is that you made mention of the virtual water systems which are individual retail establishments, is there another way of doing it, is there another way of characterizing them or regulating that you are aware of in other states?

BETSY GARA: Well the trans, it’s actually coming from the federal level, those definitions of transit, noncommunity and non-transit and noncommunity, yeah it took me a while to [laughter] to learn the difference between those with that, but it is driven by the federal level.

REP. STEINBERG (136TH): Alright, so much for that. Are there other comments or questions? Thank you and please stay engaged so that we can get it right.

BETSY GARA: I will, thank you.

REP. STEINBERG (136TH): All right up on this Bill, I’m gonna need some help here, it begins with an L, Laurie, then it looks like P. Thank you, they are from Bennett, there’s an idea, couldn’t read that either. Lauren something? All right this is our last change on 7193. Was there anyone else who signed up or is interested in speaking? If not, we are going to be moving on to 5898. First up is Jim Naughton. I do not see him here. We’ll move on and come back if he shows up. Kim Callianan? If we moved along a little faster than some people expected. How about James Young? All right.

JAMES YOUNG: I believe Kim Callianan is in the lobby, sir.
REP. STEINBERG (136TH): I’m sure she’ll show up shortly then, but please continue.

JAMES YOUNG: Good afternoon Honorable Chairman, Honorable Committee Members, I am James Young. I live in Mystic, Connecticut. I’ve submitted some written testimony which goes into matter of some depth beyond which we will be able to talk about today.

I am here as a representative of the Elder Law Section of the Connecticut Bar Association. The Elder Law section advocates for the rights and interests of the elderly including those who are disabled as many are. The Elder Law Section has about 470 members. The Elder Law Section has conducted a lengthy and extensive review of the issues that arise in the area of compassionate aid in dying. The Elder Law Section conditionally supports Committee Bill 5898 because for those terminally ill persons who qualify the bill would give them the right in consultation with their physician to make that most personal of decisions whether to end their lives earlier than the normal progression of their underlying disease would do.

And secondly because of the many strict checks and safeguards in the law, the law has proved to be safe in the other states that have similar laws. Connecticut would not be plowing any new ground here. Similar laws exist in Oregon, Washington, California, Hawaii, Vermont, District of Columbia and Montana by virtue of judicial decree.

The Elder Law Section looked hard at the concerns of those who feared the law might be used for the abuse of the vulnerable. After all many of our clients are vulnerable and we found no record of abuse and
believe there is no reason to think the law would lead to abuse here in Connecticut. We do think that Section 7 of the law should be amended to require the consulting physician as well as the attending physician to inform the patient of the availability of counseling.

I was meeting with a terminally ill client just about a year ago when the prior iteration of this Bill was before the legislature and this client who is a relatively young person who practiced law for quite a longtime but she can no longer do so due to her illness and she is restricted to her bed. She is quite aware of the Aid in Dying Movement and I told her that I had appeared before the legislature in previous years to testify on this topic. She told me her plan was to move to Vermont as her disease progressed so she could avail herself of compassionate aid in dying. She didn’t want to have to suffer for the last few months. I told her that I thought it would be a hardship and I was hopeful that Connecticut would adopt such legislation in the near future and she cut me off. She said I don’t think Connecticut is ever gonna adopt that law. She said that the land of steady habits has become the land of “no”. [Laughter] I argued with her but I didn’t change her mind at all. I’m hopeful that this Committee and his legislature will help me prove her wrong. If you have any questions, I’d be happy to try to address them.

REP. STEINBERG (136TH): Thank you for your testimony. I think it is important to us that we’ve heard some conjecture that those representing the elderly in our community would be opposed to such legislation because of again, the concerns about a slippery slope for unintended consequences. I’m
very appreciative of the fact that clearly the Elder Law Attorneys have put a lot of thought into this and have enough evidence to suggest that this would be a positive thing for a certain segment of your clientele. How did you arrive at that conclusion?

JAMES YOUNG: Well this started back in 2013 and in 2014, you know these Bills have been coming up before you for quite a longtime. There were certain members of our section who had clients who had gone through these things and frankly had shot themselves, who have managed to end their suffering by various ways. So as a Bar we are fairly well attuned to these things and we engaged this study, it went on for months. There were four or five very experienced attorney, there was past president of the Connecticut Bar Association who was part of our panel. We studied the Connecticut Law. We compared it to the law in Oregon. We compared to the law in Washington. We compared it the law in Vermont. We checked it section for section and we also looked at the extensive literature that exists in Oregon over a period of 20 years regarding abuse and frankly we found nothing and we understand there is fear. But we think that by honoring that fear that imposes pain on those persons who would like to avail themselves of the benefits of this law and excuse me for going on but that is roughly the process we followed.

REP. STEINBERG (136TH): is there a report that you could share with this Committee?

JAMES YOUNG: There was a memo that was written in our group but frankly this was a matter that went through the CBA has a process. The CBA’s process is that when a Bar Section wants to adopt a position,
they have to request that from the CBA. There is a process you go through. There was another Section of the Bar that was involved in this and this was resulted to the House of Delegates in the Bar. So I can’t think of a single piece of paper to put my hands on but I could probably come up with something if it would be helpful.

REP. STEINBERG (136TH): I think it would be, thank you. Are there other questions or comments? Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. I want to clarify what you suggested on Section 7 can you repeat that again?

JAMES YOUNG: Yes, Section 7 sets forth the requirements of what a consulting physician is obligated to do.

SENATOR ANWAR (3RD): And you feel the attending should be also able to do the same thing?

JAMES YOUNG: Well, the attending physician is required to inform the patient of the availability of counseling. We believe the law could be improved by adding to Section 7 a provision that the consulting physician also tells the patient that same thing. They also tell the patient there is an availability of counseling. Currently that is only required if the consulting physician believes that the person may be suffering from psychological condition which is causing him to have impaired judgement.

SENATOR ANWAR (3RD): Okay so the current way it’s written, the consulting physician can but the attending cannot.
JAMES YOUNG: I’m sorry. The attending must inform that patient of the availability of counseling. The law currently does not require the consulting physician to do so unless they determine the patient to be subject to an impairment. So we are simply suggesting that this Section 7 also require the consulting physician to tell the patient, Hey you know what they is psychological counseling available for you.

SENATOR ANWAR (3RD): So, 7, part 4 is just saying that.

JAMES YOUNG: No actually what it says is refers the patient for counseling, it says if required in accordance with Section 8. Section 8 says they shall require it if they believe the patient maybe suffering from psychological condition which is causing impaired judgement. So the consulting physician is not required to refer for counseling unless they think the patient is suffering from impaired judgement.

SENATOR ANWAR (3RD): Okay. Thank you so much.

SENATOR ABRAMS (13TH): Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. Thank you for your testimony. Again to Section 7, I’m sorry Section 9 page 10 of the printed Bill, lines 273, “The person signing the qualified patient’s death certificate shall let the underlying terminal illness as the cause of death.” Do you think that creates any legal/fiscal or other quandaries with a Bill that’s telling a medical examiner or a physician how to certify a death?

JAMES YOUNG: No. This Act was based substantially upon the law in Oregon which has been in place since
1991. It has been largely copied in five or six other states. I can’t profess to be an expert on all aspect of this Bill. I don’t want to hold myself out as that but I am unaware that this is causing a problem in these other jurisdictions.

REP. PETIT (22ND): Do you know if Oregon, once they put the underlying case on top, lists whatever procedure, medication was used as contributing in anyway on the other lines of the death certificate?

JAMES YOUNG: I don’t think they are on the death certificate. There is a lengthy form that the physician has to file with their Department of Public Health.

REP. PETIT (22ND): Thank you. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Representative Candelora.

REP. CANDELORA (86TH): Thank you, Madam Chair. I just want to add to the point about the death certificate. I think in years past the States Attorneys’ Office has always testified against that provision because it runs afool their ability to investigate deaths in situations where there could be homicide involved so I think going forward it’s probably something that this Committee should flush out. But getting to your point to on Section 8 and it was one of my concerns as well is that the, even the attending physicians recommendation is sort of qualified. They need to make a determination of whether or not the person is suffering from a psychiatric condition. Would you be in favor of either situation a patient being informed of the opportunity for a referral in every situation.
JAMES YOUNG: Not a mandatory referral. We think that these decisions largely should be left in the hands of the patients and their doctors. I think there has not been evidence in the other jurisdictions that a mandatory referral would help. I think we’re looking at people who have not very long to live and that we should trust their doctors to decide whether or not you’re suffering from the condition and if they think they are suffering from a condition then yes, they must refer them. But I think to refer everyone would be costly, it would delay the relief these people want and I think we should trust the doctors with these decisions. We trust them with so many decisions every day in end of life decision making. I’m not so sure we should especially say these people must all go. What about other people who refuse other sorts of treatment. No, I think that would not be helpful personally.

REP. PETIT (22ND): My question is not mandatory referral but should they be informed of the option?

JAMES YOUNG: The attending physician is required to inform the patient of the availability of counseling. That is part of the attending physician’s obligation. They must do that.

REP. PETIT (22ND): Okay, as I read it it’s “only if the patient in their determination the patient is suffering from a psychiatric.”

JAMES YOUNG: Yeah, that, if you. I don’t think your gonna want me to sit here and pick it out but I would be happy to point that out to you that being the attending physician must tell everybody that.

REP. PETIT (22ND): Okay, thank you.
JAMES YOUNG: The thing we’re trying to make the point of is that we think that it is not that much of a hardship to say, you know what the consulting physician must also tell ‘em hey there’s counseling available for you and then I think some people may want to pursue it, some may not. I suspect many people will already have been in counseling by the time they get that far.

REP. PETIT (22ND): Thank you.

SENATOR MINER (30TH): Any other questions or comments? Thank you very much for your testimony, appreciate it.

JAMES YOUNG: Thank you very much.

SENATOR MINER (30TH): Jim Naughton please.

JIM NAUGHTON: Morning.

SENATOR MINER (30TH): Hello, would you mind turning off the other microphone we can hear your better. Thank you, that’s it.

JIM NAUGHTON: Thank you Committee Members for this opportunity for me to share with you my thoughts on this weighty but welcomed legislation. My wife and I were raised in West Hartford, we met at 17, married at 21 after college and with our two children lived a charmed life in Weston mostly, Connecticut until an ultrasound confirmed that there was a mass in Pam’s pancreas.

For the next four years my life consisted of surgeries, infections, chemotherapy sessions and even her participation in a new clinical trial in San Antonio, Texas where we traveled together every week for eight months. Through it all Pam characteristically smiled determined to make the
best of it. I always thought of her as having had the highest pain threshold of anyone I’d ever know. But even so, her mental toughness and her optimism were inspiring to all of her doctors and nurses and to me. Grandchildren arrived and she was the ultimate baby whisperer, reader and nurse. But her condition began to deteriorate after three-and-a-half years. Over a period of 12 weeks she lost a lot of weight and became dependent on pain pumps, oxygen tanks, a drain to relieve a bile duct blockage. I was her caregiver as I had been for the previous three-and-a-half years managing all of the systems, the pumps, the drains and the phenomenal list of medications that were keeping her on an even keel. Our oncologist sent over a social worker to talk with us. One of her caregivers the social worker told us, her best one she said had just become available and we could have her come to us. You mean, I said, come and live with us and take care of Pam? Yes, she said, she’s a wonderful woman. Well then what would I do, I said? She looked surprised, she turned to Pam who said I think Jimmy can handle this, I don’t think we want someone to be in here between the two of us.

I don’t have to tell you I really didn’t realize how far down the path we were. My role had been to do whatever it took to make it possible to keep going. In retrospect we had been dealing with life and death strategies everyday but it had become our new normal and so a few weeks later when Pam looked at me on day and said I don’t want to wake up anymore. It took me by surprise. She saw my reaction and she said, “Jimmy, we’ve always know this was a fatal disease.” I spent the day grappling with that news trying to figure out where I was and how I could
help her. Around eleven o’clock that night as I slipped into bed next to her, she awoke and peered at me and she said, “Oh I thought I wasn’t going to have to wake-up any more.”

Ladies and gentlemen when the person that you have loved your whole life, with whom you fought so hard for four years to survive, says that to you, there is nothing that you wouldn’t do to help her, to give her what she wants, what she deserves to help her be released from her suffering. And so here I am, still trying to do the right thing by Pam. Last fall we would have been married for 52 years and in three weeks it will be incredibly for me six years since I’ve lost her. At the night when she said that to me, we didn’t have an option like this but if we had had it, I know that she would have wanted to take it and I am here partially because I know that she would be very happy to have me be here in support of this Bill. Thank you.

REP. STEINBERG (136TH): Thank you for your testimony and my condolences for your loss. I think the story you tell is particularly pertinent because as you describe you did have three-and-a-half very good years in which she got to see her grandchildren and you were able to enjoy many blessings but even with all that, with her toughness you did reach a point where she felt she was in a different place and wanted a personal option. I think it address a lot of the things we are wrestling with here, the challenges in trying to construct something that does not put pressure on anyone but offers them an alternative with is their choice. I don’t have anything to add other than to say thank you for your testimony because it does put a lot of perspective.
Are there other questions or comments?
Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Thank you, Mr. Naughton for your testimony. I want to look at it from the other side, as you know I was a physician before I came up here. Do you think the system failed you, that the services or other things that are available were not adequate to what you needed in your situation?

JIM NAUGHTON: Oh no, I think we went as far as we could go. I mean I mentioned the San Antonio sojourns because we went quite the distance. My job as I saw it, my role was to do whatever it took and I think that’s the way Pam felt too. She went way beyond where I think an awful lot of people might have gone. We did everything and when the time came, and I’ve heard some of the testimony here today, we were near the end and when you get to the end and you see your loved one suffering, I think it’s merciful to do something to try to help her out, had I had the chance I would have done that, no question in my mind. We exhausted, as she said to me, well we always knew this was a terminal disease. We exhausted all the options.

REP. PETIT (22ND): Thank you. Thank you, Mr. Chairman.

REP. STEINBERG (136TH): Representative, Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you again for your testimony. It is not easy to come here and share something that’s so personal and but I’m truly appreciative of your words and your experience and the pain that you’ve suffered that
you’re sharing with us. She was not in pain when she asked that?

JIM NAUGHTON: I’m sorry.

SENATOR ANWAR (3RD): She was not suffering from pain and discomfort.

JIM NAUGHTON: Oh, I think that what happened was she woke-up and realized she didn’t want to go through it anymore. She had been suffering with a lot of discomfort and pain which was being treated with pain pumps and other stuff but the existence had gotten to the point where she just couldn’t handle it anymore and this is not the kind of person that she was. She was a very, very positive mentally tough, enthusiastic and very loving mother and grandmother. She just got to that point and I, it took me by surprise. I didn’t realize that we were there yet because we had been there for quite a while, I mean several months of, so I guess she just woke-up one day and said, I just don’t want to do this anymore. I saw that happen.

SENATOR ANWAR (3RD): So for some of the chronic illness or chronic disability what sometimes happens is the person has to have the drive to keep fighting the fight and sometimes for very challenging cancers which are not as responsive that is a different disease model and I think earlier there were people who were testifying who were concerned that if we move forward with this that there is a risk that the chronic disability or chronic illnesses would not be treated well enough and people may not have the opportunity to be able to fight the fight. And I think, I know the Bill doesn’t suggest any of that, I’ve read it and I don’t think that is a risk in this situation but the clear area where there is a
need at least from what I’m gathering is oncologic illness or cancers where all treatments have failed and a person has reached a point that they are unable to continue to undergo the daily challenges that they may have with the cancers.

JIM NAUGHTON: I think that’s right, Doctor. I’ve heard people here today worrying about the slippery slope, etc. and I’m certainly sympathetic to that. I don’t think that’s what we’re talking about here nor should we be. I think we’re trying to address a different problem and I have been a witness and a part of the different problem that I think you just described.

SENATOR ANWAR (3RD): Thank you, you have very powerful testimony. Thank you so much.


SENATOR ABRAMS (13TH): Thank you for being here and you speak of your wife with such love and respect and I’m certain that when she told you that she felt she had reached the end of her life, whether physically she had or not, it was quite a surprise from someone who fought so hard. I think that you might not have been ready to hear it and might not have been in the same place and I think that is something that people who look at this Bill are fearful of that their loved one is going to want to put, to end their life at a time they are not ready to accept that, so I’m wondering if you could speak a little bit to the respect and love you had for your wife that even though you might not have been in that place you could understand where she was coming from.
JIM NAUGHTON: I don’t even know what to say to you about that, Senator Abrams. As I said, she was ahead of me on this. It was news to me that when she said that to me, I thought we were still going on and if there are people here who have been through this experience, we’ve all had parents who’ve died and loved ones some of us, there are an awful lot of things you have to do if you’re the caregiver to keep that person going. And we were doing it. We were doing them together. Just a trip to the hospital toward the end just was in a wheelchair, she was on oxygen, she had a pain pump, trying to get her in and out of the car to get to the hospital. I had something that I was supposed to go and do that was going to keep me from being able to take her that day and she wanted her sister to come down and take her. I said, “Please don’t do that, she has no idea how to take care of you. She doesn’t know the system, she doesn’t know how to do this.” Physically she just couldn’t get all that gear while Pam was attached to it into the car and out of it safely. I said can we just do this tomorrow morning and she did have the ability to do that, she said yes, finally yes, of course. You know, we can do that and she called up and put off the whatever the procedure was, it wasn’t critical that it be done that day and I was tremendously grateful to her for that because I knew what it took and she realized afterwards that she was being silly.

SENATOR ABRAMS (13TH): Well, thank you very much for sharing your story and for sharing with us a little bit of your wife and who she was, I appreciate that. Thank you.
REP. STEINBERG (136TH): And if I can add you obviously went through this together every step of the way and it’s understandable that you were willing to fight as long as she was and I think the key point you bring up is it’s very hard to put yourself in the shoes of the other person when they reach that point and I think the word you used at one point was merciful and I think the concept of mercy in this context is one we haven’t discussed enough. This could be a gift of sorts to somebody who really wants it at this point in the game. I think your perspective has really helped us understand so dimensions.

JIM NAUGHTON: I think it is really important for us to really focus on that and not be distracted by some of the other things that people are worried about but that’s not really what it’s about. What it’s about is when you get to this moment that I’ve tried to share with you. This is what we should be focusing on and trying to find a way and I think there must be a way to craft the bill that doesn’t get misused so that we can address the kinds of suffering that we’re talking about and be merciful and help end that kind of suffering. And thank you very much for allowing me to come.

REP. STEINBERG (136TH): Thank you, were there any other questions or comments? Again thank you for sharing with us today. Thank you for your testimony. Next up is Kim Callinan.

KIM CALLINAN: My name is Kim Callinan, I am the CEO of Compassion and Choices and we work across the country to both pass and implement medical aid in dying laws. So I would encourage to ask me any
questions about how the law is being implemented in other states.

In my written testimony I offer far more detail including some of the recommendations for potential amendments to the legislation. But what I wanted to do today was address some of the topics that have come up so far. As Jim and Sharon both really articulated what this legislation is really about is who decides. Who is in the best position to help insure that we have compassion at the end of life. Is it a terminally ill person in consultation with their doctor, their loved ones and their faith leader if they have one or the government? And right now the way the law works, is that there is basically the government is deciding what one’s end-of-life care would look like.

We know exactly what will happen when this law is implemented because we have a combined 40 years of experience across eight jurisdictions. If you look at the experience in Oregon only 1,500 people have chosen to use this legislation in a 20 years, 1,500. So the number of people who will use this legislation is extremely small but it brings tremendous piece of mind and comfort to people nearly knowing that the law exists. In addition, what we know from this legislation results in improved end-of-life care for everybody within a state. So what the studies and the evidence show is that it increases conversations between doctors and patients, it results in improved palliative care training and it results in people moving into hospice care earlier. So this is not an either/or, 90 percent of people who access this law are on hospice care. A third of people who go through the process actually choose not to take the medication.
But that prescription has given them piece of mind because they have the autonomy to make the decision themselves of when the pain and suffering has become too great.

Somebody asked the question earlier well we already have palliative sedation where a doctor can give somebody as much pain medication until they die, why do we need this. The reason that we need this is it takes the practice of palliative sedation which puts all the control on the doctor’s hands and it gives control to the patient and it puts protections in place. Palliative sedation has no regulations around it. A doctor is prescribing it and family members are implementing it. This puts the control in the patient and allows them to decide when the time has come. Thank you.

REP. STEINBERG (136TH): Thank you. You obviously have done quite a bit of research based on your testimony. How did you become a proponent of medical aid-in-dying?

KIM CALLINAN: So I experience both a good death and a bad death in my life. I had a really bad experience with my grandmother who had an advanced directive that was denied and it was horrible to watch somebody to be violated like that at the end-of-life and then my grandfather had a really good death where we got flown-in, got a chance to say good-bye to him, my children were there, we got to tell him that we loved him and it was exactly the way someone should get to end their life and that called me to come to this issue and work for it.

REP. STEINBERG (136TH): Thank you for that. Given your testimony maybe you would be a good one to help us answer this question. As you’ve seen with this
Committee we were very particular about labels and phrases. You’ve heard this concept of Medical Aid In Dying conflated with physician assisted suicide. Could you help us understand the distinction?

KIM CALLINAN: Sure. So physician assisted suicide I would say is an inaccurate term. Physician assisted suicide, there is a very big difference between this and suicide. Someone who is choosing to commit suicide has a mental health disorder and they are going to die. But with Medical Aid In Dying the person already has a disease that is taking their life and they aren’t choosing to end their life, they are choosing to end their suffering and those are really two very different things.

REP. STEINBERG (136TH): And you also made mention of how this could potentially strengthen the quality of palliative care in the State of Connecticut. Since Oregon is the really the state we’re all kind of looking at do you have any understanding of their experience with palliative care since that passed the legislation?

KIM CALLINAN: Yes, so what the evidence and the data shows is that after the law has been implemented that it has really contributed to increased use of hospice so people move into hospice earlier and there is less hospice misuse. It has resulted in better palliative care training for doctors and has resulted in increased conversations between doctors and patients. Patients come in, they ask about the law and then they end up choosing other end-of-life care options and that all comes because of the implementation of Medical Aid In Dying.
REP. STEINBERG (136TH): One last question. We’ve heard a lot of concern from the disabilities community with regard to the slippery slope and potential misuse of that. Are you aware of evidence of that in Oregon’s experience?

KIM CALLINAN: Actually absolutely not and there is an organization Disability Rights Oregon which is Oregon’s disability rights organization and they have drafted a letter which we would be happy to share with the Committee that talks about the experience in Oregon. They haven’t gotten a single complaint in the 20 year history in Oregon. The only complaint that they’ve gotten from people with disabilities that it is too hard to access the law and there are too many regulatory requirements.


SENATOR ABRAMS (13TH): Along those same lines can you talk about what safeguards there are in this Bill in general and how they might compare to what’s currently in Oregon’s bill?

KIM CALLINAN: Sure so this Bill is similar to Oregon, has all the strict eligibility criteria. A person must be terminally ill, mentally competent, have a prognosis of six months or less to live and be able to self-inject the medication. So those are what we call the core eligibility requirements that helps to insure that the slippery slope does not take place. In addition to that two doctors have to certify that the person meets the eligibility criteria and is not under coercion. There are multiple written requests. Your legislation actually requires two written requests and one verbal request which we would actually say is more than is necessary and would encourage you to rethink
that. And then your legislation added in the 
require, a whole host of requirements around the 
Bill requires that each of the two required written 
requests to be witnessed by two different people, 
which totals four witnesses, none of these four 
 witnesses may be a family member or a person in a 
position to inherit any portion of the terminally 
ill individual’s estate upon death. While I 
recognize that that was done with the best of 
intentions in our experience at the end-of-life 
everyone of these steps serves as a regulatory 
barrier for somebody. So if you think about a 
person at the end of life they typically by the time 
they are at the very end of their life they have 
really very few people left around them. So when 
you put such four witnesses, no family members, 
can’t be members of the health facility you’re 
making it extremely difficult for somebody to be 
able to access the law.

SENATOR ABRAMS (13TH): Interesting, so in your 
opinion our safeguards are maybe to strict?

KIM CALLINAN: I think they are overly restrictive. 
If you actually look at the Oregon experience and in 
California the same thing has happened, a third of 
the eligible people are unable to get through the 
law with the existing protections in the Oregon 
legislation. So adding more into it is going to 
mean that more eligible people can’t get through the 
process. You also have in your Bill there is a 
restriction that the working relationship between 
the attending physician and consulting physician 
that they can’t share office space and that is 
another provision, again I understand in theory why 
you would want it and respect why you guys are 
trying to make the Bill even safer but the Bill
already protects patients and it is hard to find doctors who practice. There is a period of time it takes to get doctors comfortable practicing and you are really restricting people access to the law.

SENATOR ABRAMS (13TH): Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Madam Chair. Thank you for your testimony. I am going to speak on a topic and I want you to help me go through this. Take your patients with cancer. When a person has been informed that they have a cancer we get them ready for a fight. We say this is gonna be a fight, you have to get ready for this fight and you will be able to win this because we know when people are go with a positive attitude to take care of their illness and take care of the medications, they do better with the mindset. And depending on the cancer most of the time people are able to beat it. But the ones who are unable to, after some time, it becomes an internal wall that is going on and it is all about control and people say that, and I’ve heard this said, that “I will not let the cancer win.” Do you think a component of the patients when they make that choice they are making this because they want to go on their own terms rather than the terms of the cancer?

KIM CALLINAN: Yeah, I think there is a couple of reasons that people make the choice. One choice is that they like autonomy. They want to know if their suffering becomes too great they have the option available and that is why about a third of the people don’t actually choose to take the medication because their suffering never became to great and they don’t want to die, they want to live. So absolutely, I think that is a big piece of it and
what people will tell us is that get peace of mind simply from knowing that they have this prescription medication in their hand.

The other thing that we do hear quite a bit though from our supporters is, you know, cancer is a poison. I mean chemotherapy is a poison, so we are poisoning a person’s body with the chemotherapy treatment and different people react to different treatments, it depends on what the treatment is. So we are poisoning the body and it is really a difficult experience for people depending on the treatment. What people will say to us is, I want to try that one last miracle cure but I am afraid that it is going to make my suffering so great that I can’t stand it. So please I want to be, I want this medication so that I can try that one last miracle cure and know that I have an option if it was just too much.

SENATOR ANWAR (3RD): Right and I would just make a little correction about there are different cancers and different chemotherapies that in the last five years for cancer treatments we have seen far more than in the last 50 years. The new onset, the new treatments, the immunotherapies they are doing some amazing shrinks and amazing results, right. I think that it is worthwhile to keep that in mind. The other part is that the subsegment of the patients we are exploring is a very miniscule amount of patients. Is that fair?

KIM CALLINAN: Yes, it’s a small number of people who will choose to access the option but a tremendous number of people get the peace of mind and comfort from knowing that the option is available.
SENATOR ANWAR (3RD): And has the needs plateaued in Oregon?

KIM CALLINAN: There’s actually been a slight uptick in Oregon. We’re talking about fewer than one percent of patients, so I mean dying people, so it is really small but it has actually gone up a little in the last four years.

SENATOR ANWAR (3RD): Okay. And have you been in conversation with the patients in this situation?

KIM CALLINAN: Oh, all the time, yeah.

SENATOR ANWAR (3RD): Tell me about the spiritual challenges and what they go through because from spiritual they mention every life is sacred and we need to have a protection of life and so how do people reconcile with that, the people of strong faith?

KIM CALLINAN: Yeah, so I think that it really, really depends on what the person’s faith is. What I hear a lot from people who have a strong faith is there is no way that my God would want me to suffer with the kind of symptoms that I have and that man has actually created the suffering. You know, we are the ones who have extended life and who have added these treatment and now what I am simply doing is allowing there to be an option to end the suffering that has been created.

SENATOR ANWAR (3RD): Thank you and let’s say there is another state a law passes, what happens for the medical training and then training of the workforce for the physicians to be able to learn this that the State of Connecticut for example has no clinicians who have had any experience or understanding or maybe full willingness, so how does that workout?
KIM CALLINAN: So it is interesting Connecticut Medical Society adopted a position of engaged neutrality, it wasn’t a straight neutral position and what engaged neutrality means is that they are committed to supporting doctors to help them learn through this process. We as an organization stay within states and work with states on the implementation of the law. We have a doc-to-doc consultation line where doctors are from states that currently have the legislation provides support to those doctors who are new in the state. We come in and we do trainings across the state. We’ve worked with palliative care doctors, with hospice doctors so there is now actually quite a wide network of doctors who have experience and they really come in and they serve as mentors to doctors in newer states.

SENATOR ANWAR (3RD): Can you share with me, in any of the relatively new states which mean the last four to six years when this was implemented what went wrong?

KIM CALLINAN: Mostly the experience, the National Academy of Sciences just did a two day conference in Washington, D.C. where they brought together clinicians and everything, what we heard most frequently was the biggest challenges were that there were too many regulatory roadblocks and dying patients couldn’t get through the process in time. So there wasn’t a lot going wrong in terms of there was no coercion or abuse and actually doctors who previously were not supportive of the practice were getting up and saying that is definitely not the problem. The problem is people can’t get through the process in time. So there is a period of time where you have to educate doctors to get them
comfortable practicing, pharmacists, you have to get pharmacists who are willing to practice and so there is an adoption period that you go through but those are the biggest challenges.

SENATOR ANWAR (3RD): Thank you so much for your time.

KIM CALLINAN: Thank you for your questions.

SENATOR ANWAR (3RD): Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Madam Chair. Good afternoon. You are speaking of doctors who do this and pharmacists and, who, I guess where are these doctors educated from, who sets up the curriculum so to speak, the educational process for them to do this?

KIM CALLINAN: So doctors are, wherever doctors can get their degrees from. So the goal of this is for doctors, you know, your doctor to practice. So hospice doctors, family physicians, oncologists I mean it is any doctor that somebody sees can potentially go through. So we work, we work with all kinds of national and state associations. We just authorized in Hawaii and we have gone out and done trainings with, you know, the Hawaii Hospice Association, various different physicians that are out there.

REP. ZUPKUS (89TH): So, first of all who is “we.”

KIM CALLINAN: We, Compassion and Choices, the organization.

REP. ZUPKUS (89TH): So, you setup the education for the doctors to learn how to do this?
KIM CALLINAN: We do setup education for the doctors but so do lots of independent organizations. So as an example Geiser Health System has a supportive policy and they do clinical trainings with their doctors in order to educate them. So we serve as a resource but the medical system itself in the same way doctors learn about any other type of practice that health systems take on that role and responsibility.

REP. ZUPKUS (89TH): Thank you.

SENATOR ABRAMS (13TH): Representative Candelora.

REP. CANDELORA (86TH): Thank you, Madam Chair. Thank you for your testimony. In Section 8 there has been some discussion about the, you know, the referrals to a counselor for a patient. In other states we heard testimony prior that we would want the second doctor to be able to also refer somebody if it’s determined that they are mentally depressed or have some sort of psychological issue. Do you think that is something that every doctor who is signing off on this should provide a person or offer them the ability for mental health treatment?

KIM CALLINAN: So I don’t think the assumption should be that because somebody is requesting this option, that they need mental health treatment.

REP. CANDELORA (86TH): I’m not making that assumption.

KIM CALLINAN: But certainly the attending physician and the consulting physician should be evaluating the person to see whether or not they are mentally capable of being able to make an informed decision. And if the person is not mentally capable or they
are unsure whether they are then there should be a referral.

REP. CANDELORA (86TH): Okay, cause it is one thing I struggle with in this section, you know, I understand we are putting safeguards in place but, you know as a member of this Committee I typically don’t like to dictate how medicine is practiced and I feel like there is a level of detail here that is providing a directive to the medical field of when they should be making referrals and I’m just wondering if a blanket referral is just more appropriate to free the doctors hands of making the determinations rather than dictating only in these circumstances?

KIM CALLINAN: Yeah so I would actually, I agree with you that you want to be really careful not to legislate too much and to leave it in the hands of the doctor and the patient. And I think that actually a mandatory referral is over legislation because you are then telling the doctors that every person needs a referral.

REP. CANDELORA (86TH): And that is not what I’m saying.

KIM CALLINAN: Oh, okay, sorry.

REP. CANDELORA (86TH): What I’m saying is offering, you know, letting them know what services are available versus putting in statute of when a referral is necessary. I think we are agreeing and I was kind of saying the same thing. In the Oregon law I have seen some bill proposals I guess apparently looking at sort of eroding that law, changing it so that healthcare providers would
include nondoctors to make referrals. What is your organization’s position on something like that?

KIM CALLINAN: Sure, you’re talking about nurse practitioners and physician's assistants. So there has been, if you look back to when the Oregon legislation was implemented, it was long before the practice of nurse practitioner and physician's assistant really taking off. And you’ve seen those two professions really having played an increasing role in that medicine. So from our perspective what they do is they are licensed, they are trained, they know how to provide treatment and that it would make complete sense for them to also be able to participate in the same way they are able to participate in all kinds of end-of-life care.

REP. CANDELORA (86TH): So your position is that you would be okay with that position?

KIM CALLINAN: Sure.

REP. CANDELORA (86TH): I think that is part of the issue here and it’s a concern of the slippery slope.

KIM CALLINAN: But can I just address that? So I think when you are talking about the slippery slope, there is what can the law do that helps insure that eligible people, that those people who are eligible are able to access the law.

REP. CANDELORA (86TH): Right, so that.

KIM CALLINAN: So that is not is not a slippery slope.

REP. CANDELORA (86TH): I’m gonna leave it there, okay. So also in the Oregon law there is seeking an expansion of a definition of terminal disease to include “one that within reason medical judgement
would produce or substantially contribute to a patient’s death.” Is that something your organization would support, a more expansive definition?

KIM CALLINAN: No. So I can explain the difference for us is where the slippery slope happens is if you change the eligibility criteria. So we are very clear that the eligibility criteria needs to remain a terminally ill person with a prognosis of six months or less to live and be able to self-inject the medication because those are the things that help insure the patient is in control and has autonomy over the decision making. There is other things within the legislation that are serving as their barriers so a person is not able to access the law and when the Oregon legislation got implemented, there was no data or experience and there was no evidence so the bill drafters at that time threw in tons and tons and tons of requirements in order to insure that there wasn’t any abuse or coercion. And now we have 40 combined years of experience across eight jurisdictions and we know what the impact of the legislation will be. And so it’s smart what society should be doing is looking to say how do we make sure somebody who is eligible, somebody like Jim’s wife who clearly is eligible and is at the very end and is suffering is able to get the prescription and doesn’t have to die with the dignity she is looking for. So those are the differences and that is how you insure there is no slippery slope. You need those white lines.

REP. CANDELORA (86TH): Thank you.

SENATOR ABRAMS (13TH): Representative Petit.
REP. PETIT (22ND): Thank you, Madam Chair. Thank you for your testimony. I would like to go back to palliative care, hospice care and I’m sorry if I missed this, I had to step out during your testimony. If you believe there is just intrinsic or inherent to the palliative care hospice process that makes it inadequate to the needs of people in those programs.

KIM CALLINAN: No, that is a great question. And I don’t think it is an either or. So we as an organization are supportive of the individual person and having the most amount of options they can to relieve their suffering at the end-of-life and for the vast majority of people hospice will be enough. But there is a segment of people who are looking for autonomy and where the pain is so great that they need this option available for them. And so we would like to see this option added as one option. Most people 90 percent of people who choose this option will also be on hospice care so it is not an either/or and we know that the implementation of this legislation results in improved hospice use. People move into hospice earlier than they do when legislation is not in place.

REP. PETIT (22ND): That would be good here, apparently we do poorly in Connecticut despite our educated state and being the birthplace of hospice we don’t do very well for reasons that are hard for me to comprehend. Do you believe that this option changes hospice in anyway and specifically does do hospice care providers, can they provide that information and say, this is an option or encourage is maybe the wrong word, suggest or forbidden in states, you know, in Oregon are they forbidden to
have that discussion if they are part of palliative care team?

KIM CALLINAN: So the legislation here and also in Oregon gives doctors and providers the option to opt in or opt out of taking about it. So if there is a provider who works at a hospice who is not comfortable they are not required to. They can refer to somebody else who is able to have that conversation. Typically we would never recommend that somebody recommend this as an option to somebody. That is not the intent of the law the way it’s drafted. It’s an option available to people who want it. So if someone asks somebody who works at a hospice for it, they will either get referred to somebody else or that person would be comfortable sharing the information with them.

REP. PETIT (22ND): So I don’t know if it sounds silly or macabre but in terms of a list when hospice comes in and says you can have a special bed, you can have a special mattress, and you can have oxygen, and there is a list, the hospice plan, the palliative care plans at other places does it list aid-in-dying as an option at the end?

KIM CALLINAN: Oh, that is not how it is implemented within Oregon and the other states. The person comes in and is making the request and then actually the law requires that they are counseled on all available other end-of-life care options when they make the request. So a lot of people do ask for it and it’s really their shorthanded way of saying I don’t want to be in pain and I don’t want to suffer and it results in greater conversations between doctors and patients and they move into other end-of-life care options and that is why hospice usage
rates go up. So it takes a really difficult conversation and it brings it out in the open.

REP. PETIT (22ND): Thank you. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Senator Anwar.

SENATOR ANWAR (3RD): Thank you, again. So I had a patient of mine, her husband had passed away and we were having a conversation and she said something, “I’m interested they kill people who are critically ill, so I’m up all night trying to preserve life, whatever it takes and with all the technology and all the science and then she asks me about this and she said I wish I had moved my patient out of the state and this is about a couple of years ago. And I asked her why and she said because of the law. And I asked her further how would it have made any different and I told her my views were that look, I’m up all night trying to preserve life with whatever it takes and I am not supportive of this. And she made a statement that made me think and I want you to reflect on this statement if you could. You are more experienced that is why I’m saying this. She said that every individual who is against this is one ugly death away from their loved one to be for it. Have you heard this?

KIM CALLINAN: Yes, I say it quite regularly. It’s the truth. I mean if you look, I testify across the country and I often go in front of lawmakers who previously opposed the law and the next year, it just happened in Maryland, the lawmaker is up saying, I’m sorry I opposed this law last year. I just sat at the bedside of my mother, my grandmother, my daughter, whoever it was and I watched them suffer an excruciating end and they
should have had this option and they begged me and pleased with me to help relieve their suffering and there was nothing that I can do. It’s a very, that’s why this movement is gaining momentum.

SENATOR ANWAR (3RD): Yes, this was the first time I heard from somebody in the privacy of a conversation and it was painful and this person, because of that suffering of her husband who was going through posttraumatic stress at that time, so what left her with a different level of an illness because she saw her loved one suffer to the level that she did. And it really shook me a little bit. I’m fortunate I have not experienced that and I hope I never will but it made me think a little bit. Thank you so much.

KIM CALLINAN: Thank you.

SENATOR ABRAMS (13TH): I just wonder too lastly if you could speak a little bit to the idea that the person going through this knows their body, knows what they are going through in a way that no one else does and that sometimes they get caught in the medical machine, I don’t mean that in a derogatory way but in all of these people trying to help but feel that their voice gets lost when really they know what they are experiencing and become, in fact, I think hyper entuned to what is happening to their body as they are progressing in their disease. Can you speak a little bit to that?

KIM CALLINAN: Yeah, absolutely and we see this happen all the time. I mean I will say the people who chose this option desperately want to live and are storyteller in Hawaii who has been advocating for this law, 56 rounds of chemotherapy treatment. Our DC advocate who advocated for this law and
finally did use the option something like 35 rounds of chemotherapy treatment. These are fighters. They want to live desperately but they have a disease that is taking this life and as medical technologies have advanced there are more and more treatment options and those treatment options have benefits and they have burdens and at some point, some people get to the point where the consequence, the burden of that treatment option is so great and so devastating that there is no longer quality of life. There was a doctor that I just met from the City of Hope and the City of Hope, I don’t know how many of you are familiar with City of Hope but, you know, premier cancer institute. Well they have a supportive policy where if the patient is interested in this option, they support them. And I was talking to one of the City of Hope doctors that was there and I said, you know, I testify across the country and people are concerned about abuse and coercion what would you say to them if you were on the stand and she said, the last four patients that I have that I, you know, gave this option to were, came in on a gurney. They had no quality of life. They were days, weeks away they wanted some autonomy over the end and there was nothing left for them. Those are the kinds of people that are using this option they are just looking for a little bit of compassion and a little bit of dignity.

SENATOR ABRAMS (13TH): And I would also say that I think that we have to acknowledge that the use of the, even the thought that someone might be put into a situation of pain and suffering, it used as psychological torture, you know, and so I think that just knowing for some people that is what they are
facing, it might not have to face, can make all the
difference in what life they have left.

KIM CALLINAN: Absolutely true.

SENATOR ABRAMS (13TH): Are there any other questions
or comments? Thank you very much.

KIM CALLINAN: Can I answer the death certificate.

SENATOR ABRAMS (13TH): Absolutely.

KIM CALLINAN: So the question came up a lot about
the death certificate. So the CDC puts guidelines
out. The purpose of a death certificate is to be
able study the underlying condition in a disease and
if people were to put, you know, something else and
not mark the underlying illness and this condition
then it will skew your public health data. You will
no longer know that it’s cancer or something else so
that’s why it is so important that you are following
the CDC guidelines and you are using the underlying
illness on the death certificate.

SENATOR ABRAMS (13TH): And would that, the other
question that came up, is that somehow fraudulent to
be doing that?

KIM CALLINAN: No, because that is what happens with
the underlying illness in anything. So for example
in the situation where a doctor does give somebody
pain medication and needs palliative sedation and
that’s when they get pain medication until they
eventually die or are in a coma, you don’t put
palliative sedation down, you put the underlying
illness down. If someone choses to voluntarily stop
eating and drinking the doctor doesn’t write down
voluntarily stopping eating and drinking as the
underlying illness. They might make it as step along the way but it is not the underlying illness.

SENATOR ABRAMS (13TH): Thank you. Thank you very much. Debbie Murray.

DEBBIE HOWLAND MURRAY: Hello. I’m Deborah Howland Murray, I thank you for this opportunity. I am not a medical expert. I am a recent widow fulfilling a vow to fight for death with dignity legislation made when my husband of 34 years, David Murray, died of cancer.

David knew his chances were slim. Yet, he maintained that his cancer was a gift, one that opened his eyes and heart to a deeper love of family and of life. He was unfailingly positive. Attending physicians brought their interns to speak with him, finding fertile ground for their students' learning in his musings on life, cancer and death.

At one point in the course of the disease, Dave developed such severe lung dysfunction from the treatment that he was admitted to the ICU at Yale New Haven Hospital. I was told to summon our large family to say goodbye. In a barely audible voice, David shared individually the things he loved most about each child, child-in-law, and grandchild. This is how he had envisioned his last moments with family. Retrospectively, I believe perhaps it would have been a kindness for him to be granted this as the last final encounter he wished for, with his heart and lungs giving out on that day. But they did not. As the disease progressed and treatment after treatment failed, David expressed anger about one thing, and one thing only. He could not exercise agency over the last great act of his life - his own death. He considered death a formidable
hurdle we all must conquer, and therefore quite an achievement. He desperately wanted to live well in the time afforded him, and part of living well meant dying well when death was inevitable. He wanted to exit gracefully before the pain was unbearable and all dignity lost.

But it was not meant to be, not in a state lacking the necessary legislation.

Our country was founded by people who believed in rights of the individual, tempered by the good of the whole. To force a dying person to endure rather than die peacefully and comfortably, serves no one. Nor should a person be required to end one’s life under such circumstances. The law must offer a personal choice, made according to individual conscience.

The medical community has given us the miracle of life prolonged far beyond what was imaginable years ago. I applaud the Connecticut State Medical Society for acknowledging that when the end of life is imminent, doctors can also bestow the miracle of a serene and dignified death.

In David's memory, I implore you to take heed and grant us control over our own deaths, even as you seek to ensure our rights in life. The two are really one and the same.

SENATOR ABRAMS (13TH): Thank you. REP. STEINBERG (136TH):

DEBBIE HOWLAND MURRAY: I would be happy to answer questions.

REP. STEINBERG (136TH): Thank you for your testimony and thank you for choosing to honor your
husband’s death with this testimony today, very effecting. You use the word “dignity” which frankly has been used by both proponents and opponents of this legislation. I think they mean very different things. I got the sense that those who oppose this legislation view dignity as something that is emphatical to taking one’s own life like in any fashion and dignity can be achieved through excessive suffering, is that your sense of what dignity means in this context?

DEBBEI HOLWAND MURRAY: Dignity in this context to me means that one would be able to assert one’s right as an adult, not be reduced to what one was an infant, as David was. I have to say David went through hospice, he died at hospice in Branford. They could not keep him out of pain and they wanted him to stay in a four man ward while he died. That is not dignity. It’s not good for the other people in the ward either. But to me dignity is to be able to, as I said, to have agency over this. This is part of life. Our death is the last part of our life and to be able to do that, without someone taking care of you and you are unable to take care of your own bodily function and to just make the decisions that we all make as adults, to me that’s dignity.

REP. STEINBERG (136TH): I would agree with you. It sounds like dignity is something that we should be able to chose rather than have someone else impose their definition of dignity upon us. Are there comments or questions? Thank you for taking the time to testify today. I really appreciate it. Next up is Paul Bluestein.
PAUL BLUESTEIN: Senator Abrams, Representative Steinberg, members of the Public Health Committee, my name is Dr. Paul Bluestein and I live in Bridgeport. I was a practicing OB/GYN physician and former chief medical officer of ConnectiCare for 20 years prior to my retirement in 2013. I’m here to testify in support of House Bill 5898. I take issue with one particular statement that was made earlier, which is that medical aid in dying is a violation of the Hippocratic Oath. It’s not, at least I don’t believe it is. Let me begin by telling you that the Hippocratic Oath is not used currently in any medical school in the United States, not one. It also does not say do no harm. It does say that you swear by Apollo.

Let me tell you about one of the patients that I cared for when I practiced who died from metastatic ovarian cancer. In spite or radical pelvic surgery, in spite of chemotherapy, in spite of radiation, it became clear that no treatment was going to reverse the course of her disease. She developed ascites. Ascites is the buildup of fluid in the abdomen, often times more than a gallon fluid in the abdomen as a result of malignancy. She looked nine months pregnant her abdomen was that swollen and in order to relieve the pressure of that buildup, a needle had to be stuck in her abdomen every three or four days to drain off a gallon or more of fluid. Her breathing problems were significant because of that abdominal pressure and she couldn’t sleep lying down because she couldn’t breathe when she was lying down.

But that wasn’t the worst thing in her mind. The worst thing was that as a result of the surgery and the radiation, she had developed a rectovaginal
fistula, an opening between her rectum and vagina so the feces constantly drained out of her vagina for which the only treatment available was to put her in diapers. The odor and the pain and these indignities were intolerable to her. All she wanted was to die a peaceful death before the cancer had stolen all of her humanity from here. Physicians can extend and prolong life, yes, that’s true, but I don’t understand how doing that in situation like this is doing no harm. I think it is doing monstrous harm.

I think that doctors want to think of themselves as healers, I do, but there comes a time when more healing is not possible and then I think that there’s a time for compassion and honesty and heeding the wishes of the patient, listening to the patient, listening to what they want and having mercy. That, I think, is doing no harm and that is consistent, I believe, with the Hippocratic Oath.

REP. STEINBERG (136TH): Thank you, Doctor, for a little bit of education about what the Hippocratic Oath is and isn’t and it’s application today, but I think to your point, a physician is best served doing what’s in the best interest of his or her patient at any given time and I think the example you gave, which seemed quite extreme, maybe one of those instances in which ought to consider that this is an appropriate option. Are there -- Yes, Representative Hennessey.

REP. HENNESSY (127TH): Thank you, Mr. Chair. Welcome, Paul, thank you for your testimony. That’s pretty much all that I had to say. We’re happy to see you. We are members of the same church, we sang together in choirs, and --
PAUL BLUESTEIN: I won’t sing.

REP. HENNESSY (127TH): Neither will I, but I just wanted to thank you. As you know, I am a co-sponsor of this bill and I will continue to be for exactly the testimony that you presented.

PAUL BLUESTEIN: Thank you, Jack. Let me add one thing which is lest you think that for me this is an academic discussion, I will tell you that my wife and I, we’ve been married for 38 years, we’ve had a discussion about what we’d like our end of life to look like for three decades and six months ago she was diagnosed with breast cancer, so this day I was no longer academic. This is now a kitchen table conversation that takes place in our house, so much so that you’ve heard other people talk about moving. My wife and I have put down money to reserve a place in Colorado, in a CCRC in Colorado, in case we have to move there. Don’t make me move away from the state that is my home. I think it’s time for Connecticut to become one of the states that is more progressive rather than less progressive. Thank you.

REP. STEINBERG (136TH): Thank you, Doctor. I think more and more families are having that kitchen table conversation going forward. Any other comments or questions? If not, thank you for your testimony.

PAUL BLUESTEIN: Thank you.

REP. STEINBERG (136TH): Next up is John Pike.

JOHN PIKE: Senator Abrams, Representative Steinberg, and members of the committee, thank you for your time. My name is John Pike. I live in Middletown and I’ve been a licensed physician assistant for the last 43 years practicing at St.
Francis the last 25, mostly in critical care. I’m also the Connecticut state director for the American Academy of Medical Ethics. I’m testifying in opposition to House Bill 5898. It’s kind of a little difficult sometimes to go back to a little bit of a sterile discussion, if you will, after a series of very poignant and emotional tales, some stories, very much so.

To date, the American Medical Association and the American College of Physicians have remained opposed to physician-assisted suicide. I’m disappointed as a member of the Connecticut State Medical Society that it has abandoned it’s principle of opposition by adopting a position of engaged neutrality. In my opinion, this is an evasion of responsibility which will not continue, particularly when additional government rules will force physicians to refer for this rather than being neutral, which is exactly what has happened in Canada where physicians who refuse to refer for assisted suicide can lose their licenses, right of conscience issues. So why has this failed every year it’s been introduced and what makes it somehow less dangerous this year than in the past? And you may rightfully ask, isn’t it compassionate to assist with suffering at the end of life? Absolutely, but you don’t have to kill the patient to kill the pain and suffering.

My concern is with -- where physicians, and we’ve heard some earlier discussion on this, that have been since Millennia to have that respect and trust that they will always be their healer now being asked to be complicit in their death and for the physician to -- the healer becomes the killer. You talked about the dangers to elderly patients and disabled and I won’t go through that, you have my
testimony, but what happens in our country when our lives are not be able to be lived by an overburdened healthcare system. The terminally ill, the elderly, the disabled or mentally ill, perhaps even the poor, could be targets for ending their lives. When does this slope become so slipper and it’s not a cliché that euthanasia creeps in as another country.

This is now legal in Canada. I pointed this out last year. Do you know the name of the law Canada uses to carry this out? It’s called medical assistance in dying. Does that sound familiar compared to what the name of this law is? I know my time is done, so I was going to point out about the death certificate issue, that’s been discussed, but I think it was a little bit subterfuge because it talked about -- but we’re being asked to lie the physicians who are asked to do that. They are being asked to lie and it does have consequences with the insurance, for instance, and that’s one of the reasons why they’re not ask to put down suicide on that death certificate. They’re asked to put their illness down. So I think I’ll stop there. Thank you.

REP. STEINBERG (136TH): Representative Cook.

REP. COOK (65TH): Thank you, Mr. Chairman, and thank you, Doctor, for being here. First I want -- I just want to make sure I understood, so the Medical Society is not taking an opposition or a support in this bill as it reads. Correct?

JOHN PIKE: They’re taking what’s called engaged neutrality, if you will. Interestingly, two years ago, Dr. Michael Barron, who was a long time editor of the Connecticut State Medical Society Magazine, wrote an editorial about this and discussed
particularly neutrality and he wrote let’s evaluate some arguments. Philosophy tells us neutrality is not neutral, it’s not making up your mind on an issue. If you’ve taken a position, it’s by definition a positive action and not neutral, hence one cannot take a neutral stance on torture. If you’re neutral on torture, this position indicates that torture is acceptable and he went on to say -- but this was in Medical Society’s editorial where they were staunchly against it being neutrality, so they made that change.

REP. COOK (65TH): So from what you just said then, by taking a neutral stance means and what you’re feeling is they’re supporting the bill?

JOHN PIKE: I think they are, yes, Ma’am.

REP. COOK (65TH): So then my second question, which I might take a little pause with, you say a doctor is supposed to heal the pain? In your testimony, you had just said a doctor’s responsibility is to heal the pain and I’m not quoting you word for word, but that was kind of the insinuation of what you’re saying, am I correct?

JOHN PIKE: Yeah, it’s that trust that patients have always had of a physician to be that, not be the person who is going to end their life, and always have that trust that they’re going to do the best thing for them and be their healer instead of being complicit in their death, so it comes down to a trust in my opinion.

REP. COOK (65TH): So what happens when you get to that point when the doctor cannot heal the pain and the only definition or the only outcome of healing the pain is a state of fog and not communicative and
just being in existence with no ability to have any type of life, that’s not healing the pain. That’s hiding the pain until, you know, your body decides that it’s giving up.

JOHN PIKE: I understand what you’re saying, but I – and we’ve talked about this. It’s been discussed many times about the role of hospice and where maybe it could be better and could be improved where again, you’re not asking the physician to be complicit in your death and that’s where our objection is to a great degree.

REP. COOK (65TH): I don’t think it’s -- and I’m not -- I don’t think it’s a battle of -- between us. I don’t think that being -- I don’t think that you’re being complacent in death, I don’t look at it like that at all, just as I don’t look at it like you’re being asked to lie on a death certificate and I’m sure you were in the room when I discussed my stepmom.

JOHN PIKE: Yes, Ma’am.

REP. COOK (65TH): In February, she was given a terminal outcome. She would live three months without chemo, less than a year with it, with no guarantee what the middle ground looked like. That was already her death sentence, so once she died, regardless of whether she died from morphine which is that sense what happens. The doctor gave her enough morphine that her organs indirectly shut down. She still died from lung cancer. So the terminal cause of death happened months before the actual death took place. It was just a matter of time. So regardless, I believe, on how we do out of this world, we all know that she died of cancer.
JOHN PIKE: Well, in that particular case her death certificate rightly said that it was cancer as opposed to somebody that’s taking their life by suicide and you can call what you want, but it is suicide, and putting that on the certificate.

REP. COOK (65TH): If the doctor would not have increased her level of morphine to help shut down her organs, she could have lived for another week or two in horrific pain of which she begged to get out of, so what is the difference?

JOHN PIKE: I think it’s again going back to where you’re asking the physician to be --

REP. COOK (65TH): She did ask.

JOHN PIKE: But I’m saying you’re asking the physician to be actively killing that person or in this case, this bill to give them the medication to do it or euthanasia where you’re actively taking a part in ending their death. In hospice situations very often and I’ve seen this doing critical care where we would involve palliative care, we decided to withdraw support on a patient for instance, that, you know, they were on multiple drips and so on and so forth where we’re getting palliative care involved. Very often they would give a substantial dose of morphine and medication and basically it would -- it would suppress their respiration. That, you know, that would hasten death. There’s a fine line I think between giving them enough to, you know, make them comfortable and actively ending their life. That’s a tough question. That’s a difficult question.

REP. COOK (65TH): So I think that’s my point. I think the point, you just said it exactly that,
there’s a fine line between what we want to believe is acceptable and medically okay and what we already do, but we don’t -- we don’t associate it to be what we don’t want it to be, for whatever the reason that might be, and I think that’s where we’re wrong because at the end of the day if a patient is laying in a hospital or laying at home and we are going to tell them they have to suffocate, starve to death, die of dehydration, what kind of quality of care is the medical world giving them because we said you can’t choose this and I’ve lost in the last four years five immediate family members, sitting by their bedside watching exactly that happen and I will tell you, not one person should have to be forced to go out that way if they don’t choose to and that’s where I struggle, so thank you.

JOHN PIKE: I understand. Thank you.

REP. STEINBERG (136TH): Thank you, Representative Candelora.

REP. CANDELORA (86TH): Thank you, Mr. Chairman. Thank you for your testimony. I know this is a -- you know, it’s a highly emotional subject. It’s difficult for everybody. I think obviously we’ve all experienced death. I think one of the positives about the state of Connecticut is our palliative care system and our hospice system. Over the years it’s second to none I think of any state in this country and I think that’s the positive of our current healthcare system in that we don’t -- I think we get better care to our patients who are dying than in some other states and I’m just happy over the years that we have fought to protect that care in Connecticut, but I’m glad you’re here as a doctor.
JOHN PIKE: I’m a PA, just to clarify, I’m a PA.

REP. CANDELORA (86TH): Well, I’m glad you’re here because I am concerned about the Medical Society’s position in this and to your point of taking a neutral stance. It ties our hands on the ability to ask them the questions that we need to ask them. And I have served on this committee when these bills come up and their objections raised a lot of interesting conversations. And I wanted to just reference one of them if you could to speak to it, but we all want dignity in dying and like I said, under our current hospice structure, I think it’s there. My concern is in this bill in section nine, once a patient is determine to be qualified to receive the medication, we’re then saying that the doctor and the patient, they counsel the qualified patient concerning the importance of having another person present when the qualified patient self-administers the medication, dispense, or prescribe for the aid in dying and not taking the medication in a place of public. So that’s the requirement of once somebody is given a prescription to end their life, the minimal requirement is that a doctor advised them make sure somebody is with you and don’t do it in a public place, to me, that’s a little bit disconcerting and I don’t know if you could just speak to that. Is that a standard that we should be establishing for our medical society?

JOHN PIKE: Well, I mean, the whole idea of assisted suicide is not a standard I think we should be establishing to start with, but one of the things that has often come up in other places where people were given that medication, didn’t take it, hung on to it, and of course we’ve often also talked about the hundred pills or whatever that many people
couldn’t do, keep vomiting them up and so on and not getting it and then the medication taking a long time. There’s been a lot of data about the patient taking a long time to die, even after taking the medication, but hanging on to it and there have been anecdotal cases, I couldn’t quote it for you, when families have gotten involved in that medication is hanging around not immediately taken. You know, they’ve given it, it’s sitting there, and then families get involved in that and kind of push that along. I don’t if that answers your question.

REP. CANDELORA (86TH): Yeah, I mean, I think that just is the concern. I see what we’re trying to do to give somebody a choice, but I’m not sure the framework on the back end is even there to make sure that the choices they make have the safety net and the compassion and care that we’re looking for and I think -- I appreciate that point because I do struggle with that. And then the last part, you did reference the death certificate and that’s another piece. I know in the past, the State’s Attorney’s Office has testified against it because we’re essentially falsifying death certificates.

JOHN PIKE: Correct.

REP. CANDELORA (86TH): What are a couple of the ramifications that you see that’s negative in doing that?

JOHN PIKE: Well, I think it’s one own integrity to start with. You know, when you’re signing that, it’s a legal document. It’s used in any number of things, you know, in estates and so on and so forth, and especially when it comes with insurance. I mean, there are insurances that if suicide was on that certificate, they would deny payment, but if
their illness is on there, even though, you know, their cancer or whatever it was on there, of course, they’re going to pay, but that’s not the way, that’s not the reason they died. They died because they took a lethal dose of medicine that ended their life and you could say, well, they’re ending their suffering, they are ending their life. It’s suicide.

REP. CANDELORA (86TH): Thank you. Thank you.

REP. YOUNG (120TH): Any more questions? None? Thank you for your testimony.

JOHN PIKE: Thank you.

REP. YOUNG (120TH): Next up would be Jennifer Law.

JENNIFER LAW: Can you hear me?

REP. YOUNG (120TH): Good afternoon.

JENNIFER LAW: Good afternoon, members of the legislature and Public Health Committee. My name is Jennifer Law and I live in Salisbury, Connecticut. Thank you for allowing me to speak today in support of House Bill 5898. I am here to tell you my mother’s story. I addressed this committee last year at this time. My mother’s story has not changed. It seems that the role of a doctor to help relieve pain and suffering somehow takes a twisted turn at the end of life and that death is somehow viewed as something to be avoided at the emotional cost of the patient, whereas in reality, death is a natural part of life. It is the one thing that we all must do, yet when the end of life is near we are robbed of the chance to control that end.

My mother, Anne Paul Law, died at the age of 85 with a sound mind. She was able to say goodbye and then
slipped away, but her road to getting there was excruciating and heart wrenching. She had lived a full and rewarding life, but in spite of leading a lifestyle which is the picture of health, she suffered from stage 2 hypertension and she had suffered multiple debilitating strokes over many years which caused her to no longer be able to live with dignity. This is not true for all people, but for my mother simply being alive was just too hard so she decided after much reflection to stop her medications, which had not prevented her strokes and which she hoped if she stopped would hasten her death.

She consulted her physician who suggested she may live three months and he wrote her a prescription for hospice. A year and a half later, my mother was still waking up each morning. She was doing her best to get through each day hoping that maybe that night, if she was lucky, she would die in her sleep. Meanwhile, her body continued to crumble. Two years after she stopped treatment, she knew she had to take more drastic measures. She couldn’t be patient any longer, so she decided that her only recourse was to stop eating. On October 21, 2015, my mother, a small, frail woman, announced it was time. She had four ice cubes a day to ease the suffering of terrible thirst which she never had another bite of food. We began to count, day one, day four, seven, and this went on, 18, 27, 35. On day 45, she did not have the strength to sit up and stopped the four ice cubes.

On day 48, she died. I’m almost finished. My mother was able to end her own suffering by starving herself to death and it took 48 days. Some might think so the doctor was wrong, she had two years,
she might have had even longer, but that is not the point. My mother was able to control her death, which more than anything is what she wanted, but after a long life with no end at the end of her tunnel, no light at the end of her tunnel, she should have been able to choose a more peaceful end if she had wanted to. In a civilized society, a person should not have to starve one's self for 48 days to gain relief, but because fate decreed that she must suffer through an epically long final decline, she had no recourse but to stop eating.

In seven other states in the U.S. as well as the District of Columbia, her physician could have granted her peace by giving her the ability to choose her end of life in a more dignified and less painful and prolonged process. In such an educated and sophisticated state of Connecticut, it seems incongruous that needless suffering is a product of public policy. My mother would be grateful to you for no longer forcing others to follow in her horrendous end of life ordeal. Thank you.

REP. YOUNG (120TH): Thank you and that’s an awful story, but does anyone have any comments or questions?

STANLEY GREENBURG: Good afternoon to the committee. Okay, I am testifying in favor of Bill 5898, AN ACT CONCERNING AID IN DYING. I’ve decided to take a more abstract or higher level approach to the subject instead of a case study. I’ve made sort of an avocation of studying this issue and in particular, reading arguments against it and so what I have to say is this; first the case for medical aid in dying is made up of facts. For example, the actual wording of the bill, of course, it’s a fact.
It’s surprising how many opponents of the bill sound like they haven’t actually read it. Another fact, it’s been mentioned already, about 40 years of combined positive experience in the states have aid in dying laws, fact. The third fact, national polls and Connecticut polls show between 55 and 70 percent support aid in dying. There are more facts, they’re out there. I even have some, but I best move on.

The arguments against aid in dying involve false assertions, speculation, misdirection, which is pretty acute, and fear. I only have enough time to give a few examples, even though I have a lot. One is, and we’ve heard this, doctors are supposed to heal, not kill. So it sounds right. To begin with, the word kill is certainly pejorative and it’s an appalling way to describe what doctors do in aid in dying situations and I’ll ask for the heal, not kill, part; this falsely asserts that doctors have two alternatives; heal or kill, and of course doctors should try to heal and they should try to extend the patient's life, but when and if, despite all that, the patient faces a miserable death, aid in dying provides the option of a good death instead, so it isn’t either/or. Certainly you heal, but there comes a point where you can’t, aid in dying.

Okay, another thing, I realize time really flies, a lot of people equate euthanasia with aid and dying which of course is wrong. Euthanasia usually somebody else does somebody in, so the summary statement is that the reasons for and the need for aid in dying are real, they’re based in fact. Even seemingly valid arguments against it don’t hold up if you question them and think them through or if you ask me to explain what’s wrong with them. Aid
in dying will affect only the people who are qualified for it and choose to use it. It has no effect on anyone else. I’d be happy to answer any questions.

REP. YOUNG (120TH): Thank you for testifying. Any questions or comments? Jack?

REP. HENNESSY (127TH): Thank you, Mr. Chair. I’d be interested in hearing another example.

STANLEY GREENBURG: Okay. Here we go, one is when people -- people have claimed that doctor’s prognoses about six months to live are sometimes or even often wrong because people can survive longer as if well, there you go. Why take this seriously or, you know, this could happen, but if you think about it, which is sort of my biggest point, think it through. It’s a silly argument. Aid-in-dying patients don’t want to die. When they’ve been interviewed, they bristle at any suggestion that they’re suicidal. These are really people who want to live, they just know what they’re dealing with and so if they find things are going unexpectedly well after six months, what do you think they’ll do? Well, my six months is up, I’ll take my medication and I’ll die. Of course not, they’re happy to be able to live longer and they’ll live all the extra months and years that happen to come their way, so the idea that there’s a problem because the prognosis may be wrong, it’s silly, it’s wrong.

You know, another one is coercion. If somebody is going to die anyway, why on earth would you to coerce them take the pills now because you could be up for murder for that. What is the -- That makes no sense. Why would you coerce somebody is going to
die anyway, but yet, that’s a very favorite word of a opponents of the legislation, people get coerced.

REP. HENNESSY (127TH): Well, thank you. I know a family member that will move out of the state if we don’t pass this, so thank you.

REP. STEINBERG (136TH): I’m tired of hearing about people who are moving out of the state. I’d prefer to avoid that for any reason. Are there any other comments or questions? If not, thank you for your testimony.

STANLEY GREENBURG: Thank you.

REP. STEINBERG (136TH): Next up is Anita Lindsey.

ANITA LINDSEY: I’d like to speak on behalf of H.B. 5898, death with dignity. In the Spring of 2017, the front page of the New York Times published a six-page, full-page article about a distinguished Canadian who had recently taken advantage of a new law permitting medical aid in dying. The article detailed how this law enabled him to end his life peacefully and with dignity. The Times received hundreds of letters, I think something like 700 letters. Mine was one of those chosen to be printed in the paper the following Sunday and so I would like to read that letter.

I read about John Shields’s last days with particular interest because my husband, Norman Lindsey, passed away in a hospice two weeks before. The words of Mr. Shields’s doctor were particularly poignant for me. She said, "give people good information and let them do what they think is best for their family." We did not have that choice. I feel nothing but resentment and anger toward those in the Connecticut legislature who think it is their
right to prevent us from choosing how to end our life once told that we have a terminal illness with less than six months to live.

Norman had lung disease and I watched this lovely, vigorous, intelligent man lose his ability to walk even a few steps, use the bathroom, breathe without the aid of oxygen, read, eat, drink and speak. As a woman cited in your article asked, “Who owns my life?” Several months before Norman died, we had a conversation about medical aid in dying and my feelings about it and his. He said to me, “Well, do something about” and so I’m here to ask you to please do something about it. Thank you.

REP. STEINBERG (136TH): Thank you very much for your testimony. You really are doing something about it and honoring his memory. We appreciate that. Are there comments or questions? Thank you very much for your testimony today. I really appreciate it. Next is Tollie Miller.

TOLLIE MILLER: Hi, I’m Tollie Miller and Representative Steinberg and members of the Public Health Committee, I’m speaking in support of H.B. 5898. I have two very personal reasons to support this bill and this is actually the third time I’ve testified on this bill in the past years. About 20 years ago, I attended the death of my dear friend Peter in Boston. In the last stages of AIDS, Peter decided that he wanted to die at home with friends present and procured the means to do that. He was extremely ill at the time, having been rushed to the hospital twice for swelling in his windpipe that almost cost his life. His anorectic body was besieged by anal fissures, virulent sinus infections, persistent nausea and diarrhea, and a
multitude of other secondary infections. He was in pain 24/7. He made a choice to end his life at 37 and not to prolong his agony.

It was a foreign idea to me at the time, but in long talks with him and in the witness of his pain and courage, I became convinced of the appropriateness of this decision. It was his decision to make in the face of certain continued agony and I support that choice to this day. And then 15 years ago, I attended the death of another dear friend, Earline, in Massachusetts. Earline’s death taught me that palliative care is not always effective. After her diagnosis of kidney cancer, Earline courageously lived her life as fully as possible. As a primary caretaker in her last few months, I watched her pain increase to excruciating levels. A fine hospice program was involved and everything possible was done to alleviate her pain.

However, once the cancer had spread to her bones, the pain simply could not be controlled. I held her hand often as she screamed in agony, as her porous bones began to break when she moved in bed. She was taken to a hospital and given a direct line to bring the pain meds into her as powerfully as possible. Still, she screamed and moaned through her last 48 excruciating hours of life. The experience was shattering. Even the hospice personnel acknowledged that there are cases like this where pain control is not possible. Her daughter and friends were distraught to watch this wonderful woman succumb in such a horrific fashion. I never want any of my loved ones, or myself, to face that kind of pain without some means of control of ending our own agony.
Just a few more sentences, I believe that it is the choice of each individual of how and when they die if faced with a terminal and painful death. This is simply about protecting the right to choose release from agony. By more than two to one margins, my fellow Connecticut citizens believe this choice should be in our own hands. I urge you to support this critical legislation. Thank you.

REP. STEINBERG (136TH): Thank you for your testimony and for the examples and stories that you told. I do agree that this is simply about personal choice. Are there any other comments or questions? If not, thank you for your testimony. Next is James Russell.

JAMES RUSSELL: Hello, my name is James Russell and I live in Ridgefield, Connecticut. I speak in favor of House Bill 5898. I was a caregiver for my wife for 18 years. She had chronic progressive multiple sclerosis. She was in a wheelchair for most of that time and when she died, her death was filled with suffering, pain, and fear. My mother had terminal breast cancer. She had breast cancer for 16 years and her death was filled with suffering, pain, and morphine-induced delusions. I believe both would have chosen to end their lives had it been an option, but it wasn’t.

Now, I’ve diagnosed. I’ve had squamous cell carcinoma in my tongue. Fifteen percent of my tongue has been surgically removed, but I survived, but the doctor told me if the cancer returns to my lower jaw, one of the options would be to have my jaw removed, so I’m testifying today while I can still talk. A friend of mine, a dear friend and neighbor of mine, said he would like to be here, but
he’s suffering from end-stage terminal prostate cancer, said in the state of Connecticut, if you’ve been told you have six months or less to live, you are no longer a truly free person. You do not have the freedom to decide how and when you choose to die. You can hope that palliative care will be enough and for many of us it is, but not for everyone.

This proposed bill does not negate the possibility of receiving palliative care. It simply gives the terminally ill another choice, a way out of unnecessary suffering. They can end their lives in a peaceful dignified way. This expresses our compassion, our choice, our rights, our freedom, and peace of mind. Some who oppose this law suggests it will in some way affect them. This law affects no one who chooses not to use it, no one. There are multiple safeguards. In fact, a similar law has been in effect in Oregon for 20 years and used by 1,500 people without a single report it has ever been misused.

Washington State, Vermont, California, Colorado, Hawaii, Montana, Washington DC have similar laws. Each state has laws that the right to die is just that, a right. Connecticut calls itself the Constitution state. We should lead the way and ensure that our citizens have the ultimate liberty, the right to choice, to die with dignity without pain, without suffering, surrounded by friends and family. Thank you.

REP. STEINBERG (136TH): Thank you for your testimony and for your story and we hope certainly any surgery you need to go through leads to the least diminishment of quality of life, which is so
important to all of us. Are there questions or comments? If not, thank you for taking the time to testify today.

JAMES RUSSELL: You’re welcome. Thank you.

REP. STEINBERG (136TH): Next is Dr. Rob Russo.

ROB RUSSO: Thank you, Representative Steinberg and other members of the committee. I’m Dr. Rob Russo. I’m a physician from Fairfield County. This is my fifth time in front of the legislature testifying on these issues. First let me say that I am a past president of the State Medical Society and I’m presently on the council of the State Medical Society, but I do not have the authority to speak directly for them, but I can answer some of the questions that were raised. First, there’s no reason to argue about the Hippocratic Oath. It’s written -- My granddaughter would Google it to show you what it takes to learn what it is. It is important to realize the American Medical Association is opposed to this legislation.

The status of the Connecticut State Medical Society is in this neutral position. The reason is in that neutral position is to increase the dialog about death and dying. It isn’t an endorsement of this bill. If you read the testimony by the president, Claudia Grouse, it specifically says that. A couple of things, I’d like to back up and make it a bigger picture view because the examples that are usually given in testimony or anecdote, they’re sad, they’re tragic, and they’re said through tears, but the truth is anecdotal examples are not research. They’re not scientific, they’re not medical, they’re individual tragedies that most people have sooner or later in their lives. My biggest concern with the
Bill is that I believe the bill has built in inequities for the citizens, but what worries me the most is that as you go through this process of dying, there’s hospice, which is relatively new to the scene, and then there’s daycare.

If you’re a single mom or if you’re indigent or you’re a patient who is alone in the world, family may live somewhere else, they may have died, you can’t afford daycare. Hospice comes in with a nurse once a day. They can increase that to twice a day, but no one stays with you at night. If you’re a single mom and you live with your parents and the mom is about ready to die from cancer or from whatever illness it is, you can’t afford to quit work, you can’t afford to sit with them as they recall their life. Should we make aid in dying before we make paid family leave so that those people that are dying would have the ability to have their family around them wasn’t based on the economics.

The other issue is everything in medicine changes extremely rapidly, pain management, the drugs we use. When you look at the Oregon experience going back 20, 30 years, you’re looking at drugs that no drugs was used to combat the complexities and the complications. We now have anti-nausea, we have better antidepressants, we have better anti-diarrheal medications, so the in quotes discomfort and pain are much better managed today and they will be much better managed next year as all the new drugs come to market. So I really think we need --

REP. STEINBERG (136TH): Doctor, can I ask you to summarize, please?
ROB RUSSO: Yes. What I really believe we need to
do is step back, do what the State Medical is
asking, which is have a wider discussion so that we
can talk individually about the bill and it’s
difficulties and not rush to aid in dying when I
don’t believe it’s an equitable solution.

REP. STEINBERG (136TH): Well, thank you for your
testimony, Doctor. I would like to say that we’re
exactly rushing this and that we’ve had this bill
before us almost every other year going back for
quite some time.

ROB RUSSO: You’re rushing against 2,500 years of
medicine.

REP. STEINBERG (136TH): Well, I agree with you.
Hospice care may not be as ancient as Hippocrates
himself, but I would suggest that we’ve hospice in
this state for a good many years and we have a lot
of experience with it. I would also agree with you
that if you hang around here long enough, you’ll see
us pass family leave in this state and that will be
one thing we can address, but I guess the last thing
I would end with is your comments about technology.
I think you’re absolutely right. We’ve made
tremendous progress in recent years in hospice and
other ways, but I view that advance as a two-edge
sword, that technology can keep people alive
virtually indefinitely. We can negate virtually all
feeling to palliative care and even though we may be
able to feel less pain, I don’t know if that equates
to quality of life or doing what’s in the best
interest of the patient, so I’m as sanguine as you
are about technology being the pure good that is
going to solve this problem because I’m not sure
that simply blotting out somebody’s pain is the same
thing as offering them a good life. I’m sorry, do you want to respond?

ROB RUSSO: I don’t think it’s just an issue of controlling pain. I think it’s the issues of comfort and the quality of life. It’s the definition of quality of life that needs to be discussed and is it different for different people. I’d rather answer further questions of necessary. Representative Candelora has a question.

REP. CANDELORA (86TH): Thank you, Mr. Chairman. I think that’s sort of exactly what I was just wondering and you sort of spoke to the inequity possibly of palliative care, if you could expound on that. Is there a difference, does it relate to private insurance versus Medicaid or if you would just speak to that a little bit of how that inequity occurs.

ROB RUSSO: Sure. I think first you have to look at hospice. Hospice is in an ever-changing mode. It’s heavily regulated about what the hospice personnel can do, how long they can do it, what drugs they can use, whether or not you go to the hospital, and how many times you see the nurse. The whole rest of the process about insurance and daycare, daycare is not covered by insurance at all so you’re -- the process is financial, so how do you pay for those sort of things, the better your insurance product, the better the payment system is. The problem I have is the influence on the patient. When you sit with a patient and you start talking about these are your options, when you explain the options to a patient that has a single mom, daughter and can’t stay with her and you tell you the financial burden will be overwhelming and then give them option you can end
it now, that’s not the same as talking to somebody who has the wherewithal to say we can guide you through this.

The argument that was started about palliative sedation versus assisted suicide or whatever name you want to give to it is very germane to that one point. When you’re discussing with a patient this is what we can do, the patient's reaction and the support group around the patient, their reaction is wait a minute, we can’t afford that. I don’t want to be a burden to whomever is supporting it, how do I do it. To offer this as a way to that person is unfair when society knows that there are other people who can easily cover it.

REP. CANDELORA (86TH): And also throughout this bill, one of my concerns is, you know, as a committee, how much we get involved in dictating patient care and I think we -- I appreciate the fact that we need to, if we’re going to go down this path, you want to make it heavily regulated to address all these issues that are cropping up. In Section 7 and 8, there are provisions that make recommendations for psychiatric evaluation if a person is depressed so that’s it’s causing them impaired judgment.

ROB RUSSO: That’s showing up in a bill that hasn’t been financed out. Who is going to pay for that if you can’t afford to pay for as a patient?

REP. CANDELORA (86TH): Right, and even aside from the cost, is this how we want to structure how a doctor makes referrals?

ROB RUSSO: Yeah, I don’t think the doctors are that easily influenced where they would read a bill and
say I’ll ask the patients these questions and I won’t ask the patient these questions. I think the physicians, because of their experience and because of the increased amount of education and conversation about death and dying and everything that goes with it, I think we’re getting better at it. I think we need to get better. I think that’s the stance of the State Society which is let’s talk about it, let’s figure out exactly what it is. I heard some of your questions earlier that are very germane to the argument about wait a minute, this bill is 16 pages long and the gal that was here before that talked about national -- she has amendments, we have amendments as physicians, State Medical has amendment. It’s just not done yet. You’re not finished cooking this problem. This problem needs a lot more thought than it’s been given.

REP. CANDELORA (86TH): I appreciate that, so I’m not necessarily crazy on this issue. One of the things I struggled with on the medical marijuana issue is when we pass this regulation, we’re essentially giving -- having the doctor certify a patient and once that patient is certified, they can go and really self-medicate to treat whatever illness they have. Fortunately, we have a dispensary situation where we require pharmacists to be there, so there’s some level of consultation. My concern with this bill and if you could speak to it is, you know, in Section 9, the doctor is to counsel the patient to tell them of the importance of having somebody there when they self-administer and to not do it in public and to me I was just thinking if we’re going this route of an end of life, wouldn’t we want somebody -- a little bit more guidance,
trained medical professionals there. I mean, I just went through a colonoscopy and there’s somebody there when I’m given anesthesia to monitor my heart rate to make sure that process is okay. Wouldn’t we want that as well?

ROB RUSSO: Yeah, I think the issue around this is the timing of somebody who would consider taking those pills, alright? It’s one thing to be relatively healthy, although terminally ill and being given permission to take pills and being in the last ten days or so of your life, I mean, a lot of us have been in that position where near the end of life you say to somebody take these pills, they’re not in any condition to know what the pill is, so when -- is there a limit when the patient becomes mentally incompetent who decides that? There’s no question in my mind if I’m a physician and I would do something like this, I would be there when the patient took the pills. I don’t think it’s fair having read all the other complications of taking these pills to say to a husband or wife or a child give these pills to your mother and then not have somebody there that knows what’s happening, especially if it’s in the low numbers that everybody anticipates, why would you not do that?

REP. CANDELORA (86TH): Right, and what are some of those complications?

ROB RUSSO: They can’t hold the pills down. They vomit the pills and then instead of dying over the short course, they have seizures, they soil themselves, there’s no control. A lot of them throw up because the pills do make you nauseous, especially if you take them -- the recommendation is ten at a time or whatever it is. If you get to like
halfway through, a lot of people just throw up. It’s better to have somebody with medical background and knowledge to be there saying one, it’s an expected process and two, this is what we’re going to do about it and if there is a seizure, you can give them the valium or whatever you use to control seizures. To say take it at home on a dark night, we shouldn’t be doing that. And I don’t think, by the way, that many doctors would do that. I think they would help.

REP. CANDELORA (86TH): I appreciate that and that’s my next worry is then will we start seeing legislation that would change to say doctors aren’t going to be certifying. We’ll have the PA do it or an MA do it or somebody else.

ROB RUSSO: Well, I think in something this serious, you’re going to see amendments to this bill every second. There’s just too much happening in pain management, in the techniques of comfort and there’s always going to be somebody that comes back and says wait a minute, we should do this now because this is old, this is new, and I mean, it’s on TV. You can see the television. You don’t even have to go to the hospital anymore to get your injections. You can wear the patch and that solves the nausea. There’s going to be -- There are in the pipeline, the FDA, there’s hundreds of drugs coming out now to make that part of life much better.

REP. CANDELORA (86TH): Thank you. I appreciate your testimony.


SEN. ABRAMS (13TH): I think the point is it’s up to the person to decide whether or not that the relief
of the symptoms is enough when given those options. I agree with you that it’s so much better and I would also point out, you know, that I’ve been present with two people who passed away at home who were under hospice care who did not have the ability to use aid in dying and there was no physician present during those times either, so I appreciate what you’re saying in terms of if someone chose to have a physician, they certainly could make that happen, I hope that would have that kind of relationship if that’s what they wanted, but I don’t think this is any different than any other way that people pass away at home. There’s often not a medical professional available or there with them.

ROB RUSSO: Yes, but this is an active process. If the patient was under palliative sedation, there would be a medical person there.

SEN. ABRAMS (13TH): I’ll say that in the two instances that I’m referring to, I appreciate it, but we want to try to keep comments down. We spoke in the beginning about everyone feeling comfortable, so let’s continue to do that. The two instances that I spoke of, they were both under hospice care and getting palliative treatments, but there was not a medical professional there at the time.

ROB RUSSO: IV or oral?

SEN. ABRAMS (13TH): Oral both cases. Thank you.

ROB RUSSO: It is not easy to anticipate death following palliative sedation, following oral. It is very easy to predict it during IV.

SEN. ABRAMS (13TH): I appreciate that.
ROB RUSSO: I meant to -- I should have clarified that.

SEN. ABRAMS (13TH): And I’m just pointing out that, you know, there are -- I’m sure that my two instances aren’t the only ones, that there are many times when people pass away at home without medical professionals available. Thank you.

REP. STEINBERG (136TH): I share your concern about this expanding because things do change, but I have every confidence as long as Representative Candelora is on this committee. We’ll make sure that it doesn’t move too fast and make sure the picked people have the right experience, so I’m very confident. Representative Cook.

REP. COOK (65TH): Thank you, Mr. Chairman, and thank you, Doctor, for being here. So as you’ve sat here and listened, you know, there’s been multiple stories, emotional, personal, and the like. I walk into this room not supporting a piece of legislation the way that it is written for concerns. I do, though, support somebody’s right to make a decision on their own and I as a person that seeks medical care has the right to refuse medical treatment, so I just don’t think that that right to refuse medical treatment should also force me into making decisions that are inhumane, which leads me to what you just spoke about on the medication side of this. And I’m not sure what you know about it and I hate to put you on the spot with it, but if you do or if you don’t, you can say one way or the other.

Every time we’ve heard this bill, and so I’ve sat on this committee now for five years or five terms and we’ve heard it at least once every term so, it’s
been a conversation of 90 pills or give or take that amount, maybe it’s lessened now, maybe it’s different now, what are the options if in fact this was a conversation of right to choose and humanity and dignity and people can get on board, and I’m not saying it’s going to happen this year, I don’t know what’s going to happen, if that would be the case, a crystal ball, we’d all be rich and that would be a great thing, what is, in your medical profession and understanding, what are we talking about when it talks about number of pills for consumption for this conversation and what we’re looking at now to take place?

ROB RUSSO: As of now, it is that large volume of pills. If you wait a while, the numbers will come down, the potency will come down, the route of administration will come down. Rather than oral, it would be IV. There are many alternatives, but none that have satisfied the ability to take medication unattended at home or wherever that is for today going to change that 90-pill experience.

REP. COOK (65TH): So in other states though, there is not a 90-pill mandate; there’s other options. I believe there are two or three other options. Can you speak to those?

ROB RUSSO: No, because my experience is basically on this date and Calvary Hospital in the Bronx, so the truth is, no. I do know that this date, the background and the research done today is the 90 pills. You can figure out other ways of giving patients medication that would kill them, but the real question is, is that the way this state and the majority of the other states are presently the same.
REP. COOK (65TH):  So then if a patient is sitting there in front of you as you’re practicing medicine and your oath is to give patient care and the patient says this is what I want?

ROB RUSSO: Yes, but --

REP. COOK (65TH):  Hold on. This is what I want as the patient, where does that -- where does that change from the doctor’s decision and then to the patient's decision?

ROB RUSSO: And that’s what I began to answer when I started. The real question is very few, if anybody, makes that decision about ending their life by themselves. They do it by talking to people around them. Most people, the person with the greatest amount of trust and the greatest amount of faith in that person is the doctor, so they’re opinion weighs more on the patient on the person more than just about anybody else, but the family does, too. The family participates saying look, we don’t want you to suffer, we don’t want you to do this, that, and the other, so when we talk about a patient wants the right to be able to make that decision, they don’t make it alone. They really do listen to the doctors. They really do listen to family members and if they’re religious, they’ll listen to a minister or a rabbi or a priest or somebody like that.

I haven’t seen a lot of patients in isolation make that choice unless there’s a burden. Remember that in Oregon, pain isn’t in the top three reasons that people ask to be able to aid and die. Some of the more important ones to them are I don’t want to be a burden. I don’t want to be a financial burden. I don’t want to be an emotional burden. If you look
at the reasons on the form, pain is in the middle of the top ten pack and if you look at places with even more experience like Amsterdam and those things, pain hardly ever shows up, and as we go through now in the change, pardon me for going to back to the same example, but as things change, that will become less a concern. It won’t be pain, it will be something else like this fear of being a burden or fear of death or things like that.

REP. COOK (65TH): I struggle with the fact that people do not make this decision on their own and I struggle with the fact that people do not make this decision because of pain because I know firsthand both of those are wrong and as much as you might see one perspective, it is our job on this side to see all perspectives and as much as we have waited for modern medicine to cure diseases and figure out a way to eliminate all of the things that we all experience in life and would like to see eliminated, I do know that watching people die and the amount of horrific pain in making the decision that they are done with this life for no other reason but just that, they cannot handle the pain any longer is really something that I think we all collectively, regardless of what side of the aisle you are on, regardless of what side of this decision you are on, that has to be the only conversation we have is about the dignity and somebody’s right to make the decision on their life to not have to live in pain.

ROB RUSSO: Yes, and that is really the purpose of palliative sedation, which is take that person in overwhelming pain and to sedate them to the level isn’t driving the illness.
REP. COOK (65TH): And then what kind of life is that and then are you not now putting -- now you also have family members that are waiting weeks, sometimes months, sometimes years, for that body to give out because we’re keeping that person in a sedated, somewhat vegetative state and I will say, my family completely knows, don’t keep me alive that way. That is not life and that is not living. That is by somebody else choosing the fact that I am not willing to let my body pass on. So thank you. Thank you, Mr. Chair.

ROB RUSSO: Yes, but I do think further education about palliative sedation is important. If you look at the hospice regulations, hospice is not allowed by regulation to give morphine for more than ten days, so the fact that somebody lingers with palliative sedation, you’d have to go back to the process and the procedures to look at them saying is it being done correctly. You should not be in a vegetative state during palliative sedation and that is in the medical and scientific research that that length of time, you’d have to go back and look at what you’re doing with either the morphine dose or whatever medicine you’re using because the reason the ten-day limit is set at hospice is that research.

REP. COOK (65TH): So the definition of sedation and vegetation in your professional opinion are different?

ROB RUSSO: No, not the way you worded it. You would in the beginning of palliative sedation go into a coma. If you call that a vegetative state, it means that they’re not coming out of it. You can lighten sedation and bring somebody back out of it,
so it’s not a vegetative state. It’s a sedated state.

REP. COOK (65TH): Okay. Thank you.

SEN. ABRAMS (13TH): Hi, Doctor. I just wanted to ask you, you mentioned something about the form and it’s my understanding that the physician would be the one to fill out the form to identify the reason the person was requesting support and aid in dying. Is that correct?

ROB RUSSO: Yes, the patient and the physician usually work together to fill out the form.

SEN. ABRAMS (13TH): And then I also wondered that you were talking about swallowing the pills and it’s my understanding that when it was pills, those would often be opened and put into a liquid for a person to drink as opposed to -- for a lot of people, swallowing pills, particularly towards the end of their life, is quite difficult. Is that also correct?

ROB RUSSO: Yes, but again, it’s in measured doses. You can’t put all of the pills in a solution.

SEN. ABRAMS (13TH): Right, but they’re not expected necessarily unless they so choose to swallow 90 pills. That could be broken up or put into a liquid of some kind?

ROB RUSSO: They’d have to drink the liquid that is equivalent to that, yes.

SEN. ABRAMS (13TH): Right. And then the other thing I would say is that right now, are you familiar with something called BDMT2?

ROB RUSSO: No.
SEN. ABRAMS (13TH): Which is a liquid form which is now being used for people, but --

ROB RUSSO: No, again, my experience in Connecticut is limited because we don’t do it.

SEN. ABRAMS (13TH): Yeah, yeah, okay. I just wanted to clear that up because I know that’s something that’s come up. Thank you.

REP. STEINBERG (136TH): Any other questions or comments? If not, Doctor, we’ve taken a lot of time today. I hope you don’t bill us for it.

ROB RUSSO: I appreciate you listening.

REP. STEINBERG (136TH): Thank you again for your testimony. Next up is Judy Kilty.

JUDY KILTY: Judy Kilty, Enfield, Connecticut. Thank you so much for the opportunity to speak to you today. My story is anecdotal, sad, with tears included. It’s also factual because it actually happened. In 1989, two years after my father died from cancer, my mother was diagnosed with mouth cancer. Over the next four years, she had two surgeries, several six-week sessions of radiation. In the summer of 1993, she was diagnosed with metastasized terminal lung cancer. She had been given a life expectancy of two to four months. We arranged a large family reunion so she could say her good-byes. She had time to decide what dress to be buried in and the distribution of sentimental items. By now, she had a realistic view of what was going to happen to her. During this time, she expressed to me many, many times her fear of dying with severe pain. I promised her I would not let that happen. I was unable to keep that promise. During the last
week of her life, we brought in hospice to help with the transition. By this time, she was semi-comatose and moaning in time saying you promised me no pain, you promised. It’s too much. She developed a fever of 106 degrees for three days. We had earlier decided not to have a feeding tube, so she was literally starving to death. Hospice was an incredible help, but they did not have the authority to end the pain and fever and starvation. I had broken my promise to my mother. She needed a compassionate end to the torture she was forced to endure.

Everyone, family, hospice, and doctors knew there was no hope for survival, but she had to endure four days of incredible pain before she died. This should not be allowed. Last July, with a shattered heart, we had our 14-year-old dog euthanized. What a blessing it was to end the horrific pain our sweet dog had been experiencing, but we couldn’t do the same for my mother. You might think that four days spent dying is not that long, but I spent those 96 hours holding her hand, watching my mother wrenching with pain, unconscious and burning with fever and starving. A proper dose of morphine or whatever now would be prescribed would have brought a peaceful, humane death to my mother. She deserves to at least be treated as compassionately as our dog. I understand there are legal and personal and medical decisions which must be addressed before giving the people the right to make a dignified death. I made a promise of no pain to my mother. I broke that promise, along with my heart, and the ability to end the unspeakable, horrific death that was ready --the horrific pain that was readily available, but not yet legal. I implore you to do the humane
thing, the right thing, and pass this bill. Thank you.

REP. STEINBERG (136TH): Thank you, before you leave, just for a second. Thank you for your testimony; you know, you’re not the first to make the analogy that our pets, that we treat them with more mercy than we do our love ones. I’m not saying that’s the perfect equivalency.

JUDY KILTY: It’s the love that we felt for both. It might be different, but it was true love for my mother and my dog.

REP. STEINBERG (136TH): And we want to do right by all our loved ones. I certainly appreciate your testimony in that regard. Are there other comments or questions?

REP. STEINBERG (136TH): Representative Arnone.

REP. ARNONE (58TH): Yeah, I’d just like to thank Judy for coming out today from my district and to speak on this and I’m sure we’ll have many conversations in the future. Thank you, Judy.

JUDY KILTY: Thank you.

REP. STEINBERG (136TH): Next up is PJ Schimmel.

PJ SCHIMMEL: I’m PJ Schimmel from Norwalk. On April 16, 2017, my beloved wife, Moregan Zale, passed away. We had been together 36 years and her death left a hole in my heart. She had been diagnosed with ovarian cancer in January of 2010. In July of 2016, we were told that it had spread and she had three to eight months to live. She was at peace with dying, even happy with a death sentence, because she suffered from several other conditions and her quality of life was low. She had no bucket
list. She had lived life and enjoyed it and was ready to move on.

She did not die of natural causes. She took her own life by VSED, voluntary stopping eating and drinking. She chose this course because she thought it was the only way left for her. She had tried to OD in October on a lethal mixture of morphine and alcohol. After one of the saddest nights in my life, she was alive in the morning. I made her promise not to try any other methods that might leave her brain damaged but not dead. She would have loved to go to Vermont and take advantage of their right-to-die law, but her condition ruled that out. Watching her die of VSED, first at home and then at hospice, was one of the hardest things I have done. She lasted for 23 days without water or food. Seeing someone shrivel up and die of thirst is inhumane, but it was her wish and I respected her decision, though it tortured me.

She was a very strong willed-woman. I told everyone I met at hospice that I would be come here to testify when a right-to-die law came up in Connecticut. Moregan wanted this law badly. So I’m here for you, honey. Please pass this bill.

SEN. ABRAMS (13TH): Thank you so much. I’m sorry for your loss. Are there any questions or comments from the members of committee? Thank you very much. Stephen Mendelsohn. Welcome.

STEPHEN MENDELSOHN: Senator Abrams, Representative Steinberg, members of the Public Health Committee, my name is Stephen Mendelsohn, I’m autistic. I am on one of the leaders of Second Thoughts Connecticut, which is part of the Connecticut Suicide Advisory Board. I also serve on the Board
of Euthanasia Prevention Coalition USA and on the MOLST Task Force. You have my extensive written testimony. I’ll try to briefly summarize seven pages in three minutes. Again, we have the exact same bill essentially as we’ve had for two years. The claim by proponents that they’ve listened to the disability community’s arguments is not true. The claim by proponents that there have been no abuses or complications in states like Oregon and Washington that have it is also not true. I have six pages from the Disability Rights Education and Defense Fund of abuses and complications. I’ll be happy to email it to the committee after the hearing.

A couple of points I want to point out to the hollowness of the safeguards quite a bit here, suicide contagion and on that issue, I want to point out the state of Connecticut Suicide Prevention Plan 2020 because in 2015, Connecticut became the first state to explicitly say that assisted suicide -- that disabled people have a right to equal suicide prevention services and that assisted suicide is part of the problem and I quote, “until recently, the Connecticut Suicide Advisory Board was considering assisted suicide of the terminally ill as a separate issue from suicide prevention. The active disability community in Connecticut, however, has been vocal on the need for suicide prevention services for people with disabilities. There may be unintended consequences of assisted suicide legislation on people with disabilities.”

Bill Peace who Kathy mentioned earlier writes that, “many assume that disability is a fate worse than death, so we admire people with a disability who want to die and we shake our collective heads in
confusion when they want to live” and they give a bunch of recommendations, including doing not assume suicide is a rationale response to disability and then it goes on, you know, people who outlive their diagnosis.

And I think, one of my other points that I think is really important is the issue of expansion. The leaders of Compassion and Choices and Right To Die organizations have explicitly said they want to come back for more bites of this apple. When Compassion and Choices president, Barbara Coombs Lee, came here to Hartford in October 2014, she declared her support for assisted suicide for people with dementia and cognitive disabilities unable to consent, CT news quoted her as saying “it is an issue for another day, but no less compelling.

We have more radical bills in New Mexico or expansion bills in Oregon and we even just had the testimony for Compassion and Choices CEO basically saying that they want to weaken the safeguards in the bill, so if this were enacted, it would move into the hands of judges and I cited the opinion of the Deputy Attorney General and then we have State V. Santiago in which the Connecticut Supreme Court overturned an attempt to make a compromised death penalty bill in this state so that we would eliminate the death penalty, but keep Dr. Petit’s murder -- and the murderers of Dr. Petit’s family on death row.

You can’t create that. The very concept of self-administration, six months to live, terminal illness, and mental competence are arbitrary in that sense and while we in the disability community view this as adherent discrimination about our right to
suicide prevention services, the other side will eventually, once they pass this in a enough states, go to the courts, strike down these restrictions, and that’s how we get to Canada, Belgium, the Netherlands, where we have euthanasia for mental suffering.

SEN. ABRAMS (13TH): Okay. I’m going to have to stop you there.

STEPHEN MENDELSOHN: Okay, as the Reverend Dr. King says in his dream, we all have inherent dignity. We don’t have to die to get it. We shall overcome. Thank you very much.

SEN. ABRAMS (13TH): Thank you, sir. If you’d like to send anything to the committee, of course you’re free to that. Are there any questions or comments? Thank you very much for your testimony.

STEPHEN MENDELSOHN: You’re very welcome.

SEN. ABRAMS (13TH): Peter Wolfgang.

PETER WOLFGANG: Good afternoon, members of the committee. My name is Peter Wolfgang and I am the President of the Family Institute of Connecticut Action and I am here to testify against 5898, the assisted suicide bill for the fifth time in seven years and because of that, because it’s the fifth time in seven years, instead of just reading my testimony, what I want to do instead is follow up on some of what you just heard from Stephen about how these bills get expanded.

So for instance, just since our last hearing on this in 2018 and this goes to the slippery slope, the foot in the door argument, whatever you want to call it, in Delaware, there was a bill that would have
allowed people with intellectual disabilities, this was last year, a bill that would have allowed people with intellectual and developmental disabilities to access the drugs and now just in 2019, and it’s only March, Minnesota and New York, this was the most significant expansion of bills that we’ve ever seen on this, Minnesota and New York, no residency requirement, Minnesota and New Mexico, non-physicians can diagnose and prescribe, Oregon and Minnesota, elimination of waiting periods so the patient can receive the drugs almost immediately.

New Mexico, the original bills allowed consultation by telemedicine and defined terminal illness as in the foreseeable future. A number of bills had no requirement that the patient be seen in person. And there were the Oregon expansion bills that Representative Candelora, you referenced one of these, that terminal illness will now mean a disease that will produce or substantially contribute to a patient's death. Think about that. That doesn’t mean that the patient is dying, it doesn’t mean that the disease is incurable or irreversible, it doesn’t mean that the patient has a short time to live. It doesn’t mean that the particular disease will eventually cause death. It only means that it is expected to contribute to a patient's death in days, months, years, or decades.

Now, I know that we’re here talking about a bill that supposedly and by your definition this is not assisted suicide, to us that’s Orwellian, but that a bill that only allows you to commit assisted suicide if you are diagnosed as having six months or less to live and you’re mentally competent. We ought to be able to take advantage of the fact that we’ve been hearing this bill almost every year since 2013 and
that these things I just mentioned have happened in the other states where this has already become law. We ought to be the beneficiary of that knowledge because there are folks coming up here from the other side saying well, this is very moderate, this is very moderate, we have all these safeguards, but you can see in other states where the mask has already come off.

And I would -- I’d draw your attention to what Stephen said quoting the Compassion and Choices president when she was here in 2014 in favor of allowing it for those with mental disabilities as well.

To summarize, two points; a testimony before me, Representative Cheeseman, focus in on what she said about the American Medical Association, the fact that they did an exhaustive two-year study on this. Connecticut did not. A testimony coming after me, Margaret Dore, pay very close attention to what she has to say about abuse, that falsification of the death certificate, very important. Thank you.

SEN. ABRAMS (13TH): Thank you very much. Are there any questions or comments? Representative Candelora.

REP. CANDELORA (86TH): Thank you, Madam Chair. Just wanted to speak to that, the death certificate, if you could because you’ve around here a lot for it and it doesn’t seem we have the advantage of the State’s Attorney’s Office here. What are some of the issues for that?

PETER WOLFGANG: So the -- It was very interesting that this came up, actually, when the head of Compassion and Choices was testifying and she addressed the issue only in terms of what it has to
do with medical research, but as you mentioned, Representative Candelora, the opposition to this comes from the Chief State’s Attorney’s Office. They submitted testimony in 2015 against that bill.

I think they will be doing that again this year, although they did not have it ready in time for this hearing, but their concern is that this greatly affects the ability to conduct murder investigations and, you know, this goes some things you’re going to hear from other speakers throughout the day and some you’ve already heard about, in terms of how this bill is structured -- when you have a couple witnesses there, when you request from the doctor the right to have the prescription to take your own life, but you don’t need witnesses when you actually take the drugs. I think you spoke to this earlier today, that it doesn’t have to be public, it can be private. I think it’s defined as you ingest the drugs. We don’t know that the person really did it voluntarily.

These are the things that I know concern the State Chief Attorney’s office. This is -- I would recommend the testimony. In fact, if you wait a moment, I can give you the number right now and you can look it up on the Connecticut General Assembly’s website because I had here in my notes. Okay, the 2015 bill was 7015. If you go to that bill on the Connecticut General Assembly’s website for the year 2015, I encourage all of you to read the Chief State’s Attorney’s testimony on the falsification of the death certificate. And look, you heard it from I think Representative Cook said that she was sympathetic to the underlying cause here, the underlying concept of the bill, what its proponents
would call death with dignity, aid in dying, but she was concerned about this particular bill.

I think that is why this bill dies every year. I think that was what most concerned the Chief State’s Attorney. You know, the Chief State’s Attorney doesn’t have an opinion on assisted suicide one way or the other. Their concern was that death certificate, the way, the genie that they’ll let out of the bottle in terms of being able to do proper investigations of potential murders and of course, the Chief State’s Attorney would speak to it better than I could, but these are all the -- I would encourage you, I could give you the numbers of all the bills right now.

In 2013, the bill was 6645. In 2014, the bill was 5326. In 2017, the bill was 7015 and I think in 2018, it was 5417. Those were the four previous years in which this bill got a public hearing. I strongly encourage you to re-read all that testimony, as well as this year’s. All the arguments -- and Stephen’s right, those arguments really haven’t been taken into consideration because the bill you have this year is almost exactly the same bill, but I would encourage you to go back and re-read all that testimony in addition to this year’s testimony and then I would add to it the things I’ve already talked about.

The folks from the other side who are up here are going to tell you only six months are left to live, mentally sound, that was the tune they were singing in 2013. Look at what their friends in other states are doing where they already accomplished this in other states and then they moved on to the next
thing. That is the path you’re putting us on if you legalize assisted suicide. Please don’t do it.

REP. CANDELORA (86TH): Thank you.

SEN. ABRAMS (13TH): Representative Arnone.

REP. ARNONE (58TH): The argument that laws will change, when we have to make laws, considering what’s going to happen later is only a consideration. All laws do eventually change. That to me is a fear of -- a fear of what you want the fear to be and I’m struggling to be able to take that argument just to say because a law may change that we should not consider a law in front of us. No laws would be passed and I just want to make that point and it to me is kind of a side road we shouldn’t be taking.

PETER WOLFGANG: Except, Representative Arnone, I’m not talking about hypothetical fears. I’m stating actual facts. I am describing to you bills that have now come up in the other states that are far ahead of us on this that have already legalized assisted suicide. There’s nothing preventing you from looking at these other states that are ahead of you at the way they’ve tried to open this further and ask yourself is this really the path we should go on? The fact that laws change isn’t a reason not to consider all the evidence.

REP. ARNONE (58TH): So in that too, we have over 5,000 bills that are thrown out every session also, some make it, some don’t, so if you can email me the ones that have actually changed, I’d like to see that. Thank you.

SEN. ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony.
PETER WOLFGANG: Thank you

SEN. ABRAMS (13TH): Susan Okamoto.

SUSAN OKAMOTO: Good afternoon. I am opposing this bill. I am a retired nurse whose work experience pertinent to this issue includes employment in nursing homes, a public high school, a psychiatric facility and an oncology unit. I have aided people of various ages in dying by giving them support and making them comfortable. Words have meaning. Changing the meaning of words is an effective tool in changing the culture, getting the culture to accept something that has never been okay. Promoting assisted suicide as aid in dying is no exception. The euphemism is far more palatable and even attractive, even though assisted suicide is a more accurate term, which I will use.

Ironically, this bill states in the first paragraph, and I did read the bill, by the way, of Section 15 that nothing in it authorizes a physician or any other person to end another person’s life by assisting suicide. I suppose this bill’s proponents argue that prescribing and/or dispensing medication, another euphemism because it’s really drugs because medication isn’t for causing death, that they argue that this is not assisting a suicide. Is it that this action facilitates it? No, it seems the authors of this bill would say we’re not even talking about suicide at all since the death certificate resulting from this type of death authorized by the bill must have the underlying fatal disease listed as the cause of death and Peter Wolfgang just spoke about the dangers of doing that. One lie leads to another. You’re lying on the death
certificate, you’re, you know, lies that are going to be sanctioned other places, in other words.

The other problem, too, is skewing statistics, you know, when we look at, you know, the morbidity of a disease, we’re seeing more people are dying of it sooner, so it’s more morbid, so our six month estimates are going to be skewed and, you know, that’s going to contribute adversely to the whole thing. I’ll jump to Representative Cook’s comments about I think the words she used were preventing a person from dying and that’s what we would be doing by not legalizing this. Talk about preventing, what are we doing to prevent someone from dying that is going on here and, you know, after a while people accept it, so you know, I’ll just stop there because a lot of what I was going to say has already been said except as a nurse in a public high school dealing with children who both committed suicide or attempted suicide or were very depressed and suicidal, the -- you know, we’re saying that suicide is okay, basically, and they’re going to say my psychological pain is very great and if I just may say, this whole slippery slope thing, it’s not only that, you know, we’ve seen this happen, but the people who have chronic diseases who are in pain a lot or people who have disabilities or have a sense of a loss of dignity that’s going to be in perpetuum even though they’re not, you know, going to die anytime soon, they’re going to have a very good legal argument to challenge in the courts.

Whether you want to pass legislation or not to expand this, they’re going to have a very good argument saying well, why do I have to have a diagnosis of only six months to live.
SEN. ABRAMS (13TH): I’m sorry, I’m going to have to stop you there. Are there any questions or comments from the members of the committee? Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. Thank you for coming in. So you’ve been doing this for how long?

SUSAN OKAMOTO: Doing what?

REP. PETIT (22ND): Your caring -- helping patients.

SUSAN OKAMOTO: I think I said I’m retired, that’s what -- I am retired.

REP. PETIT (22ND): But how long did you do it for?

SUSAN OKAMOTO: I did oncology at the beginning of my career for about a year and a half. I worked at the high school for 17 and a half years full time. I worked in the Institute of Living on various units because units kept closing because the decrease in population, you know, the whole managed care thing, so I was moved around a lot, but I had geriatric experience there. I worked there for five years and the nursing homes was about two and half years. I didn’t work while I raised my family.

REP. PETIT (22ND): Sure. I guess I was asking because I -- the same question I asked somebody else before, you know, my experience over 30 years was that hospice palliative care worked pretty well for most of my patients and I asked somebody prior did they think there was something intrinsically flawed or inherently wrong with hospice/palliative care as we currently provide it, is there huge holes. We know statistically that we’re probably not doing, either physicians or other providers are not doing a
great job getting people into it early enough or patients are not asking for it or some combination, but do you think, based on your experience, that there’s something intrinsically inherently flawed with hospice/palliative care as we’ve currently practiced it?

SUSAN OKAMOTO: You know, I have not really worked in hospice care other than one summer I volunteered because I was asked by a neighbor if I could fill in. Again, you know, the situation where hospice doesn’t cover 24/7. This person was dying at home and so I -- it was this gentleman’s wife and so I went there on a daily basis for all of like two and a half weeks before she died, but I did learn a lot by seeing the nurse and talking to the nurse who did come in and that was -- that, too, was like ten years ago I think, so I can’t really speak to that except I know that hospice will give morphine to try and manage the pain and the side effect of that is that the breathing is so depressed that a person stops breathing. That’s different than giving morphine to try to kill someone or giving any drug to try to bring death about, so you know, I just kind of add that, but I don’t have that experience, no.

REP. PETIT (22ND): Okay. I appreciate that. Thank you, Madam Chair.

SEN. ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony today. Barbara Jacobs. Welcome.

BARTHBAR JACOBS: Thank you very much and good afternoon, committee, and thank you for listening to me in three minutes. My name is Dr. Barbara Jacobs. I am not a physician, I am a clinical bioethicist.
I’ve had 30 years’ experience in nursing and for the last 20 years, actually, I’ve been a clinical bioethicist, both at Georgetown University and here in Hartford. What I’d like to -- I’m totally changing my testimony. What I wrote is fine and I submitted that, but after listening to today, I would like just to answer one question about the difference between physicians who are prescribing medicines during a palliative care encounter with their patients versus prescribing medicines in the context of aid in dying.

We ethicists look at the moral calculus of an act based on the act itself. We look at the agents of the act, we look at the motive of the act, and we look at the consequences, so clearly the difference here is about motive and intention and I’d like to tell a story as I was listening to Representative Cook and another person tell his story about pancreatic cancer. I just two years ago took care of my brother, John, who was diagnosed with pancreatic cancer. He was at home, wanted to be at home. The prognosis was extraordinarily poor. We initiated hospice/palliative care for him and I must say that the hospice/palliative care system left me with a complete tool kit, if you will, for what to do to help him with his discomfort and his pain and other problems that he was having.

The difference in my giving him the morphine or Dilaudid that I gave to him was that I did not do it with the intention of killing him. I did it with the intention of reducing his pain and suffering and that is the difference between what palliative care and hospice experts do and what the aid of dying is suggesting. There is no intention of causing one’s death. He had a peaceful, quite death.
The AMA, I was going to speak to that, but we have already made the point that the AMA does not support this, but why doesn’t the Connecticut Medical Society. The difference is in what I call argumentum ad verecundiam, is that the American Medical Association has the authority to put out a code of medical ethics which is huge, a huge column of work, and they have made the statement that they do not support it. I want -- This just isn’t going to work. I want to talk about the death certificate. To ask a physician to write on a death certificate that the cause of death is not due to the ingestion of medications that he or she prescribed is immoral. It is not telling the truth. It violates the principle of beneficence and fidelity.

We have palliative care from mid-state to Dempsey, from Bridgeport to Yale, from Hartford to St. Francis. The question is do we need this or do we need to help people who would not be able to qualify for this if you will and help them with their plan of death. I suggest to you that I have been on two public health committees before, one about what to do in the case of pandemic and I’ve been MOLST Advisory Board. We have MOLST here in Connecticut. We have the ability by law to help people who are either at the end stage of a serious life-limiting illness or in advanced chronic progressive state to be able to fill out their wishes for the end of their life. We do that, we have the tools to do that, and I think to say, and this is my last comment, I’ve heard it twice today from Representative Josh Elliott and he on Channel 8 said “this is only going to be available for people with
a diagnosis of six months or less or only people who are in deep and dire pain.”

As far as I know, there’s nothing in this legislation or law or act that says this is for patients who are in deep and dire pain and we already know that that is fourth on the list or fifth on the list of six reasons of end of life concerns from Oregon and the psychiatric evaluation issue, only three people in 2018, 21 years of Oregon’s work with issue, only three people, 1.8 percent --

SEN. ABRAMS (13TH): Okay, I’m going to have to ask you to stop. Thank you.

BARBARA JACOBS: Thank you for listening.

SEN. ABRAMS (13TH): Thank you for being here. I just want to point out, do you see this is an either/or because I don’t. I mean, I believe in palliative care if that’s one someone chooses and I appreciate what’s available and I don’t see that being diminished if that’s what someone chooses because of this legislation, but it sounded like what you were seeing, you might see them as an either/or?

BARBARA JACOBS: I’m not too sure I see them as an either/or. No, I would say no. I mean, 90 percent of the people in Oregon have hospice care, so for whatever reason, they’re still having problems. What I’m -- I guess what I’m trying to suggest is that -- and we’ve heard Compassion Choices say this legislation has been around for 21 years. Times have changed, medical science has changed, medical ethics has changed, so many things have changed. My suggestion would be we need to take a broader, more
extensive look at the literature, at the medical science at the law philosophy science and see if what was the law 21 years ago would be still relevant today and maybe we could not make it an either/or decision, but we could work on something else together. I just think more work needs to be done.

I’ve heard so many misconceptions today. I mean, someone asked what BDT meant or those medications. That’s digoxin, valium, chloral hydrate and something else and propranolol, a beta blocker that they giving to a third of these patients as medicines to use to end their life and don’t doubt if you put digoxin with valium, morphine sulfate, and propranolol into your system, you will die and that will be the cause of your death.

SEN. ABRAMS (13TH): Thank you. Are there other questions or comments? Thank you very much for your testimony. Ann Boers. Good afternoon.

ANN BOERS: Good afternoon, members of the committee. My name is Anne Boers. I am a resident of West Hartford and I work as a Pro-Life advocate in the state of Connecticut. I am here today to urge you to vote no on proposed House Bill 5898, which would allow doctors to prescribe lethal doses of medications to enable their patients to end their lives by suicide. I am asking you to vote no based of the simple premise that suicide is not healthcare. The idea of a physician dispensing medicine that does harm to the point of death runs contrary to the role that doctors are privileged to play in our society.

The role of the physician is to assist healing, prolong life, and offer hope to those who suffer.
To be in opposition to suicide is not to deny the existence of suffering on the part of the patient, but rather is to be against the idea that killing or death is the solution to that problem. I strongly urge you before you vote examine the statistics on suicide in the states where this has already been legalized in our country. I believe wherever assisted suicide is legal, there is a higher rate of suicide in the state overall. Do you lawmakers want to be a part of this trend? We need to pay attention the type of language that is encoded in this type of law. We hear words like compassion, aid, and dignity, but these words run in contrary to the action of encourage a person to take their life.

When you take away the word compassion, what you reveal is actually the opposite, encouraging others to end their lives prematurely, for whatever reason, eases our burden of caring for them, of validating their dignity as persons and it relieves us of suffering alongside them. There is nothing dignified about ending your own life and I say this with all the sympathy in the world to the people who have watched their loved ones suffer and die and I have, as well. Encouraging this is preying on people’s despair and I really wonder if we want to encourage this in our state. Given the advances in modern medicine, we are in a wonderful position in this day and age to ease the pain that goes along with illness, whether physical or mental.

We also need to be aware that when society legalizes killing, what becomes allowed, -- if I can just say one more sentence? Thank you. When killing becomes allowed, it can quickly become recommended and then it becomes -- it can become mandated. The stories of abuses in countries where this is legal are many
and who knows how many individuals’ lives are being ended by those who do not have their best interest at heart. I encourage you to please read all the statistics on this and think about it very carefully. I’m also very concerned about the youth in our country. I have teenagers and young adult children and, you know, this idea that suicide is a good thing is very frightening me. I thank you for your time.

SEN. ABRAMS (13TH): Thank you for your testimony. Are there any questions or comments from members of the committee? Thank you very much for your testimony.

ANN BOERS: Thank you

SEN. ABRAMS (13TH): Brian Callister. Oh, good, you knew who you were.

BRIAN CALLISTER: Brian Callister, Dr. Brian Callister, I’m a physician, medical professor from Reno, Nevada, past president of the Nevada State Medical Association, and governor-elect in Nevada for the American College of Physicians. I’m here speaking on my own behalf because of a situation that threw me into this, so I’ll jump right in. I’d like to start out by saying that contrary to what proponents say, legalizing physician-assisted suicide limits your choices and access to care. Why do I say that? I had two patients about a month apart in Reno, Nevada, both of which required life-sustaining and treatment and life-saving treatment. One needed to go to Oregon because that’s where they were from and one needed to go to California.

We set up the transfer, we had the patients ready to go in each case and in each situation, the insurance
medical director said to me on the phone, we’re not going to cover the procedure or the transfer and then almost as an aside, by the way, have you talked to them about assisted suicide. They will tell you that there’s no cause and effect; that insurance companies deny things all the time and they approve things all the time and they don’t infer a cause. I don’t feel like I am naïve enough to believe that.

And in fact, what really saddened me is I went back to the doctors’ lounge in shock to share with my colleagues and they looked at me sort of calmly and said Brian, why are you surprised? It’s legal in those states, they can bring it up, they can offer it. If that wasn’t enough, I started to dig into the situation of physician-assisted suicide after that and you’ve heard today throughout the day these gut-wrenching stories of pain and suffering at the end of life and it really does break my heart to hear about this and that people have to do through that, but I have to tell you that the facts just don’t bear that out as far as that being the main reason for utilizing assisted suicide.

In 20 years of Oregon data and I have that data right here, in 2017, 21 percent of people requested the prescription because of pain or even a future concern of pain. What were the number reasons; 88 percent, number one, less able to engage in activities making life enjoyable. Now that’s a serious social issue. The last time I checked, it’s not a good reason to kill yourself. And finally the suicide contagion aspect needs to addressed. In the first 15 years after this bill was passed in Oregon, the national suicide rate went up by 23 percent. The suicide rate in Oregon, the general suicide rate, during that same time period went up by 48
percent, really stark contrast. Those numbers are from the CDC, by the way.

SEN. ABRAMS (13TH): Thank you very much. Are there any questions or comments? Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. Thank you for your testimony. I don’t know if you’ve been here for most of the testimony. There’s been a number of questions about the death certificate and how it should be filled out. I wonder if you have a personal opinion or data or thoughts based on what’s happening in other states?

BRIAN CALLISTER: Yeah, absolutely. What the Compassion and Choices said about it skewing research is absolutely correct, but she had it absolutely backwards and I’ll tell you why. If you’re putting down lung cancer as the cause of death when we don’t know if that patient might have lived six months or six years, we’re skewing the mortality data to make us think that lung cancer actually killed them sooner and more often than maybe it otherwise would. So it’s skewing the data to suggest mortality rates are higher and more severe than they might otherwise be.

Also, I’ve always wondered, I have to wonder, if filling out a death certificate like that with the wrong diagnosis doesn’t constitute Medicare fraud.

REP. PETIT (22ND): Thank you for that. Thank you, Madam Chair.

SEN. ABRAMS (13TH): Representative Candelora.

REP. CANDELORA (86TH): Thank you, Madam Chair. Thank you for your testimony. Question another
point, I think it was made in previous testimony, was the improvement to -- potential improvement to hospice care and I was wondering if you could speak to that because I was a little confused. Does it free up other patients to be able to get those beds on the one hand because it seems like there’s a finite group of people that utilize the assisted suicide provision. Are you familiar with that?

BRIAN CALLISTER: Yes, I am, and I can’t help but wonder if the time limit does have a role. I have no way to prove or disprove that, but if you go beyond the time limit for hospice, you have to be recertified and so on and so forth. Well, keep in mind that nationally 18 percent of patients outlive their prognosis on hospice, 18 percent. That’s a substantial number. We’re very good, pretty good, at giving you a terminal diagnosis. We’re very, very poor at predicting life expectancy, including how much quality time you might have left.

Once you’re at the very end, I think everybody can tell you’re at the very end, but we don’t know with a lot of these disease processes if you’re going to go three months, six months, six years whether it’s cancer or a chronic illness and along those lines, something somebody brought up earlier today that I heard with regard to hospice and terminal definitions, indeed, if you stopped your insulin and you stopped your chronic medication, you would be eligible for assisted suicide based on this law and there have been cases in Oregon of things as simple benign neoplasm, that means not cancerous, listed on the death certificate, chronic respiratory illness, diabetes, all of those things have been on death certificates in Oregon. This is not without -- This
is not without perverse negative consequences, financial and otherwise.

REP. CANDELORA (86TH): I want to get to that point with the diseases. You know, if you are diabetic and you stop taking your insulin, you could create a terminal situation within six months and therefore potentially be under that definition, no?

BRIAN CALLISTER: That’s exactly right, because it does not specific with treatment, therefore if I could honestly say you stop your medication, you’d be terminal in my opinion in less than six months, six months or less, you’d qualify, as simple as that.

REP. CANDELORA (86TH): And then the last question was a part that I struggle with is the back end of this process where the medication is prescribed and the patient is put out to pasture to administer on their own without medical supervision. I guess -- Do we have to do it that way if we had this legislation?

BRIAN CALLISTER: Well, I don’t see really a good protection there no matter how tight you might think you could write it and the reason I say that is you have to have multiple witnesses up front to get the prescription, but once you get home, who’s to keep a freeloading grandson from suggesting or actually putting the capsules, which is usually what it was, it wasn’t pills, it was capsules, 90 seconal capsules, 100 milligrams, a lethal dose is 9 grams, put it in granny’s applesauce. There doesn’t have to be any witness. Why have there not been tremendous investigations into all of this; because there’s no witness. There is no healthcare provider at all present in 80 percent of these cases over 20
years and the physician was not present in 90 percent of cases, so you’re not going to have investigations for things that people don’t witness.

REP. CANDELORA (86TH): And the legislation written this way because doctors, because of their oath, can’t be part of that process, is that -- Is that why you wouldn’t have it administered in the presence of a doctor?

BRIAN CALLISTER: Well, I look at it two ways. One, it was 20 years ago and it really hasn’t been changed or updated, but I think a lot of physicians aren’t going to take the time to witness that death. They’re not going to take the time to go to that patient's house. They’ll send a nurse, they’ll send a social worker, busy people. Now that’s my own hypothesis with that. I don’t have any proof of that one way or the other. What I do have is the numbers; 90 percent of cases, no physician present.

REP. CANDELORA (86TH): Thank you, I appreciate it.

SEN. ABRAMS (13TH): I had a couple questions. I’m wondering if you’ve ever spoken to a prescribing physician or have any direct knowledge of the training that they go through?

BRIAN CALLISTER: Forgive me when I kind of smile when I hear that, palliative care and hospice are specific specialties for which there’s training and you can be board certified in hospice and palliative care. That’s not true for aid in dying. In fact, what I’ve seen out there is Compassion and Choices, which by the way, used to be known as the Hemlock Society before it morphed into Compassion and Choices, which was a poison. I found that interesting. Compassion and Choices partnering with
a very perilous assisted suicide healthcare system called Kaiser Health in California, they provide internal training, so there’s no specific legal requirement that says this training is going to turn you into an expert in how to write a deadly prescription. You know, I could write you that right now, it’s pretty easy to do.

SEN. ABRAMS (13TH): But my question is, have you ever attended any of those trainings or spoken to any prescribing physicians?

BRIAN CALLISTER: I actually gave a CME course in California on how to ensure a patient autonomy in a time of California’s medical aid in dying law and some of them were there, so yes.

SEN. ABRAMS (13TH): Thank you. I also just wanted to just clarify something. In this particular bill, terminal illness is defined as means the final stage of an incurable and irreversible medical condition, so it has to be both because it says and there. That’s my understanding, but we can look more into that.

BRIAN CALLISTER: But translation from layperson language to medical language, the words you said mean absolutely nothing. If you were a diabetic who stopped your insulin, I could say all three of those things are true. You’re irreversible, you’re incurable, and now you’re terminal.

SEN. ABRAMS (13TH): I’m going to disagree with you on that.

BRIAN CALLISTER: Are you a physician?

SEN. ABRAMS (13TH): I would also say that you were talking about the fact that --
BRIAN CALLISTER: Go ahead, I’m sorry.

SEN. ABRAMS (13TH): Okay. I also want to say that you were talking about a doctor having a difficulty deciding how long a patient might live?

BRIAN CALLISTER: Right.

SEN. ABRAMS (13TH): But in this particular situation, the patient has control over when they feel like the time has come for them.

BRIAN CALLISTER: So it brings up an interesting point. The patient may not know if they have three weeks, three months, or three years, most of which -- almost all of which might be good quality time. What’s to keep them, you’ve heard this, on a dark and stormy night, but it’s really true, from saying I don’t want to face this down the road. I’ve got the pills in the nightstand, I’ll just take them now, and, you know, with that in mind, you have to remember that most people are going to be genuinely sad if they get such a bad diagnosis and that so-called safeguard of mental health counseling, referral, all of that, in 20 years of Oregon data, less than 4 percent -- less than 4 percent of the patients have been referred and I do not know of a single case where they actually were denied the pills, not one.

SEN. ABRAMS (13TH): Thank you. Any other questions or comments? Thank you very much for your testimony.

BRIAN CALLISTER: Thank you.


STEPHEN LYON: Good afternoon, Senator Abrams, members of the Public Health Committee,
Representative Candelora, who I had the honor of interning for 12 years ago, time flies. Also my apologies to Senator Abrams. In my written testimony I submitted, somehow I typed Senator Adams and not Abrams, so my apologies. You have my written testimony, so I’m not going to go word for word. I want to address a couple of issues that I’ve heard mentioned throughout this morning and afternoon testimony. The previous individual talked about this more eloquently than I can, but one of my primary issues with this is the death certification. We are perpetrating a fraud on the people of the state of Connecticut and the medical community.

My primary worry is the same issue that he brought up is messing with medical statistics and mortality rates. When doctors give their advice to patients and give their diagnosis about how long they are going to live, as is required by the statute, you have to tell someone if they have left than six months to live, they do that based on medical statistics. We are going to warp these to make it look like these medical conditions have a higher mortality rate than they do. This is inaccurate. When Representative Elliott spoke earlier and said his explanation for why we put the underlying cause on the death certificate was to protect the doctors. We should focus on protecting patients, not protect the doctors. Yes, doctors are important, but their primary role is to protect their patients’ wellbeing.

The second reason I opposed this bill is for a more personal reason. I, like many other young people, have many friends who have committed suicide and yes, I understand the protections of this bill are specifically dealing with people who have diagnoses
of less than six months to live; however, the logic remains the same and we must apply the same logic to every situation. What we’re telling people is that your circumstances dictate the value of your life, your pain dictates the value of your life. We’re dealing with people say an epidemic of suicide in our communities, in our minorities communities, and our LGBT communities. We’re seeing this and we’re telling them -- we’re supposed to be telling them that death is not the answer for your pain. Death is not the answer for your situation. We’re sending mixed messages if we tell people that death is an answer when you have six months to live and you’re in pain, but not the answer when you’re going to spend 30 to 40 to 50 years dealing with chronic depression. We need to think about the long-term implications of laws like this. I’m happy to answer any questions. Thank you.

SEN. ABRAMS (13TH): Thank you. Are there any questions? Representative Candelora.

REP. CANDELORA (86TH): I just want to take an opportunity to give you a shout out. It’s good seeing you here again today, 12 years goes so quickly.

STEPHEN LYON: It’s my first time testifying. I submitted five years in the past, but I finally had the opportunity to testify, so thank you.

REP. CANDELORA (86TH): Thank you.

SEN. ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony. Nice to see you back here.

STEPHEN LYON: Thank you.
SEN. ABRAMS (13TH): Laura Borrelli. Welcome.

LAURA BORRELLI: Thank you. Thank you, Senator Abrams, and members of the Public Health Committee. I testify before opposing Bill 5898, AN ACT CONCERNING AID IN DYING FOR THE TERMINALLY ILL PATIENTS. I am a hospice nurse. I have over 32 years of experience and currently working for Franciscan Home Care and Hospice Care and a member of the Hospice and Palliative Care Committee for our Connecticut Association for Healthcare at Home. I’ve seen firsthand how precious and purposeful life is to its natural end. Bill 5898 forsakes that premise and falsely aligns the notion that unnatural means can provide compassion for the dignity of the human person.

I have witnessed what true compassion is and how providing for the dignity of each individual did not come from wanting to eliminate them or their perceived suffering. It came from wanting to walk along with them and provide individuals with interdisciplinary hospice care through their natural dying process and personally I’ve had a father-in-law and my dad and my mom each go through this experience, each of whom suffered different debilitating diseases, but were all were provided dignity and care and never abandoned to face the reality of their dying process alone.

Through each of their naturally dying experiences, my family had the opportunity to offer true compassion and care and presence as we integrated the loss of our beloved. Representative Abrams, you mentioned that there’s no difference in seeking the aid in dying and an actual process, well there is, the process that offers individuals to share tears
and words of love and forgiveness and sorrow freely spoken and in the process of dying itself can only be fully accomplished if done so naturally. Any other way is artificial and does not bear the same emotional or spiritual benefits and Bill 5898 does not provide aid in dying, but provides aid in accomplishing death.

It is physician assisted suicide I do believe and naming it by any other euphemism or falsifying a death certificate lacks accountability. There is more to dying than the ceasing of a beating heart. There is more to bearing witness to one’s love than eliminate the uncomfortable. Death is a moment in time, but dying is a process that takes time and it in those moments that we are offered the opportunity to express our full human potential. I’ve seen sons and daughters come to the bedside of their loved one and grow in strength as they came to understand the importance of this process. We as a society cannot orchestrate with the same benefit the results which occur naturally. An in conclusion, I would like to say that a natural death does involve usually no food and that is not starvation and no drink and that is not dehydration. An increased temperature, incontinence, pain, shortness of breath and congestion at the time are all symptoms that can be managed by a hospice care team. There is value to the very end and there are valuable lessons that can be learned if we choose to listen to those who are dying. Representative Steinberg mentioned that blotting out somebody’s pain does not make a good life. Well, I say that blotting out somebody’s life does not make a good death. Thank you very much for listening to my testimony and I’ll take questions if you need me.
SEN. ABRAMS (13TH): Thank you very much. So I was saying I’m from Meriden and I know the work that you do and I very much appreciate the work that you do and I’m not sure I said what you quoted me as saying, so I just want to be clear that I do appreciate the work of hospice and I think it is a choice that people should have, but I also see this as being another choice that people should have available to them and in not in any way to diminish the work that you do, so I just wanted to be clear about that and thank you.

LAURA BORRELLI: Thank you, Senator Abrams.

SEN. ABRAMS (13TH): Any other questions? Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. First of all, thank you for all those years of service, 33 years, that’s a long time.

LAURA BORRELLI: Twenty-two at Greater Bristol VNA, so.

REP. PETIT (22ND): You started when you were ten years old.

LAURA BORRELLI: Yes, exactly, thank you.

REP. PETIT (22ND): And thank you for making the statement about the feeding and liquids. That’s a common discussion with family members who think it’s a terrible way to go and people are typically more comfortable when they’re not fluid overloaded, when their guts not bogged down they it’s not working anyway and it’s often a difficult psychological hill for people to climb when a loved one is dying. Same question I’ve asked a bunch of times and I beg the indulgence of my colleagues here and that’s about
hospice and palliative care because my experience was that the teams and the process was typically very good to excellent. If you gave it a harsh assessment, do you think we’re missing, deficient in many areas in the hospice care we provide in 2019? Are we not doing all the things we should be doing?

LAURA BORRELLI: I think the conversation is what’s key and having that conversation early and frequently with your loved ones is what’s so important as well as with your healthcare providers and letting them know your end of life wishes and I think it’s through those conversations and that’s why I say the natural process is so important because of you allow for that natural process to occur, a lot of those conversations can take place and without that, with trying to orchestrate something, it does not gain you the same benefits.

So yes, do we have further to go with hospice care in the state of Connecticut? Absolutely being -- I don’t know if we’re 49th right or if we’re still at 50 in terms of length of stay. Yes, we have further to go and I want to continue that conversation, but more importantly, it is available to us and it is something that can help individuals and their families through difficult times.

REP. PETIT (22ND): We’ve heard from multiple folks that pain is not a major issue, but it’s typically a major issue when the general talks about it. They perceive that to be the biggest issue. I don’t know if it’s based on TV or misperception or whatever, so I’ll go there and say in general, do you think most pain is controlled with the current medications that are available?
LAURA BORELLI: Yes, it very definitely is. The current medications we have available to us are adequate enough so that we can make those adjustments necessary in the dying process to maintain someone’s comfort. We do have to realize, though, pain comes in all levels as well and that’s why it’s interdisciplinary as far as our team is concerned in terms of hospice. It could be spiritual, it could be psychosocial. There are many different instances where individuals have suffered greatly and it wasn’t because of physical pain. That suffering had to do with the relationship that needed to be mended and again, allowing for that natural process to allows the time that it takes for those things to occur and to happen.

REP. PETIT (22ND): Thank you very much. Thank you, Madam Chair.

SEN. ABRAMS (13TH): Representative Candelora, did you have -- Anyone else have any questions or comments? Again, thank you so much for your service. It’s important work. Thank you.

LAURA BORELLI: Thank you.


PHYLLIS ROSS: Senator Abrams, Representative Steinberg, members of the Public Health Committee, my name is Phyllis Ross from Lyme. I’m here today to support HR 5898 and I’m here because of my mother’s tragic death. In her last six months of life, she was under hospice care, but they could do little to help her except administer medication to for pain, but it was not the pain that distressed her most, it was the total helplessness she felt. She could not walk, dress or feed herself. She was
incontinent, couldn’t sit up by herself, and had to be turned in bed to prevent bed sores. She wished her suffering would end, but that was not possible. Now you have a chance to make a crucial decision that would give terminally-ill patients, like my mother, a humane end-of-life option.

Please consider the following; currently there are seven states and Washington DC that have medical aid in dying laws similar to our bill. There are 19 more state legislatures considering bills and that number is growing. Much of the opposition we’ve heard today is based on conjecture and fear that it might lead to illegal or inappropriate actions, the slippery slope that they’re talking about. However, that has been thoroughly disproven. States that permit medical aid in dying, including Oregon with 22 years of experience, have had no legal problems, no abuses, and no successful challenges to their laws. Those who have made this claim today that there have been problems or that we can anticipate problems have shown us no evidence to prove that this is true.

As of 2019, as you’ve heard, the Connecticut State Medical Society no longer opposes medical aid in dying. Their position is engaged neutrality, protecting their members’ freedom to decide for themselves what medical aid in dying options to provide. So where do the people of Connecticut stand on medical aid in dying? A 2015 Quinnipiac poll showed 63 percent would allow it. Only 34 percent were opposed. A majority of people favored this legislation two to one. Therefore, I urge you, please vote for HR 5898. It’s the compassionate thing to do and what the majority of your constituents favor. Thank you.
SEN. ABRAMS (13TH): Thank you for your testimony. Are there any questions or comments from the members of the committee? Thank you very much. Susan Adams. Welcome.

SUSAN ADAMS: Thank you. Senator Abrams, Representative Steinberg, and members of the Public Health Committee, my name is Susan Adams, vice-president of Alliance Integration at Masonicare. Masonicare is a full continuum of care specializing in senior services and has a statewide home health and hospice presence. Our current palliative and hospice census is over 400 patients. I am also the past chairman for the Connecticut Association for Healthcare at Home board of directors and the current committee chair for the Government Relations Committee. Every one of us is going to die at some point. You may only get one chance to do it the way you want. There are no do-overs. Should this bill move forward, it must be done in tandem with education about patient choice. There are many viable alternatives to the options outlined in this bill.

Death is a not one size fits all. Educated decision-making encompasses not only the opportunities to know what other choices are available, but also to truly understand all of the components of each choice. Having the opportunity to explore options, ask questions, get complete and accurate answers, and consult with family and friends is the right of every individual who is given the opportunity to make a choice. The time to gain the knowledge of options for end of life care is not when death is eminent. We all have a responsibility to our family and friends, as well as ourselves, to begin that educational experience now,
not when emotions are running high or time is running out.

Palliative care is for people of any age and at any stage in an illness, whether that illness is curable, chronic, or life-threatening. If you or a loved one are suffering symptoms of a disease or a disorder, be sure to ask your current physician for a referral for a palliative care consult. Hospice care is available to a patient if two physicians determine that the patient has six months or less to live if the terminal illness runs its normal course. Hospice is a form of palliative care, but offered later in life.

The state of Connecticut is 49th in the nation in terms of length of stay for hospice patients, which is deplorable, and means that patients who sign on to hospice programs in Connecticut are not able to experience all the benefits of the program due to the very short periods of time they will receive services. They are very personal decisions to choose an end of life plan and which one and the best one for them and their family is dependent on education and full transparency.

We implore you to include patient education and patient choice when considering the future of this bill and please invite the providers of palliative care and hospice care to the table to support further development of the language. Thank you for taking time to listen to my testimony.

SEN. ABRAMS (13TH): Thank you for your testimony. Are there any questions or comments from the members of the committee? Representative Candelora.
REP. CANDELORA (86TH): Thank you, Madam Chair. Just to ask the question about the way this bill is constructed right now, it’s just what I struggle with is the fact that we would be prescribing medication and telling the person to be taking it alone or with -- I’m sorry, with somebody there, not in public. I’m sure, you know, I’m guessing that hospice care obviously -- you don’t follow that course of if a person is at end of life, I guess, how is the recommended treatment, what setting should the person be in?

SUSAN ADAMS: We take care of hospice patients in their homes, wherever that may be, so it may be a nursing home, it may be in their own home, it may be their daughter’s home.

REP. CANDELORA (86TH): And if this bill did move forward, that is something that you would have the ability to help with? I guess what I struggle with is we talk about compassionate care under this bill and I’ve had personal experience, and many of us have, with end of life situations where hospice care has come into our home and assisted us when somebody was dying of cancer. Under the provisions of this bill, it almost mandates a disconnect between hospice care and somebody ending their life because if they’re prescribed this medication to end their life, the recommendation is have it be with somebody and not in a public place. To me, that’s the opposite of compassionate care and I’m just wondering if that makes sense, is there a role for hospice to play?

SUSAN ADAMS: I think hospice does a lot of education for patients and choices that they have for end of life. I think our problem in this state
is that we don’t give people the time to make that decision. When we get calls that somebody needs to be signed on to hospice and they’re dead before we can ever get to them, we’re not doing our job in terms of education about end of life.

REP. CANDELORA (86TH): Thank you.

REP. STEINBERG (136TH): Thank you, Representative. Any other questions or comments? If not, thank you for your testimony today. Next up is Suzanne Gross.

SUZANNE GROSS: Good evening, Senator Abrams, Representative Steinberg, and members of the Public Health Committee. I too have been here for five years and I do speak and again, I’m the administrator of Franciscan Home Care and Hospice Care and have served in this type of ministry for over 35 years and our agency serves individuals and families in 30 towns in central Connecticut and our various home health care programs, in them we have about 180 employees, 15 Franciscan Sisters, and 16 volunteers and some of our programs do include mental health services. I am here again to oppose legislature that would endorse -- we aren’t calling it assisted suicide, we’re calling aid in dying, but we’re here to oppose House Bill 5898 because we believe it gives terminally ill patients or persons the wrong message.

We believe life is precious and we have served people of all faiths, people of no faith over these past years and what is true for all, as death draws near, every patient provides us with a special opportunity to care and to be there for patients, their family members, their friends as Laura testified to, and help them know how important they are. We would probably say
that death probably the most important moment of our lives. In Connecticut we have excellent hospice care providers who daily provide compassionate care to those who are terminally ill. Palliative care has improved remarkably over the years, but as we’ve heard say today, there’s much more we can do in terms of education.

Clinical persons are here today addressing the advances in pain management and others have testified how that isn’t the leading cause for people to choose this kind of -- the heart of this bill. We have also been told that we providers who are opposing this bill are trying to prolong death and that is not the case either. You heard our hospice director testify we’re really here, really trying to help people have the most meaningful time at the end of their life. It is my experience that the patients at the end of their life long for support. They long for the opportunity to complete unfinished business, time to reconcile with family and friends -- oh dear.

Same problem, I talk too much, I guess, so anyway, instead of eliminating -- can I just finish this sentence and then I’ll give the closing -- instead of focusing on eliminating the pain and suffering, the arguments of those promoting House Bill 5898 see to be focused on how the patient gets eliminating or the sufferer. There’s an avoidance of the use of the word suicide in this bill and we find that unfortunate because we think it does encourage it and one of the speakers before us talked about how suicide incidents are increasing already in our teenage population. So the people who care for people actually do suffer with one another and so we don’t want to undue suffering because it’s really
part of our life, but it doesn’t mean that the patient in hospice care is the only who might be called to live with a burden in his or her life. I think I have to stop, but anyway, I did half of my presentation and I submitted it beforehand though, so I do ask that you look seriously at this bill and I really respectively ask that you oppose this legislation until -- and just oppose this legislation because we can much more through hospice care.

REP. STEINBERG (136TH): Thank you. Are there questions or comments? If not, thank you for your testimony today.

SUZANNE GROSS: Thank you, Representative.

REP. STEINBERG (136TH): Next is Sharon Ostfeld-Johns.

SHARON OSTFELD-JOHNS: Good afternoon. My name is Dr. Sharon Ostfeld-Johns. I’m a recent graduate of the Yale combined internal medicine and pediatric residency program and I’m currently employed as a hospitalist physician at Yale-New Haven Hospital. I live in New Haven with my husband and my son. I’m here to voice support for the aid in dying legislation that’s come before you, the Public Health Committee. I come as a physician, but mostly as a daughter. I’m here for my mother. She was an organic vegetable farmer and a highly successful businesswoman. She started her own farm with my father at age 28 and by the time she died 30 years later, it was a touchstone in the farming community, a local legend. She was hardworking, savvy, and smart. She was the boss, a mentor, and a teacher.
It took a lot to earn her respect and even more to keep it. That’s why it was so hard when her wishes regarding her manner of death were not respected because she lived in New York where aid in dying was not legal. At 47, she was diagnosed with breast cancer and underwent standard treatment with chemo, radiation and surgery. Her cancer recurred eight years later. She did chemo again this time with more side effects, fatigue, nerve pain, debilitating swelling. The cancer did not respond to chemotherapy. She went for a second opinion, but the options were always the same; keep trying different chemotherapy agents until they either don’t work or the side effects become intolerable. She was suffering enormously and there was no treatment that could prolong her life. Things went on like that for about two years. She then developed severe vertigo and nausea and I rushed home to be with her.

It was clear from the evaluation by her primary doctor who came to our home that she had developed brain metastases. She was prescribed steroids to decrease the symptoms and those helped for a period of days. Her suffering again became intolerable and could not continue. With the assistance of her primary care doctor, a hospice and nurse service, and a palliative care doctor, she was started on a continuous infusion of opioids and benzodiazepine. She was comfortable and shortly unconscious. She told me she loved me for the last time on august 20th and died on august 26th and respectfully ask each of you to think about how much you would have to be suffering to tell your children you would rather be dead than spend one more day with them and the suffering of each stage along the process.
considering aid in dying might cause a person and then with all that suffering to not have that option available.

I don’t know if it would have made a difference in my mother’s death if aid in dying had been available to her after she requested it multiple times, but even if her death were not, her psychological suffering would have been eased tremendously in the months and even years leading up to her death had she known the option was legally available. She could have planned her death the way she planned her life, to be private and dignified. And as a physician, I took an oath to first do no harm and harm was done to my mother by withholding this humane treatment and I don’t want the same for my patients.

REP. STEINBERG (136TH): I’m going to have to ask you -- it looks like you’re ready. Doctor, thank you for your personal story and I think as a physician, you’re honoring her memory in that sense. Thank you for your story. Are there questions or comments from members of the committee? If not, thank you for being here today.

SHARON OSTFELD-JOHNS: I would be happy to answer questions about the cause of death on the certificate or about nurse practitioners and PAs being involved if those questions are still out there.

REP. STEINBERG (136TH): All right. What would be your comment with regard to the death certificate?

SHARON OSTFELD-JOHNS: So on the Connecticut death certificate, there are three slots associated with this, A, the immediate cause, B, due to or the
consequence of, and then further list to or as a consequence of. It would be highly unusual in any death related to, for example, a metastatic cancer, for that to be listed as A, the immediate cause. The immediate cause is, you know, you could say in every case it’s cardiopulmonary arrest that would be an acceptable answer for the immediate cause of death in any case, so it’s always adding complexity and further explaining what’s going on by adding those due to or a consequence of. In the section of the law that states this, it says underlying terminal illness as a cause of death and as I said, it would be unusual for the immediate cause to be listed as metastatic cancer whatever would be the circumstances leading up the death if that were the underlying cause.

REP. STEINBERG (136TH): Thank you for that distinction. We appreciate. Any other comments or questions? If not, thank you for taking the time to testify today.

SHARON OSTFELD-JOHNS: Thank you.

REP. STEINBERG (136TH): Next is Lorraine Zuwallack.

LORAINE ZUWALLACK: Good afternoon, members of the committee. Thank you for your fortitude in this difficult, difficult hearing. I’m a nurse’s specialty certification practice nursing and I am testifying in opposition to this bill. I was a hospice nurse in a very large home hospice program and in ten years, just in my experience, I’m not extrapolating to the rest of the state, but in our experience with hundreds of patients, no patient ever asked to hasten their death and they had an opportunity to take an overdose because when they were on large doses of narcotics, when they filled
those prescriptions that bottle of narcotics came in, they could have taken the whole bottle or taken the whole box of Fentanyl, put the patches on themselves, they could have attempted to kill themselves.

I’m just here to say that nobody ever tried that and we offered very, very good pain control in our hospice organization and also very good symptom control and psychological support and I believe that is what contributed to the patients just having a peaceful, dignified death and not asking to hasten their death and I would just like to read two ethical statements on ethics being a nurse; the American Nurses Association position statement on physician-assisted suicide prohibits nurse participation in assisted suicide and euthanasia because “nurses may not act with the sole intent of ending a patient's life, even though such action may be motivated by compassion, respect for patient autonomy, and quality of life considerations.”

This also goes for the states that have physician-assisted suicide. Nurses are still prohibited from participating. The other statement I would like to read, the American Medical Association House of Delegates spent the past two years examining all aspects of the issue of physician-assisted suicide. At the end of the lengthy and thorough process, in June 2018, they reaffirmed their position on physician-assisted suicide; “it is understandable, though tragic, that some patients in extreme duress such as those suffering from a terminal, painful, debilitating illness may come to decide that death is preferable to life, however, permitting physicians to engage in assisted suicide would ultimately cause more harm than good. Physician-
assisted suicide is fundamentally incompatible with the physicians’ role as healer would be difficult or impossible to control and would pose serious societal risks.”

And I also, just -- I know I’m buzzed, but there’s so many misconceptions about the use of morphine and I heard some of them flying around the room today as in the past and, you know, the people who should be addressing the issue of what morphine does to people is people that are actually medical professionals that work in the profession and actually deal with patients that are receiving it and the one other quick thing, I don’t know if you know that the death certificate in a home death in hospice, the nurse signs that death certificate and pronounces the patient dead and I, for one, would never want my name on a falsified death certificate because as the previous speaker said, there are three places on the death certificate and if this physician-assisted suicide takes place, the cause of death is an intentional overdose of narcotics and that should be on the death certificate in my opinion and Dr. Petit, I worked in home care years ago and took care of your patients in Bristol and you were great. Thank you.

REP. STEINBERG (136TH): That’s a great way to end testimony. Any questions or comments? If not, thank you.

LORRAINE ZUWALLACK: Thank you.

REP. STEINBERG (136TH): Next is Tracy Wodatch.

TRACY WODATCH: Good afternoon/early evening, Senator Abrams, Representative Steinberg, the Public Health Committee. A lot has been said already. My name is
Tracy Wodatch. I’m the vice-president of clinical and regulatory services for the Connecticut Association for Healthcare at Home. We are the association that represents the hospice providers within this state. We have 30 hospice agencies throughout Connecticut; 25 of them are members of our association, so I do feel as though I’m speaking with a united voice when I say that none of them support this bill.

We are the twixt in between at this point between the opposition and the neutrality, but we’re right about even, so we certainly have an obvious stance that we don’t support it. One thing that we do all support is that we all have a commitment to the hospice philosophy. We cherish life until its natural end and we really reinforce dignity and quality and comfort. Susan Adams did a nice job defining the difference between hospice and palliative care, so please note that. It’s in my testimony. The description of palliative care within the bill is incorrect. It describes hospice care, so if this bill were to move forward, it needs to be corrected and hospice really should be defined because it is something that we do want promoted.

Dr. Petit spoke several times today about our ranking in Connecticut and the fact that we are, indeed, second to last in the country in median length of stay. It translates into last minute hospice care, so that is something we could do much better, things that we’ve been working hard on, but we do get our patient referrals last minute and it’s very hard to provide really good care in that regard. One thing that hospice care does that this bill would not do is we provide grief and bereavement support for up to a year after the death
of the patient. We provide the support to the family and the loved ones and that is something that is so important to help the family deal with the death afterwards.

Things that we can also do much better on, we’ve been working throughout the state in collaborative nature with the several of the stakeholders from other associations. Earlier conversations, earlier referrals, the most document medical orders for life-sustaining treatment, developing standards of practice for palliative care, which is being done by the Department of Public Health’s Palliative Care Advisory Council and we’ve created new standard hospice training for all of our nursing homes throughout the state that offer hospice care. One thing that I do want to make note of in my testimony is I have several areas in my testimony that highlight problems with this bill if this bill were to go forward. We talked about the death certificate and indeed, I’m an RN, I’ve pronounced people before. I’ve signed that death certificate. I never put the reason, the physician puts the reason, so that is a problem that I would be signing something that would later be completed and it would not state something that I would want it to state.

I talked about the definition of hospice and palliative, please fix that, definition of self-administered just talks about ingesting the med. The person needs to actually be able to gather the medication and take it themselves. It should not be prepared by other people. It should be an independent act by that person. Determining prognosis, we need to have better tools built within the bill so that they can -- the physicians know what they’re deeming as prognosis. Competency, we
have a tremendous problem in this country with underdiagnosed depression. I’d like to see something in the bill about standard depression assessment tools. Attending physician is the primary responsibility of the person’s care. Many of these people may have to shop around for physicians willing to do this, so --

REP. STEINBERG (136TH): Tracy, I’m going to have to ask you to summarize, please.

TRACY WODATCH: Yeah, I will. Opioid crisis is one thing please note. If there are leftover meds, who is going to destroy them? We need to make sure we take care of that. The last thing that I think is probably more important than anything is there’s nothing in this bill about collecting data. You’ve heard a lot about data from Oregon, a lot about Washington. There’s some data from California. We have nothing to collect data. How are we going to oversee and protect what the plan is and how we’re -- how we’re doing. Please, as Laura Borrelli said and Susan, ask us to give input for anything that you move forward if you change anything else in the bill and if you’re developing policy and education. Thank you.

REP. STEINBERG (136TH): Well, thank you for that. We’re going to look at your testimony very carefully and we’ll take you up on your offer to remain engaged as we try to improve this bill to the point where more people are comfortable with it. Are there questions or comments? Representative Petit.

REP. PETIT (22ND): Just a comment, thank you for that testimony. That’s helpful and I would suggest -- your organization is in a good position, actually, to look at that data as to whether it is
the physician/provider community who delays or whether it’s resistance from patients or some combination of both. Certainly, I’m sure you’ve had the conversation with people when you say you’ll be able to have more services provided with this change in definition. Often the response softens when people hear hospice that they don’t want to hear and often are quite resistant, so -- and I’m sure you deal with that.

TRACY WODATCH: Yeah, people think hospice is eminent death and unfortunately we’ve promoted that with the last minute care and referrals.

REP. PETIT (22ND): And I think your point about leftover meds is well taken, which we talked about in the last session. Thank you, Mr. Chair.

TRACY WODATCH: May I answer the question that Representative Candelora had asked several times about whether anybody could be in the home with the person while they’re taking the medication? So this is something that I’ve asked many of the other state execs about in Oregon, Washington, California and it really would be part of policy development and individual to each agency whether it’s something that they promote or don’t promote. They certainly cannot participate in any assistance of taking the medication, helping them take the medication, but some agencies have agreed that they would, if they know about it, sometimes you don’t even know it’s going to happen, if they know about that they would sit with the person. Others, it’s not within their policy and it’s certainly their right not to want to be part of it, especially if they oppose it and it’s not part of their beliefs, so it could be, it may not be. I think it’s individual to each agency and
whatever their policies end up being based on whatever happens with this bill.

REP. STEINBERG (136TH): Thank you for that. Representative Candelora.

REP. CANDELORA (86TH): Thank you, Mr. Chair, because you brought it up now, I mean, that is something that I struggle with in this bill and maybe going forward, we could continue this conversation, but, you know, we’re trying to afford protections in making sure there’s not abuse and, you know, it’s being used appropriately, but I feel like there -- it’s very scripted and rigid in its application, so to your point, there’s not necessarily the recommendation for hospice care. It’s giving a choice, but it’s sort of -- it reads as if it’s pushing a choice and then for the doctor in the bill as it’s written, you should be taking it not in public and with somebody else present. To me, I just get concerned we’re potentially going in the opposite direction of where hospice care should be. Is that -- Do you have that concern?

TRACY WODATCH: I have a lot of concerns about the bill and I think unfortunately because it’s such a controversial issue that it can’t be forced on anybody. Obviously it’s the prerogative of the physician if it passes whether that physician wants to participate in it or not. It’s the prerogative of the person if they want to ask for it, so it should be the prerogative of all of the people involved in that person’s care whether they want to sit with the person if they’re going to be intentionally killing themselves.
REP. CANDELORA (86TH): Yeah, and I just feel like if somebody’s in that position, we should be making sure that they’re given all their options.

TRACY WODATCH: Definitely. Early conversations are key to make sure that people understand what their options are before they think that this is the answer.

REP. CANDELORA (86TH): Thank you.

REP. STEINBERG (136TH): Thank you. Any other questions or comments? If not, thank you for your testimony.

TRACY WODATCH: Thank you.

REP. STEINBERG (136TH): Next is Jean Rexford.

JEAN REXFORD: Good afternoon, Senator Abrams and Representative Steinberg and distinguished members of the Public Health Committee. I’m here today in strong support of House Bill 5898. According to a 2017 Kaiser Foundation study, seven in ten Americans want to die at home and I am one of them. The word that comes to my mind is dignity. I want to die the way I have lived with my children and my grandchildren as an integral part of my life and then should they wish of my death. Advanced medicine with ventilators, dialysis, defibrillators, feeding tubes has become the norm, but I do not believe that that is for me.

The quality of my life is not about living it longer, but about living it well. If I am unable to participate and I have a terminal illness, I would like to die before my family and I have to suffer through those final days and weeks. I was with both my parents when they died, I’ve been with friends
when they died, we have all seen suffering, but we know that there can be a peacefulness and a dignity to the end of our lives and I want that for myself and for my family. Thank you.

REP. STEINBERG (136TH): Thank you for your poignant and succinct testimony, right on time. Are there questions or comments? If not, thank you for your patience today and we really appreciate your testimony.

JEAN REXFORD: Thank you.

REP. STEINBERG (136TH): Next is Sister Catherine Mary Clarke.

CATHERINE MARY CLARKE: Good afternoon, Senator Abrams, Representative Steinberg, hello. You don’t have my testimony, in part because -- and I’m sorry for that, in part because I literally was with patients who were dying and at any rate, I think I would want to speak from my heart because listening to the testimony today, to be honest, I feel like, you know, I don’t really think I’m going to be able to convince you of anything unless you were willing to shadow me for the next couple of months going to the patients that we go to. Being one that works in conjunction with the nurses and doctors to address issues of physical pain and suffering, which of course is very real and very much a part of the decline in the process, I work with the emotional, psychological, and spiritual dimension and I -- what I wish more than anything that I could convey to you, the profundity of the experiences that these people are having in their dying process, in their natural dying process, in a way that plain and simply could never be planned or anticipated.
What comes to the fore as one is declining in a natural process, we cannot determine that within ourselves. It is in our very being, our life experiences, our relationships, and there’s a lot of healing that needs to be done. There’s a lot of work that needs to be done in the dying process and nature allows us that process. Needless to say, I believe God enters into the -- into the equation here, but even for those who don’t believe in God, with whom I have also worked and had very profound experiences, nature has a way of providing opportunity for people to work through what they need to work through and for relationships to be healed.

I have seen the most extraordinary experiences of intimacy, of relationships being -- coming to the fore in a way that people really have needed in their preparation for dying so they can die in peace. So of course I am here to speak in opposition to the bill, so thank you.

REP. STEINBERG (136TH): Thank you for your testimony. Senator.

SEN. ABRAMS (13TH): Hello, Sister. As I said before, I’m from Meriden and I know the good work that you do, so thank you very much.

CATHERINE MARY CLARKE: You’re welcome.

SEN. ABRAMS (13TH): I would like to share though, because I want to make it clear again that I very much value and honor the work that you do in hospice and that all hospice care provides. There was a testimony that was submitted from Ann Jackson who is the former Oregon hospice director who originally opposed, you know, the same kind of legislation, but
later came to a different understanding and I’ll quote, “I now believe that it was cavalier of me to even consider that hospice and palliative care professionals could indeed meet all the needs of people who were dying or that some needs, such as the need to control one’s own life and death, were unworthy needs”, so I just am sharing that because that’s -- again, I believe that people should have the choice and I believe that, you know, what you’re describing can also be experienced by someone who chooses aid in dying because I do believe there is a process that one goes through to say their good-byes so to speak or, you know, move through that and that can still be accomplished either way, but I do -- I don’t want to ever come off as somehow diminishing the work that hospice does and that palliative care provides and I appreciate that people have options. Thank you.

CATHERINE MARY CLARKE: May I respond?

SEN. ABRAMS (13TH): Absolutely, thank you.

CATHERINE MARY CLARKE: I think I failed to say that I’m the clinical social worker, spiritual care coordinator, and bereavement coordinator for Franciscan Home Care and Hospice Care and I say that because it really is all of those dimensions that I’m addressing and of course we do believe in choice. You know, there’s a choice and we support choice, of course we support choice, but the choice is to choose to let go of -- you know, vulnerability doesn’t take away our dignity. Our dignity is intrinsic to our being. Nothing can take away the dignity that we believe we are given by virtue of being created, so vulnerability doesn’t make us less dignified, so dying can be a dignified process no
matter what. It’s the person does not lose dignity even when they are really suffering at the last breath that they take.

But what we hope, what hospice hopes to convey is that the choice to allow nature to take its course, and that’s one point, actually, that I wanted to make was that it is almost always right at that point when somebody says I don’t want to do this anymore, either a family member or a patient, where that most profound moment of fear or of angst of some interior kind, that emotional struggle to let go and die and I think it’s at that moment we’re all talking about. Of course, you know, we have deepest sympathy for those who have experienced such suffering in their dying process, but it really is at that moment, that’s often a turning point that someone can say, you know, with the proper hospice care and facilitation, once can get in touch with things they didn’t even know were there and bothering them.

I won’t start here and now, but I could tell you the things that people have shared with me they have never shared with anyone and they were so much more peaceful I doing that and sometimes needed to talk things out with family members. So again, that’s why we support the natural process.

SEN. ABRAMS (13TH): Thank you, Sister.

CATHERINE MARY CLARKE: You’re welcome, thank you.

REP. STEINBERG (136TH): Next is Cary Shaw.

CARY SHAW: Hi, my name is Cary Shaw. I’m from Norwalk, Connecticut. I intended to talk to you and contrast the experience with my dog and the experience with my father. In the interest of time,
I’ll start with the father. We loved my dad. He was the stalwart of the family, caring, helping, using his skills in diverse areas from carpentry to medicine, taking care of us emotionally, listening to our problems, helping. Getting into his 90’s, he -- my father lost the use of his legs, so you could call him a disabled wheelchair person. No one ever suggested he should die because he was in a wheelchair. I’ve never heard of anybody suggesting that. He was beginning to lose his cognitive abilities. He told us many, many times that when it came to close to the end of life and being nonfunctional, that was not the joy he looked for in his life and he wanted to make sure that his sons, including me, knew that he wanted a peaceful early termination of his life.

So it was pretty clear what he wanted. Every day, in addition, he became bedridden. Gangrene was creeping us his leg. It was being treated every day to make it as slow as possible. He was very, very clear that he was on his way out and there was no doubt about it, so on the advice of doctors, hospice was called, so he was on hospice care, receiving palliative medicine. He aspirated and died. Do you know what that means, aspirated and died? It means that while he was being fed food, it went down the wrong pipe and he violently choked to death on his food. That’s the way he died. My guilt is I take action to help him die peacefully in the way he wanted. I let him die the natural death of pain and suffering, gasping for breath, and choking to death and I’m hoping that I won’t die that way and we can prevent that from happening to other people.

Thanks.
REP. STEINBERG (136TH): Thank you. Certainly that is something to think about. Are there comments or questions? If not, thank you for your testimony and for our story. Next is Bill O’Brien.

BILL O’BRIEN: Good evening, members of the Public Health Committee. My name is Bill O’Brien. I am a vice president of the Connecticut Right to Life and I’m speaking about H.B. 5898 in opposition. You have my written testimony, however, I want to get to that, but I want to hit a couple things first, if can, if I have time. One previous speaker mentioned about who decides being the principle and I’m glad she brought that up because we talked about compassion. You certainly have to have compassion. My father died from lung cancer in three months about 20 years ago. You know, I’m sure we’ve gone through similar things, but she framed it as who decides. I would say it’s not -- that’s not the key issue. The key issue is, is self-killing or any killing other than in self-defense or in defense of country an option and I would say no and that’s a key point I think.

I don’t see any other exceptions. I want to bring up what happened in Germany because I think that’s the elephant in the room when we talk about the slippery slope in the 20’s, 30’s, and 40’s and there was a bill, well, actually a program called the euthanasia program and I know this is not about euthanasia, it’s about aid in dying, but there were some similarities. One of them, we talked about safeguards. You have to have two physicians sign off on it. There you have to have three physicians sign off on it. When it came to the death certificate, here they say the underlying cause, there doctors injected a toxin to kill, again it’s
euthanasia, injected a toxin to kill, but the death certificate said they died from something else such as pneumonia or appendicitis.

So they had some similarities. They had other safeguards in it, but those safeguards quickly fell apart, just like in Canada. Their bill just about - - went into law just a couple of years ago. Within a year, they were talking about including children in that program. It looks like I won’t get to the written part, but in just in summary, you know, again the safeguards, you know, they fall apart very quickly. When the Living Will bill was here, I’ve been up here for over 40 years, I was here when the Living Will bill was passed and within a year, that was challenged in court and the court made a major change in that bill and I, you know, no bill comes up here and doesn’t get changed, so, you know, we have to watch out what we’re doing and again, that principle, I think is extremely important because after, we all know what happened in Germany, American military, they held trials, the doctors’ trials and --

REP. STEINBERG (136TH): I’ll ask you to summarize, sir.

BILL O’BRIEN: Right -- and they found crimes against humanity on behalf of those doctors that participated in that program. The program was by the doctors. It was signed by Hitler. Hitler actually rescinded the program because it was getting out of control after 70,000 were killed.

REP. STEINBERG (136TH): I think we’re getting off the theme here a little bit. Are there any comments or questions? Thank you for your testimony. Bonnell Lombardi, please.
BONNELL LOMBARDI: Good afternoon. I’m Bonnell Lombardi from Washington, Connecticut, and testifying in support of House Bill 5898, the one and only bill before this committee. I am testifying on behalf of my deceased wife, Rosemarie Lombardi, who had an extraordinary life that was ruined by an unspeakably horrible death from pancreatic cancer. Despite the visiting nurses best hospice care efforts, they were not able to consistently control both the pain and the nausea that came with the pancreatic cancer and when the morphine was able to dull her pain and nausea, Rosemarie kept repeating over, over, and over again how horrible her morphine drugged state was, but probably worst of all was the despair when as her pain and her nausea became worse, she realized that she could not get doctor aid in dying if her suffering became intolerable.

No one should have to die like Rosemarie did without the option of doctor assisted end of life. I would like to call those honored here and say or point out or reemphasize what I view as the seeming lack of standing of so many of the opponents of this bill. If this bill is enacted, nothing will -- they will not be called upon to do anything or not do anything. Now in a court of law, if there is a lawsuit, their claims will not be heard unless the claimant is personally affected by the alleged wrong. It seems to me that most of the opponents lack standing and their objection should be disregarded or given little weight.

So I would call upon the committee at this time please, please show your compassion, show your courage, put aside what would be parochial politics and vote into law House Bill 5898 and thank you.
REP. STEINBERG (136TH): Thank you. In this public hearing, we do not take standing and do a count per se. Everybody has the right to express their opinion. We’re all stakeholders in one fashion or another, but thank you for your point of view. Any questions or comments? If not, thank you. Next up is Susanna Bennett.

SUSANNA BENNETT: Good evening. Thank you for hearing my testimony. I did submit my testimony by email and just want to go a little bit -- adjust it based on some things that have been said today. I’m here in opposition to H.B. 5898 and I am opposed to it fundamentally on principle and so I just want to address a little bit of the slippery slope issue that is sometimes dismissed. So sometimes there’s a proposal that comes through for us that gets a lot of pushback initially and later is accepted by popular consent or by law and so I see that as a part of the point that we need to look at today, that we refer to now accepted practices as our comparison for what we’re going to accept in current legislation and so what we accept now sets the standard that we are going to refer to in the future.

So we have incremental acceptance of ideas, whether they’re good ideas or bad, and unfortunately we live in a society today that determines morality on that basis. It compares to what is currently accepted and makes decisions based on that rather than against an unmoving standard. So when disability advocates express concerns about the bill or when people are talking about euthanasia in Germany, it can be a little unsettling because that’s an island far off the coast that we’re talking about, but based on incremental comparative morality, that’s
how we get to that island and so that’s my concern and also just based on principle that God is the giver of life and that it is a precious thing that we need to defend and protect. Thank you.

REP. STEINBERG (136TH): Thank you for your testimony. Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Mr. Chair. Welcome. It’s always nice to see you and your family up here and I know you all come up a lot and articulate your beliefs and what you stand for and that is greatly respected and so I thank you for coming up today.

SUSANNA BENNETT: Thank you.

REP. STEINBERG (136TH): Thank you, Representative. Any other questions or comments? If not, thank you. Next up is Lydia Bennett. Maybe there is a family thing going on here.

LYDIA BENNETT: Members of the Public Health Committee, my name is Lydia Bennett. I am here in strong opposition to H.B. 5898. Those who support this bill want us to celebrate the supposed dignity and free choice it provides. Why then do we not celebrate the free choice of a soldier who commits suicide? Should we celebrate the supposed dignified choice of the teen so overwhelmed by bullying, broken family life, or self-hatred that he or she chooses to kill himself? Most suicide cases are brought on by a mental frame of reference or way of looking at the circumstances in one’s life which brings a person to the point of no hope.

Obviously a terminal illness is a difficult challenge for all parties involved, but we have seen time and again that when someone has hope, it greatly improves their situation. We remember the
great Proverb that says a cheerful heart do us good like a medicine. When we talk about dignity, we are referring not only to how a person views oneself, but how other view them. In our society, suicide carries a stigma. The proponents of the aid in dying legislation in this country are trying to create a new category of suicide substituting soft language to circumvent the stigma. The only problem is that dignity, which means worthy of honor, and being treated with respect has now come to mean little more than fully affirming one’s lifestyle choices.

People tell us that those who choose aid in dying are dying with dignity and we should respect their decision, but this is a smoke screen and not a very good one. The reality is that no one needs a physician’s aid in dying. They don’t need a special prescription. They can ingest easily accessible meds without all this fanfare. People are already choosing to die by using pills, so what’s the difference between these people and the qualified patients in this bill? The difference is that right now, we all agree that such deaths are not dignities, they are tragedies. This bill would change that. Instead of rightfully identifying the person’s choice to die as a tragedy, the choice to die becomes a good thing.

No matter what soft language we try to use, anyone who chooses to end their life chooses tragedy. We should mourn that decision and do everything we can to prevent it. Please oppose H.B. 5898.

REP. STEINBERG (136TH): Thank you for your testimony. I do not believe I have heard anybody use the word celebrate in context with this bill
today, so I’m going to differ with you on that point. Are there -- Yes, Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Mr. Chair. Thank you for coming up and as I said to your sister, you all are always up here on the controversial issues, not the easy ones. You all are always up here for those, so thank you for coming up and sharing how you feel and always with us.

LYDIA BENNETT: Thank you.

REP. STEINBERG (136TH): Thank you, Representative. Are there other questions or comments? If not, thank you for your testimony. And now we move on to Julianna Bennett.

JULIANNA BENNETT: Good evening, members of the Public Health Committee. I am Julianna Bennett and I am obviously here in strong opposition to H.B. 5898. Words seem cheap in today’s world, but they still hold weight and I urge you to be objective and honest in examining some of the wording in the bill. A patient may self-administer medication to bring about his or her death, to cause death. The definition of suicide is to kill oneself on purpose, to cause one’s death. An objective look at the wording must conclude that the bill is describing suicide, but the bill later says that prescribing meds for this purpose shall not constitute assisting suicide. By the bill’s own definition, this is inconsistent and dishonest. This bill describes self-administration of meds as causing death, but then it instructs physicians to list the cause of death as the underlying terminal illness. This too, by the bill’s own definition, is inconsistent and dishonest.
So why the dishonesty, why fudge things? It’s because words do matter. Suicide troubles our conscience, as it should, but helping people is something we all strive to do. A Gallup poll in 2013 showed that 70 percent of Americans agreed that doctors should be allowed to painlessly end a patient’s life if the patient and family wanted it, but only 51 percent in the same poll supported physician assisted suicide, a 19-point difference based on a change in wording and that’s huge. We all know that life is precious. We are reminded of that daily. When we encounter death, everything in us wants to resist, to fight, to protect life. This bill tries to artificially soothe our troubled consciences, but it can’t do so honestly or rationally. When we are honest, when we are rational, we know that death is wrong, and choosing death should never be encouraged. I ask you to please reject H.B. 5898. Thank you.

REP. STEINBERG (136TH): Representative Zupkus. Thank you, Mr. Chair. Thank you for coming up. Again, it’s always nice to see you and I appreciate your advocacy and always coming up and sharing your feelings with your siblings and your family. It’s always nice to see you. Thank you.

REP. STEINBERG (136TH): I hope you all drove up together to save on gas?

JULIANNA BENNETT: Yes, we did.

REP. STEINBERG (136TH): Any other comments or questions? Again, thank you for testimony. Next is Nancy Elliott.

NANCY ELLIOTT: Good evening, committee members, and thank you for staying so late and listening to us.
My name is Nancy Elliott. I’m a former three-term state representative from New Hampshire and I’m currently the chair of Euthanasia Prevention Coalition USA is the title, so I’m against this bill. Proponents say that this is entirely voluntary and, you know, we’ve heard it from a few people. Well, some may think that they’ve chose this, how many others are actually steered? Steered is the elephant in the room. I was at a hearing a couple years back in Massachusetts where I doctor got up and he stated he was for the bill, for the assisted suicide, and he went on to state his reasons why and then at the end, he said he felt that it was the responsibility for a good doctor to guide people to make the right choice. I don’t think he meant to say that, I think that was a slip, but is there doubt that this pro-suicide doctor would try to persuade his patients to follow his wishes concerning their assisted suicide.

They would so oh, that doesn’t happen, but one woman, Catherine Judson in Oregon where it’s legal, took her husband to the doctors, he was very ill, and she was in the room. She just kind of -- just kind of, you know, half listened. She was exhausted and her ears picked up when she heard the doctor pitching assisted suicide to her husband as think how this will help, you know, make it easier for your wife. She was so upset with that she got her husband out of there and he went on to live for another five years. That’s abuse to pitched with it.

I had -- My husband was terminally ill and we went to a lot of doctors’ appointments. If a doctor had suggested to him that maybe he’d want assistant suicide, that would have devastated him and that’s
abusive to put people through that. I just want to say just one more thing about my mother. My mother is currently in a nursing home and they had us in the routine meetings and they pressured her to sign a do not resuscitate and both her and my sister said no, we don’t want that, and they just kept bringing up reasons. When we finally got off that subject, they said well, we’re going to bring that up every three months and so when assisted suicide becomes on the table, is this what they will be doing in nursing homes where it’s very hard, people are somewhat isolated, will they be asking them repeatedly do you want assisted suicide, do you want it, and for those reasons, I would ask you to reject this.

REP. STEINBERG (136TH): questions or comments? If not, thank you for your testimony. Next is Margaret Dore.

MARGARET DORE: For the record, my name is Margaret Dore and I’m an attorney from Washington State where assisted suicide is legal. In the fine print, our law also allows euthanasia and in the fine print, your bill allows euthanasia. If I get time, I will tell you exactly why. Okay, first of all, it’s been a little frustrating to me hearing today about all the hospice testimony for all these people who are near death. Your bill, our bill, is much broader than that. This is my friend, Jeanette Hall, who was talked out of assisted suicide in Oregon 18 years ago. Okay, that’s because, as explained by a couple of the doctors, the six months to live is determined without treatment, so without treatment, she had cancer that was going to kill her probably in about six months, but the doctor frankly twisted her arm and got her to agree to treatment and anyway
I was going to give this flyer, but your system wouldn’t take it.

Also, diabetes, insulin-dependent diabetes is a terminal illness. It’s listed in the Oregon report. It’s attached to my -- I have a memo. I call it a page A-44 in the appendix. You can see that diabetes is listed as a terminal disease in Oregon, so the significance of that is that -- I’ve got an affidavit from an Oregon doctor, Dr. Tossler, that an insulin-dependent diabetic will live no more than a month without insulin so they are therefore terminal, so if any of you have chronic conditions, you may be voting to have yourself labeled terminal. Does that make you feel safe?

Okay, so then the bill’s medication to the individual, with the most obvious problem being the complete lack of oversight of the death. Two people can be there, one leaves alive, one leaves dead. The one that leaves alive inherits from the one that leaves dead. How much do you trust your family, I mean, shoot. I’m a probate lawyer. I’ve seen everything.

And then I wanted to talk about the death certificate. So the significance of the falsification of the death certificate to list the terminal illness is that is the cause of death as a matter of law. It’s not like with a normal death certificate where you might put down one cause of death and later it turns out maybe it was a murder or you wrote it down as a murder and then later you figured out it was a suicide, you can change it, but because the cause of death was a matter of law is a terminally illness. If it later turns out it was a murder for the money, too bad. The heirs still get
to inherent, so say dad signs -- dad gets a bad diagnosis, terminal illness, and his son’s back in his life and comes back and things are going okay.

And then the son says well, I hate to see you suffer, why don’t you sign up just in case and you let everybody else go over, so I’m just going to finish this. So just in case things get back, okay, so then dad goes to the doctor again, gets a surprisingly good result, like maybe he’s not going to die after all, so then the son is like oh, gee, Dad, oh, that’s great, well, let’s drink to that. One, two, three, four, five, I’ve got a special drink for you now. Put it all in bottoms up, dad dies, the death certificate is a terminal illness as a matter of law, and son gets the house. It’s a perfect crime and that’s what you’re passing.

REP. STEINBERG (136TH): Questions or comments. Representative Candelora.

REP. CANDELORA (86TH): Thank you for your testimony on the death certificate. So in a situation where -- current law where there’s an untimely death that looks suspicious, is there a delay then on cause of death until the State’s Attorney’s Office reviews it?

MARGARET DORE: I don't know, but they can change it. When you -- It’s not infallible. It’s not set into law.

REP. CANDELORA (86TH): I see, so under this -- the way this is currently written, we are establishing under law and therefore --

MARGARET DORE: It can’t be changed. So there can be an investigation. Oregon, we had a case where a guy called me and said that he’d been told that his
dad had died in the second of two suicide parties. It had been a voluntary sign-up, I only know about voluntary sign-ups, but voluntary sign-up. Anyway, he was told that his dad refused the first night and said I’m going to bed, you’re not killing me, everybody laughed, and then the next day they got a call from the wife, oh, he’s ready to do it now and when they got there, the guy was drunk, bottoms up, that didn’t sound very voluntary, and then as a probate lawyer whose also done family law, I couldn’t help but notice that the wife was 20 years younger, so if she divorced him, he would have gotten the house. This way, she got everything.

REP. CANDELORA (86TH): And then you speak to the terminal illness piece, which is somebody, you know, is withheld insulin, they do become terminal within six months. The response would be well, it’s still that person’s choice, so why should we worry about that?

MARGARET DORE: Well, I don’t know, I wouldn’t want to have a condition that I’m labeled terminal for. If you were an insulin-dependent diabetic, do you want, after this law is passed, are you going to want to be considered terminal? People could treat you differently. And also it might not be their choice. And again, everybody I’ve ever talked to has signed up voluntarily. It’s just that later, things get dicey or it can tear the families apart. So the first time I got contacted by someone, it was the daughter and her dad and the dad’s girlfriend had all been at the doctor and then the doctor said it’s brain cancer. Do you want to be treated?

Dad said no and then he said do you want to die now and dad was like well, no, and then some time after
that conversation, he signed up for the legal dose, and then after that, one side of the family and the girlfriend thought it would be really great to have a suicide party, the daughter was aghast, and he spent the last three months of his life torn over whether or not he should kill himself. The daughter couldn’t talk to me about it afterwards she was so traumatized and then the guy with the two suicide parties, his son too --

In my materials, I’ve got a study from Switzerland. They interviewed the people what went -- Do you know what Dignitas is? It’s a suicide clinic in Switzerland and foreigners go there, so people from out of the country go there. And so they interviewed like the trusted friend like a year, year and a half out, and they found that one out of five were pretty traumatized by being there. So it’s not as simple as it sounds. You know, I’m not saying this never works.

REP. CANDELORA (86TH): Right.

MARGARET DORE: Okay? I’m just saying that once you open it up -- and then the other thing is, I didn’t have -- Well, I’m going to try to give it to you tomorrow or the next day, I’ve got a -- we did with the two suicide party guy, we got -- we had a cop go in and I’ve got materials that talk about how even the cop could not get information from the State of Oregon and the cop ended up going to Compassion and Choices and they maintain the records, in other words, it’s kind of privatized, the whole system, so the state -- and also you can’t do your own study as the state because what happens is the death certificate will have the accurate name of the
patient, when they died, but it won’t say they died from assisted suicide or euthanasia, okay?

And then over here -- so that’s the death certificate and then the State of Oregon, they keep statistics for their annual reports, but they don’t write the names down. They don’t even write the names down when they’re doing the report and so over here, you’ve got the name with the death certificate, but no accurate cause of death and over here, you’ve got an accurate cause of death, but you can’t link it to anyone, so you can’t later, you know, do a study like go talk to the family members, how is this working, you can’t do that. That’s a problem.

REP. CANDELORA (86TH): Are there other bills out there that have data, you know, a data piece to it?

MARGARET DORE: They’re all the same, they’re all like Oregon and Washington, so you’d have to make it that they write the names down and that they -- so I’m going to try and get that for you guys tomorrow or the next day and then I’m probably leaving. That’s my tentative schedule right now.

REP. CANDELORA (86TH): Thank you. I appreciate that.

REP. STEINBERG (136TH): Any other questions or comments? If not, thank you for your testimony. Next up is Evangeline Bartz.

MARGARET DORE: Okay, one last thing. Okay. All the safeguards are not enforceable because of the accordance language. It’s in my materials.

REP. STEINBERG (136TH): Thank you. Evangeline Bartz, please.
EVANGELINE BARTZ: Good afternoon, Chairs and members of the committee. I’m Evangeline Bartz from Americans United For Life, a national law and policy nonprofit organization that advocates for legal protection of human life. Thank you for the opportunity to speak today against H.B. 5898, which would legalize physician-assisted suicide. Currently, the overwhelming majority of states, at least 39 states, affirmatively prohibit assisted suicide and impose criminal penalties on anyone who helps another person end his or her life. And since Oregon first legalized the practice in 1996, about 200 assisted suicide bills have failed in more than half of the states. And just in the past week or so, New Mexico and Arkansas have tabled bills to allow assisted suicide and on the other side, there’s been a passage of more protections recently and about a half a dozen states that have passed or strengthened laws against assisted suicide, including criminal penalties.

So the broad consensus then among the states against legalizing the medical profession’s participation in patient suicide presents the question then, is this overwhelming consensus, does it reflect a lack of compassion towards those who are given a prognosis, which sometimes is unreliable, of only six months to live? Well, say prohibition on assisted suicide actually reflect and reinforce the well supported policy articulated by the United States Supreme Court in Washington versus Glucksberg, namely and I quote “the lives the terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy. These lives deserve equal protection under the law.” The court further found in that opinion that there exists for the state an
unqualified interest in the preservation of human life in preventing suicide and in studying, identifying, and treating its causes.

So at a time in our country where millions of dollars are being spent to prevent suicide, we are now are entering into consideration, and by the way, that’s considered now the tenth leading cause of death, suicide, we’re now considering targeting a group of people, citizens, and actually getting involved in facilitating their suicides. It’s critical for states to protect vulnerable people, including the elderly, the terminally ill, and others such as disabled groups from abuse, neglect, and coercion. Safeguards do not always work and even speaking with regard to the bill before us on that section we’ve talked about or heard about this afternoon, Section 8, the requirement that if the physician, attending physician or referring physician, believes there might be a mental health problem, then there’s that referral, but that’s not going to really take care of the fact that we don’t -- we have, if you look at the record in Oregon, only five of 143 patients who have died from ingesting end-of-life drugs in 2017 were ever referred.

So because there’s really no --

REP. STEINBERG (136TH): Can I ask you to summarize, please?

EVANGELINE BARTZ: Yeah. Because there’s no requirement that a mental health professional see the requesting individual, it’s difficult to argue that this safeguard would accurately assess an individual’s mental state. For these reasons, I would urge that this -- that you do not pass -- do
not legalize physician-assisted suicide in Connecticut. Thank you.


REP. PETIT (22ND): Thank you, Mr. Chairman. Thank you for your testimony. That’s what I remembered most from the testimony from the West Coast last time was that Oregon availed themselves of the psychiatric help. Do you know why that is or has Oregon investigated that as to why that is?

EVANGELINE BARTZ: I don’t -- I just have the studies. I don’t know the reasons, but I have the reports of studies from the Oregon Death With Dignity Act data summary that they have -- that in 2017, only five individuals were referred for psychiatric evaluation and another study from Oregon found that only 6 percent of psychiatrists were very confident that in a single evaluation, they could adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide, so basically you’re talking about having the doctors who are not psychiatrists in the first instance kind of try to decide whether there might be a mental health issue there, but they don’t have to refer, and yet the psychiatrists themselves are saying that, you know, they wouldn’t even -- they wouldn’t be comfortable about even just themselves having a single evaluation to determine whether a psychiatric disorder was impairing the judgment of a patient who was considering assisted suicide, so really I think it’s very difficult under this safeguard or purported safeguard under this bill to really get a handle on or to be sure that
the patient's mental -- individual mental health has been accurately assessed.

REP. PETIT (22ND): Would you -- Would you have an opinion or an insight as to whether you think it should be more than one person assessing and/or on more than one visit to make a final determination?

EVANGELINE BARTZ: Well, you know, we’ve heard comments back and forth today, people saying that we don’t want -- that the legislature shouldn’t get overinvolved in regulating the practice of medicine, but when we’re talking about a decision as critical as a life, you know, it has life-ending implications and results, it would seem to me that we would want as a safeguard, if that’s what we’re trying to present here, a safeguard, that there should be some meaningful kind of mental health assessment. How the legislature --

REP. PETIT (22ND): Well, I’m a physician so I agree, but you’re right, the Public Health Committee, we’re supposed to look out for the public’s welfare, so I would tend to agree that we should error on the side of caution. I thank you for those comments. Thank you, Mr. Chair.

REP. STEINBERG (136TH): Are there other comments or questions? If not, thank you for your testimony. Next is Lauralyn Lewis.

LAURALYN LEWIS: Good evening, Representative Steinberg, all members of Public Health. My name is Lauralyn Lewis and I’m from Old Lyme. Many of you know me up here advocating for the intellectually disabled. That is what I speak to tonight. I speak as a mom, I speak as a wife, I speak as a daughter. Twenty some odd years ago I lost a spouse to cancer
who was terminal. He sat in front of an oncologist who gave us the unfortunate news that my husband had two weeks to three months to live. I am here in support of this bill, 5898, because we are shaped by our experiences. This is very difficult. I never thought I would be sitting in front of you speaking, but I find that I must tonight.

My husband didn’t want to die and did everything he could because there was a four-year-old at home that needed him. He wasn’t so fortunate and he passed away. Nineteen years later, my son who has Down syndrome, who many of you have met, was diagnosed with cancer, Stage III. It was not terminal, but he suffered a great deal. He exhausted the anti-nausea arsenal. Nothing worked. He was hospitalized many times and really went through hell and fortunately came out of it, but chemo did a great deal of damage to his body and after he went through chemo, we had a beloved cat of ours who failed because of kidney disease and I had to put her to sleep and the mobile veteran came and she got to be on my lap and we -- the vet gave her a shot and she peacefully went to sleep.

And my son, unfortunately because of the damage to chemo, ended up in the ER a number of times and was on morphine a number of times and finally my son looked at me in one of these times in the ER and he said in a great deal of pain, and this is somebody who has had a great deal -- a very high pain threshold, very high, looked at me and said he’s had enough and he wants the same medicine we gave our cat. I now have a mom who has Alzheimer’s disease. She has had a number of siblings pass also with Alzheimer’s and if she were allowed to, when she was still competent, if this law were to go forward, she
would sign on for this. She’s not going to be so fortunate and she’s very aware of her Alzheimer’s and it’s unfortunate to watch somebody -- we’re going to get to watch that slow, painful process.

I’ve been on the front lines of all of this and that’s why I feel compelled to be in front of you. Thank you for hearing me. Thank you for considering it. You know, you see me up here. I’d be happy to talk to you at any time about this. Thank you.

REP. STEINBERG (136TH): Thank you, Lauralyn, for your testimony, but let’s just say I’ll leave it thank you for your advocacy on behalf of the disability community.

LAURALYN LEWIS: And I would like to just say, a number of people have used the word the disability committee here today and here is somebody from the Down syndrome population who lives independently and if we’re going to allow them to have that freedom to live independently, then we also must respect when they go through something like this and they have fought the good fight and they say I’ve had enough. I think we need to respect that. Thank you.

REP. STEINBERG (136TH): Any comments or questions? Representative Petit.

REP. PETIT (22ND): I’m very sorry for your struggles and losses and if it’s not infringing too much, with your son, would you -- with a law like this, would you put other safeguards or would you want the law exactly as is in his case?

LAURALYN LEWIS: We’ve had to have the very difficult conversation, he and I. He has said to me that if the cancer were to come back, he would not want to do anything, that he has truly had enough
and as a mom, that is an incredibly conversation to have to have. Nobody wants to see their child go through that. Nobody wants to lose a child. You know, I’m not going to get into the editing of the bill. I just -- I think it’s important for us to really consider this is an individual choice. I am by no means sitting here and saying that I wave the banner that everybody should make this choice. My husband didn’t want to. I wouldn’t want it for my son, but I would respect my son. I watched what he went through and nobody should have to -- nobody should have to live like that.

REP. PETIT (22ND): And if I can -- He has improved now?

LAURALYN LEWIS: He is fine right -- He is fine. He is still being tested and keeping -- we’re keeping a watch. He’s stable, thankfully.

REP. PETIT (22ND): Able to eat and drink, the nausea has subsided

LAURALYN LEWIS: Yep, all of that is past, thankfully. Now it’s just the emotionally fallout, the psychological fallout, which has been quite intense.

REP. PETIT (22ND): You know, it would be my comment and maybe it’s neither here nor there, but dealing with patients -- when he hit that lowest point, that’s why you almost need a little waiting period because the sun comes up the next day sometimes, you know, whether it’s a couple days or a couple weeks and sometimes all of a sudden your viewpoint is very different. You’ve completely given up and then in a couple of weeks, he may be ready to go again, so it is difficult and I’ve seen it in both directions
where people are doing very well and fell to the bottom and were at the bottom and got back up again, so thank you for your testimony. It was very helpful.

LAURALYN LEWIS: Thank you for listening.

REP. STEINBERG (136TH): Any comments or questions? If not, thank you. Next is another Bennett here. Christina Bennett?

CHRISTINA BENNETT: I’m not related to the sisters. I was going to pretend I was, but I’m black so, I’d have to be adopted. I’m Christina Bennett. I’m from the Family Institute, but I’m actually giving up my time to read a testimony from Kristen Hanson. She wasn’t able to be here today, so I’ll just proceed with her story.

“Members of the committee, my name is Kristen Hanson and I represent the Patients’ Rights Action Fund, a national, secular, non-partisan organization opposed to the legalization of assisted suicide. One year ago, as my husband was dying, I made a promise to him to continue sharing his story to protect terminal patients from assisted suicide. JJ was a healthy 32-year-old Marine Corps war veteran who was suddenly diagnosed with terminal brain cancer. Three doctors told us there was nothing we could do. They told us to go home and enjoy the time we had left together. Thankfully, we didn’t listen and JJ had great success with treatment. He outlived his grim prognosis by over 3.5 years. During that time, our son created priceless memories with JJ and we welcomed a second son into the world. But if assisted suicide was legal at the time, JJ could have had the lethal drugs on his nightstand during his darkest days when he questioned if we’d all be
better off with him dead, fearing that he was a burden to us.

Thankfully, he didn’t end his life, but if he had suicide pills, he might have taken them, and you can’t undo that or unmake that choice. These laws abandon vulnerable patients, like JJ, who can experience periods of depression at any point following their diagnosis.

Many people who consider or go through with assisted suicide have similar fears. Twenty years of data from Oregon show the main reasons patients request assisted suicide relate to suffering, such as fear of becoming a burden to friends and family, loss of autonomy, and inability to participate in activities they once enjoyed. Pain and suffering never makes it into the top five reported reasons patients choose assisted suicide. Sadly, in Oregon, less than 4 percent of patients requesting assisted suicide are ever referred for psychological evaluation. Worse still, we’ll never truly know how many patients were clinically depressed when they took the suicide pills because once patients receive the prescription, they’re on their own. There’s no requirement for a doctor to follow up with them.

But, as a caregiver, my greatest fear is that when assisted suicide becomes a medical treatment, it injects governmental pressure and profit-driven insurance decisions into everyone’s end-of-life care.

You cannot focus on the individual patient when you look at this legislation. Assisted suicide is bad public policy because it endangers all terminal patients. It puts a disproportionate pressure on people with
disabilities and the disadvantaged, leaving a great many with suicide being the only treatment to which they have equal access. Instead, please focus your efforts on improving multidisciplinary care for terminal patients, which addresses patients’ concerns at the end of life instead of removing society’s care at a time when they need it most. Thank you.”

And she also submitted her testimony as well through email.

REP. STEINBERG (136TH): We will look for that. Thank you. Any comments or questions? If not, thank you for your patience and for hanging in there.

CHRISTINA BENNETT: Thank you, I appreciate it.

REP. STEINBERG (136TH): Next up is Susan Smith, then Jeanne Hosinski.

JEANNE HOSINSKI: Thank you for your stamina, all remaining here, and I’d like to thank my fellow speakers, as well, for their participation in the democratic process. My name is Dr. Jeanne Hosinski. I live in Stamford, Connecticut. The Connecticut State Medical Society disappointed me with their position of engaged neutrality. I am not one of their 4,500 members and neither are the majority of the 12,000 physicians in the state. The position statement was written by OB/GYNs and a gastroenterologist. I would have liked the input of hospice and palliative care doctors and nurses and in fact, when we have from them, they do not support the Bill 5898. Dr. Petit, I think the big problem is enrolling people in hospice in a timely fashion
so that they actually develop a relationship and benefit from the services.

I will also make an aside that the witnessing of suffering, and I have sat at the bedside of many patients and my father, that that can be therapeutic for the family accepting the death of the loved one. I’m not saying it’s pretty, but it can be helpful. House Bill 5898 is also misnamed. If you’re being open and transparent as a legislative body, this bill would not be called aid in dying, but physician prescription prescribed medication for patient-administered suicide. The state of Connecticut provides aid in dying already through hospice and palliative care. physician prescribed suicide is not needed unless the goal of the state is to increase suicide. Section 1, item 19, terminal illnesses, not every person who we think has only six months is actually dead in six months. We do our best to prognosticate so people can be prepared. I would not want a prognosis that could be wrong to lead to someone committing suicide because of fear of losing autonomy or control.

Section 96B, I’m repeating this even though it’s been discussed because it’s very important, the person signing the qualified patient's death certificate shall list the underlying terminal illness as the cause of death. This is actually lying. The person will die as a result of an overdose of a prescribed medication. Let’s be honest. Honesty is critical to maintaining accurate records for future studies with death records as source material for retrospective studies. This is a significant responsibility of the attending physician. If a patient with terminal lung cancer
were hit by a car, what’s the cause of death? Being hit by a car, not lung cancer.

Dr. Kubler-Ross has written about the stages of grief, death, and dying; anger, denial, bargaining, depression, and acceptance. Very patient experiences these in a different order and over a different time frame. Where they are can actually significantly affect what they’re feeling and thinking. Suicide is a real and serious problem in the U.S., particularly amongst young teens and young adults. If we allow that people’s feelings and fears of loss are legitimized, they’re taking their own life, what are we saying to these young people? I just will summarize, they’re at a very vulnerable time in their life, they’re very impressionable. A breakup with a girlfriend or a boyfriend can be totally devastating. These feelings are real to them. They’re felt very deeply and if they see that grandma and grandpa can choose death because they feel life is not worth living, they may also make that choice. I urge you to assist Bill 5898 to die in committee. Thank you very much for your time.

REP. STEINBERG (136TH): Questions or comments. Representative Petit.

REP. PETIT (22ND): Thank you for that comment. That would have been my perception, too, that it was access to it. Do you feel that it has more to do from the physician provider side, not referring or resistance to people who perceive that as sort of a death sentence if we say we’re referring you to hospice?

JEANNE HOSINSKI: I personally feel like physicians are getting better at this, about having the discussion. Certainly nurses are great at this. I
find the resistance comes a lot from the family because they think it will be burdensome to have somebody in their lives everyday or every third day coming and checking on their loved one, I don’t know what I think about that, and so I think a lot of it needs to be education of family prior to being in the circumstance because once you’re in the circumstance, just dealing with it can be so overwhelming. There are so many decisions to make, so many doctors’ appointments, you don’t have time to process oh, should I be enrolling in hospice, is that a good thing. We can’t handle one other visit, no, no, no hospice, so I really think it comes from patient education side. The physicians are doing what they can, the nurses are always the best, and that really it’s education, education.

REP. PETIT (22ND): I would agree with you, the nurses do a better job at that anyway, no doubt about it. Thank you. Thank you, Madam Chair.

SEN. ABRAMS (13TH): Any other questions or comments? Thank you for your testimony.

JEANNE HOSINSKI: Thank you for your time.


TED TUMICKI: Thank you. Good evening, members of the Public Health Committee. 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 5898, AN ACT CONCERNING AID IN DYING FOR TERMINALLY PATIENTS. I am representing myself and I have also submitted written testimony. There are a multitude of reasons why I oppose assisted suicide, but today
I’m choosing to address two or three public policy concerns.

The first is as the bill as written would allow murder. My mother died in 2013 under hospice care, but under this bill, she could have requested lethal medication, received it, chosen not to take it, but someone else could have mixed it with her orange juice and given to her against her will and killed her. She would have been murdered, the medication ingested, the death certificate is falsified. No one would know she had been murdered and it would be protected by this bill. Some people say that this would be a good public policy. I say no. I hope you agree.

Present drugs used include secobarbital, diazepam, phenobarbital, chloral hydrate, and morphine sulfate, most of which are also street drugs. Of the 2,217 prescriptions, 758 patients did not ingest the medication. Well, what happens to the medication? We already know prescription drugs are not disposed of properly, that they are sold and then wind up in circulation in society. Why add more drugs to that mix by passing this bill. How is the state going to ensure that deliberately lethal medication dispensed under state sanction is disposed of properly and is used for it required purposes of suicidal death only for terminally ill and not murder.

How is the state supposed to enforce the process when there is no public oversight? Also the death certificate would be required to be false, but under this new law, are you going to prosecute a physician who writes the truth on a death certificate? Passing House Bill 5898 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 and 
thus I ask you to vote against this bill. Thank 
you.

SEN. ABRAMS (13TH): Thank you. Any questions or 
comments from the committee? Thank you very your 
testimony, Father. Leigh Ann Hutchinson.

LEIGH ANN HUTCHINSON: Thank you for allowing me 
the opportunity to speak. My name is Leigh Ann 
Hutchinson. I’m from Andover. Distinguished 
members, I’d like all to remember that what this 
really comes down to is individual choice. I’m 
submitting this to urge you in the strongest 
possible terms to support this bill. This involves 
as a personal a decision as can be made in a 
lifetime. Please be constantly reminded that it 
contains many safeguards regarding its 
implementation and also for any suffering individual 
who wishes to utilize it to end his or her 
suffering.

These safeguards include involving more than one 
physician, parameters and conditions for its use, 
counseling, more than one request for its use by an 
individual seeking to take advantage of it, and 
restrictions on who else can be involved, such as 
anyone involved in the person’s estate, for example. 
As far as concerns by some that individuals with 
disability might be at a disadvantage if caregivers 
or family members no longer wish to care for them,
these individuals, as you can see here, have many advocates and I feel that’s it’s isolated -- the chances of this happening are isolated given the language and safeguards included here, such as in Section 1, number 9, Section 2A, Section 3A, and Sections 4 through 10.

I feel that opposing this bill would be imposing any doubts, fears, or religious beliefs you may have onto a suffering person when that could have been avoided. People who do not -- People do not want loved ones to suffer loved ones to suffer, however, some people are uncomfortable with their loved one taking advantage of what would be this opportunity because of their own reservations. If you really love the person, why do you want them to suffer? That is the question because I believe that is what you would be doing by not supporting this bill. If you don’t wish to use it yourself, then you don’t have to. Of course, you would be very upset and would miss a person close to you who used this and that is as it should be, however, please remember that it is not your fight, it is theirs, and their wishes should be honored. Please consider wishing them the best in supporting their decision instead of trying to withhold this opportunity and causing them untold suffering. Is it not unconscionable to condemn another person to suffer when they don’t need to.

I’d like to add I’ve been up here for most of the testimony. I was out of the room at times. I don’t know if this came up, but I’m concerned about new language in Section 19 that says that a person who stands to inherit from someone using this aid in dying method would not, if I read it correctly, would not be allowed to be there at the person’s
ingesting this medication at the end of life and I, again, if I read it correctly, I’m not sure what the point of that is.

SEN. ABRAMS (13TH): Thank you. Any questions or comments from the committee? Thank you very much for your testimony and thank you for being here all day, too. Kim Hoffman. Welcome.

KIM HOFFMAN: Thank you. Thank you everybody for sticking through this process. My name is Kim Hoffman. Every day, every work day, I go to a high school where I’m the school social worker. I work hard to support and guide students and their families through some of the most difficult times so that they may create a life that they want to live. On Saturday, a played a long and hard tennis match and I won. Serena Williams won’t be calling me for her doubles partner anytime soon, but I was pleased and proud of the win. Last month, I pushed hard and ran a 5K road race. I did not win and no senior Olympics for me.

Sunday, I spent much of the day recovering from the sheer exhaustion of the tennis match and the week of work and today I come before you to share another side of my story and perhaps you will better appreciate my exhaustion. My name is Kim Hoffman. I’m a 56-year-old stage IV ovarian cancer survivor. In June, I will recognize six years since my original diagnosis and in those six years, for the bulk of four years, I have been and currently am on a chemotherapy regimen. I take chemotherapy daily orally. There is no cure for ovarian cancer. My treatment is disease management. My oncologist has shared that barring any unforeseen accident, I will die from my cancer.
For as long as I am able, I plan to continue to live as best I can, whether I am comforting of students, playing a tennis match, running a 5K, or making the most amazing vegan meal you could ever dream of. I will do my best to show up. The emotional and physical suffering and the numbness and the emptiness are what I fear and dread the most about my disease progression. There will be a time when I’m no longer able to show up for my life. There will be a time when my body can no longer withstand the side effects of treatment. There will be a time when I won’t be able to tolerate the symptoms of my cancer. There will be a time when the only way to manage another day is through palliative care and symptom management. I will be dosed on drugs, not to live with exuberance, but rather to die more quietly.

I’m almost done, if I may. Thank you. Eleven years ago I sat by mother’s side as she suffered through the end stages of her cancer. I held my mother’s hand while she begged for the suffering to end. I dried her tears when the morphine couldn’t touch the pain. I held a moist cloth to her lips when she was too weak to drink. Yes, it was traumatic for me, but most significantly, it was traumatic for my mother and a tragic way for her to die. I would like to have the option to choose to die peacefully. I would like to have the option to end my life before the intense suffering sets in and before that all is left is a shell of myself straining through each moment of the day with no hope of improvement, but endless time to fear the end. Out of care and respect, I implore you to support this bill. Thank you.
SEN. ABRAMS (13TH): Kim, thank you so much for that testimony and I know you’ll understand how grateful I am to be here with you today.

KIM HOFFMAN: Thank you, Mary.

SEN. ABRAMS (13TH): Are there any questions or comments? Thank you. Shannon Sanford.

SHANNON SANFORD: Hi. Good evening, Representative Steinberg, Senator Abrams, Ranking Member Petit, Ranking Member Somers and other honorable members of the Public Health Committee. Thank you for the opportunity to provide testimony in support of Raised House Bill 5898, AN ACT CONCERNING AID IN DYING FOR TERMINALLY ILL PATIENTS. I am Shannon Sanford. I’m a registered nurse and I also have my Master’s as an oncology clinical nurse specialist. I know you have my written testimony before you, so in the interest of time I’ll use my three minutes to present the highlights.

The ANA recently issued a draft document entitled “The Nurse’s Role When a Patient Requests Aid in Dying” This document is interesting because it expresses a shift in thinking toward more neutrality on aid in dying and it allows nurses to be able to communicate with patients on these issues provided that the patient initiates the conversation. This ability of the nurse to engage the patient in a nonjudgmental discussion of the reason behind his or her request for aid in dying is essential in order to ensure that our patients understand the complete range of medical options that are available and that they can choose the one that’s consistent with their own values and priorities.
As a nurse, I consider this a small victory because on a personal level, I advocate for this bill on behalf of my father and I brought a picture of him. This is him teaching high school. I witnessed his death from multifocal liver cancer when I was in nursing school. He was very much a supporter of legislative acts regarding death with dignity. He was not the type of person that would linger in protracted dying, but unfortunately that’s exactly what happened to him. If my dad could have had complete autonomy, he would have died in his reclining chair at home, on a day of his choice, surrounded by family, having utilized some sort of medical aid in dying legislation, but unfortunately, he died in his home in a rented hospital bed after days of slowly dying from no longer eating or drinking, responding only in pain as our family watched and I injected him with morphine every two hours in an attempt to keep that pain at bay.

The thing that breaks my heart is that I really could have given him the autonomy that House Bill 5898 would have provided him and I know he would have wanted that option at the end of his life. I find it hypocritical and somewhat cruel that he could be allowed to die by voluntarily refusing food and fluid, a process that was prolonged and seemingly painful yet legal, but he could be denied access to medical aid in dying in Connecticut. So I continue to come and testify before you regarding the medical aid in dying bill every time it comes up and make myself to educate and answer questions on the bill. It’s too late for me to advocate for my dad, but it’s not too late for me to advocate for my patients. Thank you. And I’m willing to answer any questions you guys have
regarding the legislation. I did my thesis on the Oregon Death with Dignity Act when I was a nurse at the Yale School of Nursing, so I’m well versed in it. Questions earlier that you had about the death certificate, if I could speak to that, I would like to.

SEN. ABRAMS (13TH): Okay, let me -- I have to cut you off, but then I will ask you if you’d like to speak on the death certificate. What did you find out?

SHANNON SANFORD: Well, in regards to the death certificate, we have several years of data, about 20 years of data, from the state of Oregon. Primarily in Oregon, they put on the death certificate the reason for the patient, the primary reason, for the patient's death being the underlying diagnosis, but you have to think again of the reason why, you know, what’s the purpose of the death certificate and mainly it’s to certify the occurrence of the death for legal matters, i.e., settling the estate and to document the cause of death for public health statistics, so we’re not really too concerned about documenting, you know, the fact they died under the Death with Dignity Act. And Oregon goes back to find -- to further document purposes to find out who died under the Death with Dignity Act by matching the death certificate -- the names on the death certificates with the names of people who received prescriptions under the Death with Dignity Act, so they don’t need the death certificate to actually state they died under the Death with Dignity Act. They simply match the prescriptions that were written with the names on the death certificates.
SEN. ABRAMS (13TH): Thank you. Are there any other questions or comments? Representative Tercyak.

REP. TERCYAK (26TH): So if I understand correctly, that would mean Oregon would be overstating how many people are dying because of the Death with Dignity Act because people who chose to use the option they had available would still end up being counted in their statistics?

SHANNON SANFORD: They keep track of that because they confiscate or they have people return the medications that are written and are not consumed, so they keep track of the statistics of people who don’t take the medication.

REP. TERCYAK (26TH): Thank you.

SEN. ABRAMS (13TH): Any other questions or comments? No? Thank you very much for your testimony.

SHANNON SANFORD: Can I also just state that in Oregon, because I know Dr. Petit, I know you had mentioned earlier about the hospice usage, I know Connecticut ranks very low with hospice utilization, in Oregon, I know there’s been some discussion about hospice versus medical aid in dying, in 2018, and this has been pretty consistent with their statistics, 90.5 percent of the patients who took advantage of the death with dignity act were on hospice service. They noticed that the majority or the bulk of the patients are on their hospice service when they’re availing themselves to the Death with Dignity Act.

SEN. ABRAMS (13TH): Thank you, I’m going to have to -- would you like to talk?
REP. PETIT (22ND): Thank you, Madam Chair. I wonder if you’d proffer an opinion on something again asked previously in terms of giving that you work in the field, you’ve done some research on what’s happened in terms of should a person be assessed by more than one person and what period of time should elapse if you were to allow this given that people change their minds, clinical courses wax and wane, etc.?

SHANNON SANFORD: I think the 15-day waiting period is sufficient. That’s what 20 years of data has shown us from the state of Oregon. I believe that’s a sufficient waiting period and the use of the patient's primary care physician as the initial determinate.

REP. PETIT (22ND): One other or --

SHANNON SANFORD: No, no, for two, but the initial determinate should be the patient's own physician who can assess the patient's mental status and who knows the patient, you know, I wouldn’t agree with any sort of doctor shopping going on and I don’t think you see that in the state of Oregon.

REP. PETIT (22ND): And I guess it would independent practice in this state, presumably you’d want to include APRNs as well, I assume?

SHANNON SANFORD: Not necessarily, no. No, I don’t think that should be included in the legislation. The way it’s written, it’s a physician, it’s not an APRN.

REP. PETIT (22ND): All right. I appreciate that. Thank you. Thank you, Madam Chair.
SEN. ABRAMS (13TH): Thank you very much for your testimony. Thank you for being here.

SHANNON SANFORD: Okay, thank you.

SEN. ABRAMS (13TH): That’s the end of the hearing unless there’s anyone here who had expected to testify who wasn’t called? No? Well, thank you very much for being here. We’re adjourned.