Aid in Dying Legislation in Connecticut

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Issue
Summarize Connecticut's recent “aid in dying” legislation and provide an overview of related testimony. This report updates OLR Report 2019-R-0175.

Summary
“Aid in dying” laws (sometimes referred to as “death with dignity” laws) provide a procedure for a terminally ill patient to request medication to end his or her life. Connecticut’s legislature has considered this legislation in recent years (holding seven public hearings on such bills since 2013). In both 2021 and 2022, the Public Health Committee voted out a bill authorizing aid in dying, but neither bill became law.

Most recently, the Public Health Committee heard such a bill in 2022 (SB 88). This bill would have allowed competent, terminally ill adults to obtain and use prescriptions to self-administer lethal medications under specified conditions. The bill would have required a patient, before receiving an aid in dying prescription, to make two written requests to his or her physician at least 15 days apart, with each request witnessed by at least two other people.

Other States
Nine states have enacted “aid in dying” laws: California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, and Washington.

In addition, while Montana does not have an aid in dying statute, the state’s Supreme Court ruled in 2009 that doctors have a defense to prosecution for providing aid in dying to a terminally ill, competent adult patient with that person’s consent (Baxter v. Montana, 354 Mont. 234 (2009)).
Among other provisions, the bill would have done the following:

1. required a consulting physician to examine the patient, confirm the attending physician’s diagnosis, and verify that the patient is competent and acting voluntarily;

2. allowed only patients themselves, and not anyone acting on their behalf (e.g., agents under a living will or conservators), to request aid in dying;

3. required the attending or consulting physician to refer the patient for counseling upon determining that the patient may be suffering from a psychological or psychiatric condition causing impaired judgment;

4. established several procedural and recordkeeping requirements for attending physicians when they receive a written request for aid in dying and when they determine the patient qualifies;

5. allowed patients to rescind an aid in dying request at any time and in any manner;

6. prohibited health care facilities from requiring their providers to participate in providing aid in dying medication; and

7. required attending physicians to report on aid in dying prescriptions and related deaths to the Department of Public Health (DPH), and the department to annually report that information to the Public Health Committee.

About 275 individuals or groups submitted testimony on the bill. Proponents argued, among other things, that (1) decisions about end of life care are extremely personal, and thus terminally ill patients should have access to aid in dying without government interference; (2) the legislation contains sufficient procedural safeguards to protect against abuse or coercion; and (3) the experience of other states has not shown evidence of abusive practices.

Among other arguments, opponents stated that the bill (1) sends an inappropriate signal about the value of human life, and may lead to increased suicide attempts overall; (2) lacks sufficient procedural safeguards, placing patients with severe disabilities at risk of explicit or implicit pressure to choose aid in dying to benefit family members or caregivers; and (3) violates the professional obligation of physicians to do no harm to their patients.

Below is a list of recent versions of the bill and more information on the 2022 bill.

**Recent Connecticut Legislation**

Since 2013, legislative committees have held public hearings on seven aid in dying bills, two of which were voted out of committee. The bills are listed in Table 1.
### Table 1: Fully Drafted Aid in Dying Bills, 2013-2022

<table>
<thead>
<tr>
<th>Year</th>
<th>Bill</th>
<th>Initial Committee</th>
<th>Action After Public Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>HB 6645</td>
<td>Public Health</td>
<td>None</td>
</tr>
<tr>
<td>2014</td>
<td>HB 5326</td>
<td>Public Health</td>
<td>None</td>
</tr>
<tr>
<td>2015</td>
<td>HB 7015</td>
<td>Judiciary</td>
<td>None</td>
</tr>
<tr>
<td>2018</td>
<td>HB 5417</td>
<td>Public Health</td>
<td>None</td>
</tr>
<tr>
<td>2019</td>
<td>HB 5898</td>
<td>Public Health</td>
<td>Vote to hold until next meeting</td>
</tr>
<tr>
<td>2020</td>
<td>HB 5420</td>
<td>Public Health</td>
<td>None (hearing was scheduled but not held due to COVID 19)</td>
</tr>
<tr>
<td>2021</td>
<td>HB 6425</td>
<td>Public Health</td>
<td>The Public Health Committee voted out the bill; the House then referred it to the Judiciary Committee, which took no action on it</td>
</tr>
<tr>
<td>2022</td>
<td>SB 88</td>
<td>Public Health</td>
<td>The Public Health Committee voted out the bill; the Senate then referred it to the Judiciary Committee, where the bill was voted down</td>
</tr>
</tbody>
</table>

### 2022 Bill (SB 88)

Following is (1) a summary of the 2022 bill’s process for patients to request aid in dying and for physicians to respond to these requests and (2) an overview of the bill’s other provisions. For a more detailed summary, see OLR’s bill analysis.

### Requesting Aid in Dying (§§ 1-5)

To request a prescription for lethal medication, the bill would require that a patient who is under a physician’s care voluntarily express his or her wish to receive aid in dying and be:

1. an adult (i.e., age 18 or older),
2. a Connecticut resident,
3. competent (i.e., able to understand the nature and consequences of health care decisions, make an informed decision, and communicate it), and

4. determined by his or her attending physician to have a terminal illness (i.e., the final stage of an incurable and irreversible condition that the attending physician anticipates, within reasonable medical judgment, will lead to death within six months if the condition’s progression follows its typical course) (§ 2).

Under the bill, before receiving a prescription, a patient would have to make two written requests to his or her physician, separated by at least 15 days, with each request signed and dated by the patient and witnessed by at least two people in the patient’s presence (§ 3).

The bill would require that a request be in a format that is substantially similar to one set forth in the bill (§ 4).

Under the bill, a witness to an aid in dying request would have to attest, in writing, to various issues (e.g., that the patient appears to be of sound mind). A witness could not be (1) the patient’s relative; (2) someone entitled to part of the patient’s estate; (3) an owner, operator, or employee of the facility where the patient is receiving treatment or is a resident; or (4) the patient’s attending physician (§ 3).

The bill specifies that a patient could rescind his or her request for aid in dying at any time and in any manner without regard to his or her mental state. Additionally, it would require the patient’s attending physician to offer the patient an opportunity to rescind the request for aid in dying (1) when the patient submits his or her second written request and (2) prior to dispensing or prescribing medication for aid in dying (§ 5).

**Process to Grant a Prescription and Related Reporting (§§ 1, 6-10 & 18-19)**

*Initial Steps to Verify Eligibility (§ 6).* Under the bill, when an attending physician receives a patient’s first written request for aid in dying, the physician would have to determine that the patient is a competent adult, has a terminal illness, and is voluntarily making the request. The physician could not make this determination solely based on the patient’s age, disability, or any specific illness. The physician would also need to require the patient to demonstrate Connecticut residency (e.g., by showing a driver’s license or voter registration card).

Additionally, the physician would have to ensure that the patient is making an informed decision by informing the patient of (1) his or her diagnosis and prognosis; (2) the potential risks and probable
results of taking the medication; (3) feasible alternatives, including hospice and palliative care; and (4) the availability of counseling with a psychologist, psychiatrist, or licensed clinical social worker.

Consulting Physician (§§ 6 & 7). The bill also would require the attending physician to refer the patient to a consulting physician qualified by specialty or experience to make the applicable diagnosis and prognosis. The consulting physician’s role would be to confirm the diagnosis and determine that the patient is competent, has made the request voluntarily, and has made an informed decision. The consulting physician would have to examine the patient and the patient’s medical records.

Counseling Referral (§ 8). Under the bill, if either the attending or consulting physician believes the patient’s judgment is impaired by a psychiatric or psychological disorder (including depression), then that physician would have to refer the patient for counseling to determine the patient’s competency to request aid in dying.

Steps After Second Written Request (§ 9). Under the bill, after both physicians determine that the patient is qualified to obtain aid in dying, and the patient submits the second written request, the attending physician would have to take other specified steps, as follows:

1. recommend that the patient notify his or her next-of-kin of the prescription request (but the physician could not require that the patient do so);
2. counsel the patient on the importance of having someone else there when the patient takes the medication and of not taking it in public;
3. tell the patient that he or she may rescind the request at any time and in any manner;
4. verify that the patient is making an informed decision immediately before dispensing or prescribing the medication; and
5. document specified information in the patient’s medical record (see § 10).

If all of these requirements were met, the physician could dispense the medication directly, or a pharmacist could dispense it if the patient consents in writing.

The bill would require the attending physician, within certain deadlines, to submit checklist and follow-up forms to DPH concerning these cases (after prescribing the medication and after learning that a patient died from taking the medication). It would correspondingly require DPH to annually review the submitted forms and report to the Public Health Committee, with the reports not containing any identifying information about patients or providers (§§ 18 & 19).
Other Provisions (§§ 11-17)
The bill contained several other provisions concerning aid in dying requests and the legal consequences of specified related actions. For example, the bill would have provided the following:

1. a qualified patient’s act of requesting aid in dying or self-administering such medication does not constitute suicide for any purpose, including criminal laws on assisted suicide (§ 12);

2. health or life insurance policies cannot be conditioned upon or affected by a patient’s request for aid in dying or rescinding such a request (§ 12);

3. physicians and other health care providers are not required to participate in providing aid in dying medication to a patient (§ 13);

4. a health care facility cannot require a provider to participate in providing this medication (§ 13);

5. a health care facility may adopt a policy prohibiting providers associated with the facility from participating in providing this medication, and under certain circumstances the facility can impose sanctions on providers who fail to comply with that policy (§ 13);

6. its provisions do not authorize a physician or anyone else to end someone’s life by lethal injection, mercy killing, assisting a suicide, or any other active euthanasia (§ 14);

7. physicians, patients, and others who adhere to the bill’s requirements are protected from criminal prosecution, civil liability, or professional disciplinary action, but the bill does not limit civil liability for damages resulting from negligence or intentional misconduct (§§ 14 & 15);

8. its provisions do not limit the jurisdiction or authority of the nonprofit entity designated by the governor to serve as the state’s protection and advocacy system for individuals with disabilities (i.e., Disability Rights Connecticut) (§ 16); and

9. attending or consulting physicians under these provisions are prohibited from inheriting from the patient (§ 17).