

Written Testimony of Kim Callinan,
President & CEO, Compassion & Choices Action Network
Regarding SB1076, An Act Concerning Aid in Dying for Terminally Ill Patients
Joint Committee on Public Health
February 27, 2023

Good morning Co-Chairs Anwar and McCarthy Vahey and Members of the Committee. My name is Kim Callinan. I lead Compassion & Choices and the Compassion & Choices Action Network. We are the nation's oldest and largest consumer-based nonprofit organization working to improve care and expand options at life's end. We advocate for legislation to improve the quality of care for terminally ill patients and affirm their right to determine their own medical treatment options as they near the end of life.

On behalf of hundreds of thousands of Connecticut residents, the Compassion & Choices Action Network supports both Senate Bill 1075, An Act Concerning Hospice And Palliative Care, and SB1076, An Act Concerning Aid in Dying for Terminally Ill Patients.

SB1075, An Act Concerning Hospice and Palliative Care

Senate Bill 1075 establishes a Hospice Hospital at Home pilot program to provide hospice care to patients in the home, through a combination of in-person visits and telehealth. The pilot program would provide the following to patients: (1) A daily telehealth visit by a physician; (2) In-person visits by a registered nurse at least twice daily; (3) A twenty-four-hour-per-day electronic alarm system placed in a patient's home that enables the patient to obtain immediate help in case of an emergency; (4) Remote monitoring of the patient by physicians and nurses participating in the pilot program; (5) Telephone access to an on-call physician or nurse for any immediate questions or concerns regarding the patient's condition.

The pilot program would increase patient access to, and choice of, high-quality, cost-effective hospice care and assist patients and their families in having an end of life experience that reflects their preferences and values. For these reasons, we urge lawmakers to act swiftly to pass Senate Bill 1076.

SB1076, An Act Concerning Aid in Dying for Terminally Ill Patients

Passage of SB1075, An Act Concerning Hospice and Palliative Care, will improve end of life care within the state. However, it does not replace the need for passage of SB1076, An Act Concerning Aid in Dying for Terminally Ill Patients. For some patients even the best hospice and palliative care will not replace their desire for bodily autonomy over how they die. Furthermore, even the best pain and symptom management can not control all suffering.

As such, ten states and Washington, DC have authorized the option of medical aid in dying. And in a growing number of jurisdictions, Lawmakers like yourselves, are weighing the evidence in the 11 other authorized jurisdictions and crafting similar legislation so that constituents in their own states are afforded the peace of mind that this law results in. Below is an overview of this legislation along with the evidence and data from the other authorized jurisdictions.

The Medical Practice of Aid in Dying

Medical aid in dying refers to a practice in which a mentally capable, terminally ill adult may request from their medical provider a prescription for a medication that they can self-ingest to die peacefully if their suffering

becomes unbearable. Ten states, Oregon,¹ Washington, Vermont,² California,³ Colorado,⁴ Hawaii,⁵ New Jersey,⁶ Maine,⁷ Montana⁸, New Mexico,⁹ as well as the District of Columbia,¹⁰ have authorized the compassionate option of medical aid in dying. Seven of these jurisdictions authorized this end-of-life care option within the past seven years (2015-2022). Today, more than one in five people have access to this end-of-life care option.

Legislative Overview. SB1076. An Act Concerning Aid in Dying for Terminally Ill Patients

The U.S. jurisdictions that have authorized medical aid in dying through statute modeled their bills after Oregon's Death With Dignity Act and other authorized jurisdictions. They each include strict eligibility criteria and practice requirements to ensure the highest standard of care, as described in the clinical criteria and guidelines published in the prestigious, peer reviewed Journal of Palliative Medicine.¹¹ To be eligible for aid-in-dying medication, an individual must be:

- » An Adult;
- » Terminally ill with a prognosis of six months or less to live;
- » Mentally capable of making their own healthcare decisions; and
- » Able to self-ingest the aid-in-dying medication. Self-ingest means that a qualified individual performs an affirmative, conscious, voluntary act to take the prescribed medication to bring about the individual's peaceful death. Self-ingestion does not include administration by injection or infusion via a vein or any other parenteral route by any person, including the doctor, family member or patient themselves. Parenteral route means administration outside of the digestive tract including intravenous, intramuscular and subcutaneous administration.¹²

In addition, on top of the core safeguards in the Oregon legislation, this bill includes additional provisions:

- In addition to seeing two physicians, all patients are required to undergo a mandatory mental health evaluation by a trained mental health specialist who confirms the patient is making an informed health care decision free from coercion
- A patient must see their doctor every 30 days after being prescribed aid in dying medication
- Patients must be residents of Connecticut for 1 year before they are eligible for aid in dying

¹ Oregon Death With Dignity Act. Oregon Revised Statute. Available from

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx>.

² Vermont Patient Choice and Control at the End of Life Act. Available from <http://www.leg.state.vt.us/docs/2014/Acts/ACT039.pdf>; amended 2022 <https://legislature.vermont.gov/Documents/2022/Docs/ACTS/ACT097/ACT097%20As%20Enacted.pdf>

³ California End of Life Option Act. Available from

https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520162AB15; amended 2021

https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB380

⁴ Colorado End of Life Options Act, Available from:

<https://www.sos.state.co.us/pubs/elections/Initiatives/titleBoard/filings/2015-2016/145Final.pdf>

⁵ Hawaii Our Care, Our Choice Act, Available from: https://www.capitol.hawaii.gov/session2018/bills/HB2739_HD1_.pdf

⁶ New Jersey Aid in Dying for the Terminally Ill Act, Available from: https://www.njleg.state.nj.us/2018/Bills/A2000/1504_I1.PDF

⁷ Maine Death with Dignity Act, Available from: https://www.mainelegislature.org/legis/bills/bills_129th/billtexts/HP094801.asp

⁸ Montana Supreme Court Ruling Baxter v. Montana. December 2009 Available from

<https://compassionandchoices.org/wp-content/uploads/2018/06/091231-SC-Opinion-wm.pdf>

⁹ New Mexico Elixabeth Whitefiled End of Life Option Act . Available from:

<https://nmlegis.gov/Sessions/21%20Regular/final/HB0047.pdf>

¹⁰ DC Death with Dignity Act of 2016, Available from:

https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Death%20With%20Dignity%20Act.FINAL_.pdf

¹¹ *Clinical Criteria for Physician Aid in Dying*. Journal of Palliative Medicine; D. Orentlicher, T.M. Pope, B.A. Rich, (2015) Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4779271/>

¹²Cambridge University Press, "Medication Safety: An Essential Guide, Chapter 7: Parenteral Administration." January 22, 2011.

Available at:

<https://www.cambridge.org/core/books/abs/medication-safety/parenteral-drug-administration/B00E3CE7C00873D4114AA08E8B92D86>

- The age of eligibility for aid in dying has been increased from 18 to 21
- Further penalizes those who do not follow the law

While we believe– and data confirms– that these additional provisions are unnecessary and will result in more patients being unable to access the law, the bill as drafted would still afford some dying Connecticut residents much needed relief at life’s end. It’s important to note that advanced age, disability and chronic health conditions do not alone qualify a patient for medical aid in dying. The Connecticut legislation follows the Oregon model and also requires that:

- The attending qualified provider must inform the terminally ill adult requesting medical aid in dying about all other end-of-life care options such as hospice care and palliative care;
- The attending qualified provider must inform the terminally ill adult requesting medical aid in dying that they can change their mind at any time. This patient right to change their mind includes deciding not to self-ingest the medication once they have obtained it;
- A terminally ill individual is required to submit two written requests, at least fifteen days apart. Each written request must be witnessed by two people who attests the individual is capable, acting voluntarily, and not being coerced or unduly influenced.
- A consulting qualified provider must confirm the terminal diagnosis, prognosis of six months or less to live, and the person’s ability to make an informed healthcare decision prior to the attending medical provider writing a prescription.

These core safeguards - all of which can be found within SB1076 - ensure that individual patient preferences, needs and values are honored, and guide all clinical decisions, including the decision to use medical aid in dying.

Voluntary Participation

Participation is voluntary for patients and providers. No provider is obligated to prescribe or dispense aid-in-dying medication. However, if the patient transfers their care to a new provider, the provider must promptly transfer a copy of the patient’s relevant medical records to the alternate provider. The laws provide explicit authorization for medical providers to participate in the practice of medical aid in dying and protect those who do participate from criminal and civil liability as long as they comply with the requirements set forth in the law and act in good faith while meeting the standards of medical (end-of-life) care. Similar immunities and protections are extended to other healthcare providers (such as mental health professionals as well as pharmacists) and caregivers involved in the care of the terminally ill individual.

Public Support for Medical Aid in Dying is Strong

Public opinion polling from a variety of sources, both nationally and at the state level, demonstrates that the American public consistently supports medical aid in dying, with majority support among nearly every demographic group. A 2020 Gallup poll found that 61% of participants support medical aid in dying. Majority support spanned a variety of demographic groups, including 60% of people of color.¹³ Research among likely 2022 general election voters in Connecticut shows even stronger support in Connecticut than exists nationwide: more than three-fourths of voters say medical aid in dying should be a legal option.¹⁴

Support for Medical Aid in Dying is Also Strong Within the Medical Community

¹³ Susquehanna Polling & Research, Inc. USA Omnibus - Cross Tabulation Report, November 2021 (see pages 18-19). Available at: https://compassionandchoices.org/docs/default-source/default-document-library/usa-omnibus-cross-tabulation-report-final-november-2021-2.pdf?sfvrsn=74705b4b_1

¹⁴ https://www.compassionandchoices.org/docs/default-source/polling-documents/ct-compassion-and-choices-public-memo-final.pdf?sfvrsn=40e47216_1

Physicians nationwide support medical aid in dying. According to the [Life, Death, and Painful Dilemmas: Ethics 2020](#) survey released by Medscape in November 2020, more than a majority of physicians support medical aid in dying, and this support has grown by nine percentage points over the past decade (from 47 to 55%).¹⁵ Notably, physician opposition to medical aid in dying has plunged by 13 percentage points over the same time period (from 41% to 28%).

Most of the medical associations in authorized jurisdictions currently have neutral positions on medical aid in dying, including Oregon¹⁶, California¹⁷, Colorado¹⁸, Vermont,¹⁹ Maine,²⁰ New Mexico²¹, and the District of Columbia²².

There is growing recognition within the medical profession that patients want, need and deserve this compassionate option at the end of life; and this growing recognition is burgeoning into collaboration. As more jurisdictions authorize medical aid in dying, the medical community is coming together, and providers are sharing their experiences and fine-tuning their collaborative efforts to better serve dying patients.

A Solid Body of Evidence

The growing support for medical aid in dying is attributable, in part, to the fact that it is a compassionate and time-tested end-of-life care option. Researchers and legal scholars have confirmed that the experience across the authorized jurisdictions “puts to rest most of the arguments that opponents of authorization have made — or at least those that can be settled by empirical data. The most relevant data — namely, those relating to the traditional and more contemporary concerns that opponents of legalization have expressed — do not support and, in fact, dispel the concerns of opponents.”²³

The evidence is clear: medical aid-in-dying laws protect terminally ill individuals, while giving them a compassionate option to die peacefully and ensuring appropriate support and legal protection for the care providers who practice this patient-driven option.

When crafting medical aid-in-dying legislation, lawmakers no longer need to worry about hypothetical scenarios or anecdotal concerns. We now have 25 years of data since Oregon first implemented its law in 1997, and years of experience from the 10 other authorized jurisdictions, including annual statistical reports from nine jurisdictions. None of the dire predictions that opponents raised have come to fruition. In fact, there has never been a single substantiated case of misuse or abuse of the laws. The evidence confirms that

¹⁵ Leslie Kane. *Life, Death, and Painful Dilemmas: Ethics 2020*

<https://compassionandchoices.org/docs/default-source/fact-sheets/medscape-ethics-report-2020-life-death-and-pain.pdf>

¹⁶ Oregon Medical Association. Available from

<https://oma.informz.net/informzdataservice/onlineversion/ind/bWFpGluZ2luc3RhbmNlaWO9NjU0Mzk3MSZzdWJzY3JpYmVyaWO9ODc4MzYwNjk3>

¹⁷ California Medical Association. Excerpted from: CMA changes stance on physician aid in dying, takes neutral position on End of Life Option Act. June 2, 2015. Available at

<https://www.cmadoes.org/newsroom/news/view/ArticleId/26466/CMA-changes-stance-on-physician-aid-in-dying-takes-neutral-position-on-End-of-Life-Option-Act>

¹⁸ Colorado Medical Society, Statement by CMS President-elect Katie Lozano, MD, FACR, regarding Ballot Proposition 106. Available from: <https://www.cms.org/about/policies#170-ethics>

¹⁹ Vermont Medical Society, *Position on Medical Aid in Dying*, (2017). Available from:

<http://www.vtmd.org/sites/default/files/2017End-of-Life-Care.pdf>

²⁰ MMA Board Withdraws Opposition to Death with Dignity Legislation. May 1, 2017,

<http://newsmanager.commpartners.com/mainemed/issues/2017-05-01/index.html>

²¹ *New Mexico Medical Society Council Meeting Minutes 1.5.19* <http://bit.ly/2GhwbIO>

²² *Another State Medical Society Stops Fighting Assisted Death* (2017). Lowes, Robert. Medscape. Available from:

https://www.medscape.com/viewarticle/889450?reg=1&icd=login_success_gg_match_norm

²³ *A History of the Law of Assisted Dying in the United States*. SMU Law Review, A. Meisel, (2019) Available from:

<https://scholar.smu.edu/cgi/viewcontent.cgi?article=4837&context=smulr>

medical aid-in-dying laws protect patients while offering a much-needed compassionate option. The following section addresses the most common inaccurate claims about medical aid in dying and sets the record straight.

Currently, public health departments in nine authorized jurisdictions have issued reports regarding the utilization of medical aid-in-dying laws: Oregon,²⁴ Washington,²⁵ Vermont,²⁶ California,²⁷ Colorado,²⁸ Hawaii,²⁹ the District of Columbia,³⁰ Maine,³¹ New Jersey³². More detailed reports can be provided upon request.

- » Cumulatively, for the past 20+ years, across all jurisdictions, 6,378 people have taken a prescription to end their suffering.³³
- » Just over a third of people (37%) who go through the process and obtain the prescription never take it. However, they derive peace of mind simply from knowing they would have the option if their suffering became too great. Fewer than 1% of the people who die in each jurisdiction use the law each year.³⁴
- » Fewer than 1% of the people who die in each state will decide to use the law each year.
- » The majority of terminally ill people who use medical aid in dying — more than 87% — received hospice services at the time of their deaths, according to annual reports for which hospice data is available.
- » There is nearly equal utilization of medical aid in dying among men and women. There is no data on utilization of medical aid in dying by non-binary people.
- » Terminal cancer accounts for the vast majority of qualifying diagnoses, with neurodegenerative diseases such as ALS or Huntington's Disease following as the second leading diagnosis.
- » Just over 90% of people who use medical aid in dying are able to die at home. According to various studies, most U.S. Americans would prefer to die at home.³⁵

²⁴ *Oregon Death with Dignity Act Annual Report* (2021) Available from: <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf>

²⁵ *Washington Death with Dignity Act Annual Report* (2020) Available from: <https://doh.wa.gov/sites/default/files/2022-02/422-109-DeathWithDignityAct2020.pdf?uid=634756e5baf15>

²⁶ *Vermont Patient Choice at the End of Life Data Report* (2020) Available from: <https://legislature.vermont.gov/assets/Legislative-Reports/2020-Patient-Choice-Legislative-Report-2.0.pdf>

²⁷ *California End of Life Option Act Annual Report* (2021) Available from: https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH_End_of_Life%20Option_Act_Report_2021_FINAL.pdf

²⁸ *Colorado End of Life Options Act Annual Report* (2021) Available from: <https://drive.google.com/file/d/1IBp-rKSjE19YdHlx5bLA9dTB81GIM/view?usp=sharing>

²⁹ *Hawaii Our Care, Our Act Annual Report* (2021) Available from: <https://health.hawaii.gov/opppd/files/2022/07/corrected-MAID-2021-Annual-Report.pdf>

³⁰ *District of Columbia Death with Dignity Act Annual Report* (2018) Available from: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/DWD%20Report%202018%20Final%20%20%208-2-2019.pdf

³¹ *Maine Patient Directed Care at End of Life Annual Report* (2021) Available from: <https://legislature.maine.gov/doc/8664>

³² *New Jersey Medical Aid in Dying for the Terminally Ill Act* (2021) Available from: <https://nj.gov/health/advancedirective/documents/maid/2021.pdf>

³³ *Medical Aid-in-Dying Data Across Authorized States, 2023*. Compassion & Choices. Available from: https://compassionandchoices.org/docs/default-source/default-document-library/medical_aid_in_dying_utilization_report_12-13-2022.pdf?sfvrsn=697faeca_2

³⁴ According to the Center for Disease Control, in 2019 in jurisdictions that authorized medical aid in dying, 427,296 people died in total. In 2019, authorized jurisdictions report 1,027 people died after being provided with a prescription for medical aid in dying—less than 0.002% of all total deaths in 2019. Center for Disease Control, *Deaths: Final Data for 2019*, July 26, 2021. Available from: https://stacks.cdc.gov/view/cdc/106058/cdc_106058_DS1.pdf

³⁵ Kaiser Family Foundation, *Views and Experiences with End-of-Life Medical Care in the U.S.*, April 27, 2017. Available from: <https://www.kff.org/report-section/views-and-experiences-with-end-of-life-medical-care-in-the-us-findings/>

Medical Aid in Dying Improves End-of-Life Care

Oregon has long been on the forefront of end-of-life care, leading the nation in terms of the development of patient-directed practices, adherence to advance directives and hospice utilization. In fact, Oregon boasts among the highest number of people who die in their own homes, rather than in hospitals.³⁶ The experience and data demonstrate that the implementation and availability of medical aid in dying further promote these practices and improve other aspects of end-of-life care.

- » A survey of physicians about their efforts to improve end-of-life care following authorization of the Oregon Death With Dignity Act showed 30% of responding physicians had increased the number of referrals they provided for hospice care, and 76% made efforts to improve their knowledge of pain management.³⁷
- » A 2015 Journal of Palliative Medicine study found that Oregon was the only state both in the highest quartile of overall hospice use and the lowest quartile for potentially concerning patterns of hospice use.³⁸ “Concerning patterns of hospice use” is defined as very short enrollment, very long enrollment or disenrollment. This same study suggested the medical aid-in-dying law may have contributed to more open conversations between doctors and patients about end-of-life care options, which led to the more appropriate hospice use.
- » Hospice programs across Oregon did, in fact, report an increase in referrals following passage of the Oregon Death With Dignity Act.³⁹ Over 20 years later, 90.8% of individuals who used medical aid in dying were receiving hospice services at the time of their death.⁴⁰

The data from the jurisdictions that have authorized medical aid in dying and subsequently published statistical reports demonstrates that fewer than 1% of people who die annually in an authorized jurisdiction will decide to use the law. However, awareness of the law has a palliative effect, relieving worry about end-of-life suffering. About one-third of terminally ill adults who receive an aid-in-dying prescription in Oregon never even take the medication. However, they report experiencing enormous relief from the moment they obtained the prescription because it alleviated their fears of suffering.⁴¹ Quite simply, medical aid in dying is a prescription for peace of mind.

People Decide to Use Medical Aid in Dying to Relieve Suffering

Terminally ill people who request medical aid in dying do not request it because hospice or palliative care has failed to provide the best symptom control available. In fact, the vast majority of individuals who use medical

³⁶ *Lessons from Oregon in Embracing Complexity in End-of-Life Care*. New England Journal of Medicine, S.W. Tolle, MD, J.M. Teno, MD, (2017) Available from: https://compassionandchoices.org/docs/default-source/default-document-library/12.-lessons-from-oregon-in-embracing-complexity-in-end-of-life-care.pdf?sfvrsn=7f02bdc_1

³⁷ *Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death with Dignity Act*. JAMA. L. Ganzini, H.D. Nelson, M.A. Lee, D.F. Kraemer, T.A. Schmidt, M.A. Delorit, (2001) Available from: <https://jamanetwork.com/journals/jama/fullarticle/193817>

³⁸ *Geographic Variation of Hospice Use Patterns at the End of Life*. Journal of Palliative Medicine, S.Y. Wang, M.D, Aldridge, C.P. Gross, et al.. (2015) Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4696438/>

³⁹ *Oregon's Assisted Suicide Vote: The Silver Lining*. Annals of Internal Medicine, M.A. Lee, S.W. Tolle, (1996). Available from: https://compassionandchoices.org/docs/default-source/oregon/oregon_assisted_suicide_vote_the_silver_lining.pdf

⁴⁰ *Oregon Death with Dignity Act Annual Report (2021)* Available from: <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf>

⁴¹ *A Therapeutic Death: A Look at Oregon's Law*. Psychology, Public Policy, and Law, K. Cerminara & A. Perez, (2000) Available from: <https://www.ncbi.nlm.nih.gov/pubmed/12661538>

aid in dying are also receiving hospice and palliative care.⁴² Good hospice services and palliative care do not eliminate the need for medical aid in dying as an end-of-life care option. Terminally ill people should have a full range of end-of-life care options, whether for illness-specific treatment, palliative care, refusal of life-sustaining treatment or the right to request medication the patient can decide to take to shorten a prolonged and difficult dying process. Only the dying person can know whether their pain and suffering is too great to withstand. The option of medical aid in dying puts the decision-making power where it belongs: with the dying person.

What we hear directly from terminally ill individuals is that people decide to use the law for multiple reasons all at once: pain and other symptoms such as breathlessness and nausea, loss of autonomy, loss of dignity. It is not any one reason, but rather it is the totality of what happens to one's body at the very end of life. For some people, the side effects of treatments such as chemotherapy or pain medication (sedation, relentless nausea, crushing fatigue, obstructed bowels, to name a few), are just as bad as the agonizing symptoms of the disease. For others, they want the option of medical aid in dying because they want to try that one last, long-shot treatment with the peace of mind of knowing that if it results in unbearable suffering, they have an option to peacefully end it.

Only the dying person can determine how much pain and suffering is too much. This law puts the decision in the hands of the dying person, in consultation with their doctor and loved ones, as it should be for such deeply personal healthcare decisions.

Medical Aid in Dying Protects Patients

There have been no documented or substantiated incidents of abuse or coercion across the authorized jurisdictions since Oregon implemented the first medical aid-in-dying law on Oct. 27, 1997. A 2015 report from the Journal of the American Academy of Psychiatry and Law noted "there appears to be no evidence to support the fear that assisted suicide [medical aid in dying] disproportionately affects vulnerable populations."⁴³ Vulnerable groups included the "elderly, women, 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 ethnic minorities, compared with background populations."⁴⁴

Medical Aid in Dying Is Different From Suicide

The American Association of Suicidology emphatically states "aid in dying is distinct from the behavior that has been traditionally and ordinarily described as suicide."⁴⁵ With medical aid in dying, the person is terminally ill — imminent death is a reality that additional therapies won't change. People request medical aid in dying to maintain some control and comfort in their final days, to ease their pain and suffering, and to help them experience a peaceful death. Equating medical aid in dying with suicide is irresponsible and does a disservice to people who need medical aid in dying and people impacted by suicide.

⁴² By compiling the data from each authorized jurisdiction's annual reports and aggregating that over all years, we arrived at these numbers. Medical Aid-in-Dying Utilization Report (2023) Available from: https://compassionandchoices.org/docs/default-source/default-document-library/medical_aid_in_dying_utilization_report_12-13-2022.pdf?sfvrsn=697faeca_2

⁴³ Gopal, AA. 2015. Physician-Assisted Suicide: Considering the Evidence, Existential Distress, and an Emerging Role for Psychiatry. Journal of the American Academy of Psychiatry and the Law. Vol 43(2): 183-190. Available from: <http://jaapl.org/content/43/2/183>

⁴⁴ Margaret P Battin, Agnes van der Heide, Linda Ganzini, Gerrit van der Wal, Bregje D Onwuteaka-Philipsen. Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups. Journal of Medical Ethics, Volume 33, Issue 10, 2007. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652799/>

⁴⁵ American Association of Suicidology. Statement of the American Association of Suicidology: "Suicide" is not the same as "physician aid in dying." October 30, 2017. Available from <https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf>

Additionally, from a legal perspective, this proposed legislation and the Oregon, Washington, Vermont, California, Colorado, Hawaii, New Jersey, Maine, New Mexico, and District of Columbia laws emphasize with the same or similar language that: "Actions taken in accordance with [the Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law." Saying "assisted suicide" inaccurately characterizes a legally authorized, legitimate medical practice as criminal activity under the law.

Opponents of medical aid in dying use the term "assisted suicide" in a cynical attempt to discredit the legitimate practice of medical aid in dying. The American College of Legal Medicine filed an amicus brief before the United States Supreme Court in 1996 rejecting the term and adopted a resolution in 2008 in which they "publicly advocated the elimination of the word 'suicide' from the lexicon created by a mentally competent, though terminally ill, person who wishes to be aided in dying."⁴⁶ Furthermore, the American Association of Suicidology, a nationally recognized organization that promotes prevention of suicide through research, public awareness programs, education and training comprised of respected researchers and mental health professionals, asserts medical aid in dying is fundamentally distinct from suicide and that the term "physician-assisted suicide" should not be used.⁴⁷

Additionally, there is no evidence that medical aid in dying impacts suicide rates and it is a vast mischaracterization of suicide as a public health issue to assign the increase in death by suicide in a jurisdiction to medical aid in dying, when there is no data or formal study that proves this.

While there is no substantiated correlation between medical aid in dying and suicide, there is data that shows that medical aid-in-dying laws improve end-of-life care in general and hospice care specifically.⁴⁸

Medical Aid in Dying and Religion

Every religion has its own values, tenets and rituals around death. A person's individual beliefs are an important factor in their understanding of and approach to dying. While some faiths counsel their adherents that advancing the time of death to avoid suffering is immoral, others just as strongly counsel the dying and their families to leave this life in the manner most meaningful to them. Deciding to use medical aid in dying is only one end-of-life care option. Those who are strongly opposed need not use it. For those who face unbearable suffering, this option can give them both courage and hope, allowing them to live fully as long as possible and to pass peacefully when death is imminent. This is a personal decision that only the dying person can make, in consultation with their doctor and loved ones.

Conclusion

We now have 25 years of data since Oregon first implemented its law in 1997, and over a decade of combined evidence from the laws passed in the 10 other authorized jurisdictions and Montana, including annual statistical reports from nine jurisdictions and countless evidence-based studies and case reviews published in reputable, peer-reviewed journals. We no longer have to hypothesize about what will happen if this medical practice is authorized here in Connecticut.

The evidence is clear: Medical aid in dying laws which contain the same core safeguards found in the Oregon Death with Dignity Act as this legislation does - protect patients, afford the dying autonomy and compassion during the most difficult time, improves end-of-life care across the continuum, and costs states almost nothing to implement, except for the minimal costs associated with collecting data and producing the annual

⁴⁶ *American College of Legal Medicine*, Policy on Aid in Dying. (2008) Available from:

<https://compassionandchoices.org/docs/default-source/policy/american-college-of-legal-medicine-position-statement.pdf>

⁴⁷ "Suicide" is Not the Same as "Physician Aid in Dying." American Association of Suicidology (2017) Available from:

<https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf>.

⁴⁸ American Journal of Health-System Pharmacists, "Oregon Death with Dignity Act May Improve End-of-Life Care," 2001, 58(12) : 1080 <https://doi.org/10.1093/ajhp/58.12.1080a>

statistical reports.

The cost of inaction however, is immense. Without the option of medical aid in dying terminally ill individuals:

- May not try that one last miracle treatment out of fear the treatment will be too painful
- May choose violent means to end their suffering
- Will experience needless agony when they die ... while families and doctors remain powerless with no legal way to respond to pleas for help.

Terminally ill individuals don't have the luxury of endless deliberations; they need the relief that this law affords them right now. Not a single additional person will die if you authorize medical aid in dying, but far fewer will suffer.

Decisions about death belong to the dying, and good public policy enables them to engage in open conversations with their doctors, their loved ones, and their faith or spiritual leaders about their physical and spiritual needs at the end of life. Without the explicitly authorized option of medical aid in dying, people nearing the end of life, their providers and family members risk prosecution if they attempt to fully discuss, offer and access the full range of medical options.

I urge you to let the evidence, experience, data, and strong public support for this end-of-life care option guide your policymaking. Thank you again, Chair and Members of the Committee, for your leadership on this important issue.

Kim Callinan
President/Chief Executive Officer, Compassion & Choices Action Network
kcallinan@compassionandchoices.org
www.compassionandchoices.org

The Compassion & Choices family comprises two organizations: Compassion & Choices (the 501(c)(3)), whose focus is expanding access, public education and litigation; and Compassion & Choices Action Network (the 501(c)(4)), whose focus is legislative work at the federal and state levels.

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