

**Statement to the Public Health Commission Regarding the  
“Act Concerning Compassionate Aid in Dying for Terminally Ill Patients” (Raised Bill No. 6645)**

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The Shakespearian question “What is in a name?” aptly applies here. The proposed bill before the general assembly has been termed “Act Concerning Compassionate Aid in Dying for Terminally Ill Patients” when it, in fact it is at its root neither compassionate nor of aid to those who are most vulnerable within our society. Let us not skirt the issue. This is a physician-assisted suicide bill. As such, it violates the tenets of the Hippocratic Oath, violates codes of ethics from the American Medical Association and the American Nurses Association, and is prohibited by the *Ethical and Religious Directives for Catholic Health Care Services*, which all Catholic hospitals pledge to uphold. Most significantly, the bill does not accomplish the goals it purports to uphold: promotion of patient autonomy, lessening a sense of burden upon society and loved ones, alleviation of pain, and a sense of loss of self.

The proposed bill goes to great lengths to distance itself from the label of “assisted suicide”. Section 15 of the bill states that “Nothing in sections 1 to 17 inclusive, of this act authorizes a physician or any other person to end a patient’s life by...assisting in a suicide.... (RB 6645, Sec. 15, a). It goes on to state that “no report of a public agency . . . may refer to the practice of obtaining a self-administered life-ending medication to end a qualified patient’s life as ‘suicide’ or ‘assisted-suicide’ . . .” (RB 6645, Sec. 15, c). Yet, this is the very definition of physician-assisted suicide. Indeed, the American Medical Association states, “Assisted suicide occurs when a physician provides a patient with the medical means and/ or the medical knowledge to commit suicide” (AMA Committee on Ethical and Judicial Affairs Report 8 – I-93 Physician-Assisted Suicide) It goes on to state, “For example, the physician could provide sleeping pills and information about the lethal dose, while aware that the patient is contemplating suicide. In physician-assisted suicide, the patient performs the life-ending act...” (ibid.). In order to properly assess the implications and ethical considerations of this bill, we must first call it what it is.

Physician-assisted suicide is violates a central tenet of the Hippocratic Oath, which states “I will not give a lethal drug to anyone if I am asked” (Hippocratic Oath, US National Library of Medicine), as well as codes of ethics. The AMA states that:

Physician-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. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (AMA Code of Ethics, Opinion 2.211 I, IV).

As a Catholic, I am concerned that this bill violates the central tenets of the Judeo-Christian tradition; the sanctity of life and the promotion of the dignity of the human person.

As a bioethicist, I am concerned that this bill violates central tenets of ethics. I have worked extensively with terminally ill patients, and have researched and written on compassionate and holistic care for the terminally ill as an alternative to physician-assisted suicide. My work and research has evidenced that physician assisted suicide

does not accomplish the goals it purports to attain. In fact, it often undermines proper care for the terminally ill by short-circuiting the continuum of care that we owe our dying patients. This bill admirably tries to put safeguards in place to avoid the “slippery slope” often associated with physician-assisted suicide, especially with regard to informed consent and decision-making capacity. However, these safeguards are flawed and insufficient. The bill itself cautions against coercion stating “Any person who coerces or exerts undue influence on a patient to complete a request for aid in dying ... is guilty of murder” (RB 6645, Sec. 14, b). The risk of undue influence by medical professionals, family members, and society, especially if the dying patient views themselves as an emotional or financial burden to others, is significant, and no policy will be able to completely mitigate against this. Historically, this has proven to be the case in the Netherlands, where the Dutch Government’s own report (The Rammelink Report) states that physicians self-report incidences of patients being put to death who neither request or consent to physician aid in dying, and in many cases expressly refuse such intervention. Represented within this group are a disproportionately large number of poor, elderly, disabled and mentally ill patients.

Proponents of this bill will cite the experience of the Death with Dignity Act in Oregon, and will note that the bill has improved overall care for the dying in that state. They will cite a greater willingness on the part of physicians to discuss end of life issues with patients and to effectively pursue pain management. However, discussions regarding goals of care and end of life issues as well as a willingness to provide appropriate palliative care do not de facto flow from a physician assisted suicide bill, but from the desire on the part of health care providers to enter into the experience of the dying patient and accompany them on this journey. In addition, safeguards that are in place to prevent potential abuse are sometimes unmet. For example, in 2012 the state of Oregon reported that only “two of the 77 DWDA patients who died during 2012 were referred for formal psychiatric or psychological evaluation” (2012 Death with Dignity Act Annual Report, 2), and since its inception only 6.2% of all patients who received life-ending medication were referred for psychiatric evaluation.

US Jurisprudence on physician-assisted suicide has unequivocally stated that physician-assisted suicide is not a fundamental constitutional right (see USSC rulings in *Washington v Glucksburg* and *Vacco v Quill*). In these rulings, it recognized legitimate state’s interest in prohibiting physician-assisted suicide, among which were preservation of the integrity of the medical profession and avoidance of the “slippery slope”. What the Supreme Court did call for was a better use of existing resources: appropriate and aggressive palliative care, preservation of patient autonomy through Advance Directives (which, unlike this bill, continues to promote patient autonomy and self-determination even after the patient loses decision-making capacity), and the right of patients to refuse treatments that pose little or no medical benefit or undue burden, as well as the recognition of the need to provide better emotional, psychological and spiritual support for the terminally ill. In short, they called for the same things that the American Medical Association deems best practice in caring for those who are at the end of life.

I was asked to submit testimony to this committee on behalf of St. Francis Medical Center, the largest Catholic hospital in New England, and also as a professional bioethicist and educator. However, I also and perhaps most primarily write as a widower who accompanied his wife through chronic and terminal illness, and joined with her as she struggled to maintain her sense of worth, dignity, and autonomy. I was with her as she lay dying in my arms. More importantly, I was with her as she struggled to live. Fundamentally, providing “compassionate aid in dying” as this bill is called, means helping the terminally ill to see that they are not disposable. The dying have a lot to teach the living about life, if we choose to listen. We promote compassionate care for the most vulnerable among us when we affirm their existence, listen to and acknowledge their fears, aggressively treat their pain and help them alleviate their spiritual and existential suffering, not by assisting them with suicide.