Testimony in Opposition to
House Bill 5417 An Act Concerning End-of-Life Care
Public Health Committee
March 20, 2018

Senator Gerratana, Senator Somers, Representatives Steinberg and members of the Public Health Committee, on behalf of the physicians and physicians in training of the Connecticut State Medical Society (CSMS) and the CT Chapter of the American College of Surgeons (CT ACS), we are here today to provide testimony in strong opposition to **House Bill 5417 An Act Concerning End of Life Care**.

The ancient Greek physician Hippocrates, known as the father of modern medicine, prescribed specific ethics and guidelines for physicians. Thousands of years later, his Hippocratic Oath is still taken by physicians as they enter the practice of medicine. As part of this Oath, physicians pledge to devote themselves to healing and to life, and they speak the words, "I will give no deadly medicine to anyone if asked nor suggest any such counsel." As the bedrock of physician ethics, the Hippocratic Oath is fundamentally inconsistent with the underlying concept of this bill that is in essence physician-assisted suicide. Laws sanctioning the use of physician-assisted suicide undermine the foundation of the physician-patient relationship, which is grounded in trust and the knowledge that the physician is working wholeheartedly for the patient's well-being.

The American Medical Association (AMA) has come down strongly against physician-assisted suicide. AMA Ethical Opinion 2.211 states, "allowing physicians to participate in assisted suicide would cause more harm than good. 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."

Society has acknowledged the right of patients to self-determination on matters of medical care, even if the exercise of that self-determination results in the patient's death. The provision of medical care offers both benefits and detriments, and only the patient can determine whether advantages of treatment outweigh the disadvantages. However, there is a fundamental difference between refusal of life-sustaining treatment and demanding a life-ending treatment. When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease. In assisted suicide or life-ending treatment, death is actively induced by the taking of a lethal drug. Although patients cannot be forced to accept treatment against their will, even if it is life-sustaining, the inability of a physician to prevent a patient's death does not imply that physicians are free to help bring about the death.

The legalization of physician-assisted suicide would also place tremendous social and economic pressure on both physicians and patients. Insurers and managed care organizations already stress the need to reduce health care spending. There is a real and relevant fear that physicians would

be pressured into utilizing assisted suicide as a means of reducing the cost of caring for enrollees. There is also a fear that families may pressure patients to choose assisted suicide. Finally, even without overt pressure from others, patients may opt for assisted suicide as they feel they have become a physical, emotional and financial burden.

Undoubtedly, proponents of this legislation will draw a distinction between the legalization of physician-assisted suicide and the ethical parameters – arguing that even if physician- assisted suicide were legalized, no physician would be forced to participate in the practice. While true, the legalization of physician-assisted suicide opens the door to policies that carry far greater risk and presents a very slippery slope for physicians and patients. If physician-assisted suicide is made legal, where will it stop? Will it slowly spread to the disabled or those who are not terminally ill? What will keep society from assisting in or urging the death of anyone whose life is deemed worthless or undesirable? Our experience with medical marijuana has shown how quickly indications are added, even without the benefit of any evidence of efficacy, and how quickly we are willing to add new groups, as for example, children. Although the adoption process in America has been slower than in Europe it merits recognition that there has been enormous and generous loosening of criteria in European countries, including at least one proposed bill that allowed for legal suicide just for being over the age of 75. Could that happen here? It would be naive to say it is impossible.

In closing I would ask that each of you consider how this concept pits individual choice and freedom against the better instincts and needs of our society to always protect its weakest. It is cheap and easy to say, if I were in this position I would want to be able to choose, but sometimes we are called upon to make hard decisions to protect larger goals. Far better would be to expand hospice care to all of those threatened by potentially life ending illnesses to facilitate the transition from health through illness to the death that unfortunately awaits us all. This could be done without enormous expenditure and without significantly altering either our current statutes or the ethics that form the core of good medical practice.

Physician-assisted suicide goes against the obligation of the physician to protect his or her patient, threatening the physician's ethical integrity. CSMS stands strongly behind thousands of years of medical ethics and modern AMA policy against physician-assisted suicide.

Please oppose HB 5417.