

TESTIMONY OF ATTORNEY MARK W. DOST  
RAISED BILL 5417  
AN ACT CONCERNING END OF LIFE CARE

Senator Gerratana, Senator Somers, Representative Steinberg, and other members of the Committee:

My name is Mark W. Dost. I am an attorney practicing in Waterbury. I am a past chair of the Connecticut Bar Association's Elder Law Section, and I serve on the Executive Committees of the CBA's Elder Law Section, Estates and Probate Section, and Human Rights and Responsibility Section. I am a co-author of *A Practical Guide to Issues in Connecticut Elder Law*, published in 2012 by the Connecticut Bar Association. For more than 30 years, I have devoted my practice to counseling and serving clients in their 70s, 80s, and beyond, and I am an advocate of the rights and dignity of the aging and of individuals with disabilities. I oppose Raised Bill 5417, which would allow physician-assisted suicide for individuals nearing death.

First, I am no friend of suicide. Suicide is a serious public health problem, and among some populations, like veterans and youth, it is a critical public health problem. It not only destroys the lives of its immediate victims, but inflicts enormous pain and suffering on its collateral victims – the survivors – the families, friends, and other loved ones of the person who commits suicide. This bill sends the wrong message about suicide to those who would contemplate it. It attempts to set up a distinction, telling our children that it is wrong for them to commit suicide because of their psychological pain, but it is OK for their grandmother to commit suicide because of her psychological pain. Younger people contemplating suicide will not accept that distinction. In this bill, they will see only one message: that it is OK for *anyone* to commit suicide to escape suffering.

Suicide is wrong in all contexts. But assisting it is worse. Although we can have compassion for those whose psychological pain would lead them to end their own lives, we should not excuse those who would encourage or assist others in taking their own lives. The person who jumps from the roof of a building can be forgiven. The crowd below that encourages him to jump cannot.

Some proponents may object and say, "The bill applies only to those who are already dying." They try to justify themselves by saying that they have compassion for those in the process of dying. But the focus of proponents is not on relief of physical pain experienced during the dying process. Physical pain can be treated. Rather their focus is on disability and dependence. This legislation advances the idea that it is better to be dead than disabled and dependent.

We need to identify and confront our prejudice. As individuals and as a culture, we need to condemn the proposition that there is indignity in disability and dependency. Despite what our culture may say, an individual does not lose his dignity – his value – when he becomes disabled or dependent upon others for assistance. Our state constitution recognizes that.<sup>1</sup> We need to recognize it and affirm it.

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<sup>1</sup>Article XXI of the amendments to the Constitution of Connecticut, passed in 1984, amended Article fifth of the amendments to the constitution to read as follows: "No person shall be denied the equal protection of the law nor be subjected to segregation or discrimination in the exercise or enjoyment of his or her civil or political rights because of religion, race, color, ancestry, national origin, sex or *physical or mental disability*. (Emphasis supplied.)

True compassion is evidenced by Mother Teresa, who went out into the streets of Calcutta and brought in the dying and washed, clothed, fed, and stood alongside them as they went through their final days and hours. Compassion is not handing poison to a person who is dying. If compassion is our goal, the focus of our public policy should be on increasing utilization of hospice services in Connecticut and not on offering suicide as an option.

I was a member of a workgroup in the Connecticut Bar Association in 2014 that studied the issue of assisted suicide. The Bar Association that year took the position that the 2014 bill did not contain adequate safeguards to prevent abuse. I agreed with that assessment, but unlike the Bar Association, I do not find this year's legislation (the same as 2015 HB 7015) to be any better. Among the deficiencies:

1. The process laid out in the bill is entirely self-policed by physicians. This is worse than even the Oregon statute, which provides limited, though still inadequate, reporting to the State. In the Connecticut bill there is *no* reporting to the state or to oversight boards.
2. There is nothing in the bill that ensures that the physicians who choose to consult with patients on this matter are well qualified to discuss the matters that the bill requires to be discussed in the consultation. Instead, the bill actually *lowers* the physician's standard of care for patients in assisted-suicide consultations. Although the bill says that the physician is liable for negligence, it then redefines "negligence" by saying that as long as the physician acts in "good faith," he will not be negligent.<sup>2</sup> A good-faith standard in the context of assisted-suicide consultations is completely inappropriate.
3. There are no standards in the bill that ensure that the patient's request is entirely self-initiated and free from outside influence from start to finish. For example, there is nothing in the bill that prevents a physician from initiating the suicide option or recommending it as the "best" option. In my own practice, my clients, in the context of planning their estates, will often ask "What would you do if you were me?" I try not to answer that question, but rather try to make sure that the will or trust I draft for them accurately reflects *their* wishes and *their* decisions. However, a number of my colleagues will often answer that question and even tell their clients what their wills or trusts should say. The question, "What would *you* do?" is a common question addressed to professionals like lawyers and doctors, because it reflects our clients' or patients' trust in us and in our role as counselors. A physician under the bill should *never* initiate the subject of assisted suicide or personally endorse assisted suicide as the "best" option. The patient should be free from that kind of influence.

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<sup>2</sup> RB 5417, Subsection 15(d): An attending physician's dispensing of, or issuance of a prescription for medication for aid in dying or a patient's request for aid in dying, in good faith compliance with the provisions of sections 1 to 19, inclusive, of this act shall not constitute neglect for the purpose of any law or provide the sole basis for appointment of a guardian or conservator for such patient.

4. The issue of physician competence and physician attitudes is particularly a problem for severely disabled individuals who, day in and day out, experience unequal medical care because of the attitude of some physicians toward permanent disability and other conditions they are unable to “fix.”<sup>3</sup>
5. Although the bill devotes much attention to the role of the physician, the bill ends that role after the physician writes the prescription. In fact, there are no protections written into the statute once the prescription is filled.
6. The bill does not require psychological counseling. In 2013 in Oregon, only two of the 71 patients who took their lives under the statute were referred for psychological evaluation and counseling. In 2014, only three of 105 patients who took their lives were referred for counseling. That’s an alarming statistic. Psychological evaluation and counseling are effective for preventing suicide and allowing patients to cope during the dying process. Under current law, psychological evaluation and counseling are mandatory for all who express an intention to take their own lives, and it should be mandatory under this legislation.
7. Section 18 of the bill says that the authority, or jurisdiction, of the Office of Protection and Advocacy for Disabled Persons, which opposed the identical bill in 2015, will not be affected. Of course, the Office of Protection and Advocacy for Disabled Persons was abolished effective July 1, 2017; see C.G.S. Section 46a-10c. The 2015 bill, from which this bill was taken, spelled out no role for the Office of Protection and Advocacy in this process, and this bill spells out no role for Disability Rights Connecticut, Inc., the successor to the Office of Protection and Advocacy for Disabled Persons. In other words, this provision is no safeguard. It’s window dressing.

For these and other reasons, I hope that members of the committee who consider assisted suicide a right will reconsider. Suicide – assisted or otherwise – is always a terrible choice and the suicide option should never find its way into the public policy of Connecticut.

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<sup>3</sup>See D. Coleman, “Not Dead Yet,” and F. Cohn and J. Lynn, “Vulnerable People: Practical Rejoinders to Claims in Favor of Assisted Suicide,” in K. Foley, M.D., and H. Hendin, M.D., *The Case Against Assisted Suicide: For the Right to End-of-Life Care* (Baltimore: The Johns Hopkins University Press, 2002), cited in *Blick v. Office of Division of Criminal Justice*, CV095033392 (Sup. Ct. 2010), upholding Connecticut’s statute forbidding assisted suicide, Conn. Gen. Stat. §53a-56.