"AN ACT CONCERNING END-OF-LIFE CARE"
ANALYSIS of CT HB 5417 (2018)

HB 5417[1] is an Oregon-style doctor-prescribed suicide proposal.

An individual with a controllable medical condition could be considered to have a terminal illness, making him or her eligible for doctor-prescribed suicide.

To be eligible for a prescription for a lethal dose of drugs, a patient must be diagnosed as having a terminal illness, defined as "an incurable and irreversible medical condition that an attending physician anticipates, within reasonable medical judgment, will produce a patient's death within six months."[2]

However, that definition does not require that the patient is expected to die within six months *even with medical treatment,* nor does it require that the condition be *uncontrollable.* Therefore, it is possible that a patient could be considered "terminal" for the purpose of qualifying for assisted suicide even if, with medical treatment, the patient could live much longer.

For example, diabetes can be both incurable and irreversible but is controllable. An insulin-dependent diabetic patient who stops taking insulin will die within six months. Thus, under HB 5417, diabetics could be eligible for doctor-prescribed suicide even though they could live virtually normal lives with insulin.

There is documentation that this has occurred under Oregon's assisted-suicide law, the law on which the Connecticut proposal is based. In official reports from Oregon, diabetes is noted as the underlying terminal condition that made a patient eligible for the lethal prescription.[3]

A demonstrative case was discussed by Dr. Charles Blanke, an oncologist and professor of medicine at Oregon Health and Science University. He described he case of a young woman with Hodgkin lymphoma who had a 90 percent chance of living for decades with recommended treatment. The woman, however, refused the treatment. "That was a very challenging situation," he said. "You have to ask yourself, 'Why doesn't that patient want to take relatively non-toxic treatment and live for another seven decades? '" Blanke ended up prescribing the deadly overdose for the woman anyway.[4] There are many conditions (diabetes, certain types of leukemia, a disability requiring ventilator support, etc.) that, without medical treatment, would result in death within six months. However, with medical treatment, individuals with those conditions could live for many years. Yet those individuals would be eligible for doctor-prescribed suicide.

Why is the definition of "terminal illness" so broad?

If HB 5417 is approved, doctor-prescribed suicide would become a "medical treatment."

This would give insurance programs the opportunity to cut costs by denying payment of more expensive treatments while approving payment of the less costly prescription for a lethal drug overdose.

This has already been documented in Oregon – the state with the law upon which the Connecticut proposal is based. The Oregon Health Plan (OHP) has notified some patients that medications prescribed to extend their lives or improve their comfort level would not be covered, but that the OHP would pay for a lethal drug prescription.[5]

Referring to payment for assisted suicide, the Oregon Department of Human Services explains, "Individual insurers determine whether the procedure is covered under their policies, just as they do any other medical procedure."[6]

If the Connecticut bill is approved, will health insurance programs do the right thing – or the cheap thing?

A health care facility could not prevent deaths from doctor-prescribed suicide on its premises. Furthermore, a facility willing to permit assisted-suicide deaths could require nurses and certain other individuals to facilitate such deaths.

HB 5417 states that "a health care facility may adopt written policies prohibiting a health care provider associated with such health care facility from *participating in the provision of medication to a patient for aid in dying*."[7]

It also states that "a health care facility shall not require a health care provider to *participate in the provision of medication* to a qualified patient for aid in dying."[8]

However, the phrase "participate in the provision of medication" is very narrowly defined in the bill.[9] It refers only to performing the duties of the attending or consulting physician, psychiatrist, psychologist, or pharmacist. It does not include nurses and other individuals.

Therefore, facilities would not be able to ban others from bringing a lethal drug prescription to a patient or resident to self-administer on the premises; would not be able to prevent the witnessing of the written requests for doctor-prescribed suicide; and would not be able to prohibit nurses or others from picking up the drugs from an outside pharmacy and providing them to a patient or resident.

Likewise, facilities permitting doctor-prescribed suicide could require nurses to bring the drugs to a patient since such activities would not constitute "participation" as defined in the proposal.

A person "familiar with the patient's manner of communicating" could convey (translate) the patient's requests for the lethal dose.[10]

How would anyone know if the translation is accurate? How would it be possible to know if the patient is really requesting doctor-prescribed suicide?

The bill requires only two requests – both written.[11] Nothing requires that those written requests be made in the presence of the physician who will write the prescription for the deadly overdose. As written, the bill would permit the written requests to be mailed or delivered by a third party to the prescribing physician.

There is no requirement of oral requests or that any requests be made in person. The only reference to an oral request is in reference to items to be filed in the patient's medical record.[12] However, this does not mean that oral requests are required since, the same section also notes that the report on counseling is to be included, yet counseling is not required for all patients who are deemed eligible for doctor-prescribed suicide.

Under the bill, a person who would benefit financially from the person's death cannot serve as a witness to the written request.[13] However, the request could be signed at the patient's residence and witnessed by two of the heir's "best friends" who claim that the signer is competent, acting voluntarily and not being coerced into signing it.

This places victims of elder abuse and domestic abuse in great danger since they are unlikely to share their fears with outsiders or to reveal that they are being pressured by family members to "choose" doctor-prescribed suicide.[14]

The bill permits a person who would benefit financially from the person's death to pick up and deliver the lethal prescription.

The drugs can be dispensed to "an expressly identified agent of the qualified patient."[15] The qualified patient could be encouraged to authorize another individual to pick up the drugs and deliver them to the patient's residence.

All of the "safeguards" in the bill cease the moment the prescription is received.

The bill contains eight references to the fact that the prescription is to be "voluntarily" requested. However, nothing in the proposal states that the drugs, once prescribed, must be knowingly or voluntarily taken.

Why are there no safeguards at the most important part of the process – at the time the patient takes the drugs that will cause death?

---

[1] The text of HB 5417 is available at: https://www.cga.ct.gov/2018/TOB/h/2018HB-05417-R00-HB.htm.
[2] Sec. 1 (19).
[3] Official report for 2012 deaths under Oregon's Death with Dignity Act, pg. 6, fn. 6. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf (last accessed 3/8/18).
[4] Tara Bannow, "Rural Oregonians Still Face Death with Dignity Barriers," *Bend Bulletin,* August 14, 2017. Available at: http://www.bendbulletin.com/health/5512373-151/oregonians-can-choose-how-their-roads-end (last accessed 3/8/18).
[5] Susan Donaldson James, "Death Drugs Cause Uproar in Oregon." *ABC News*, August 6, 2008. Available at: http://abcnews.go.com/Health/story?id=5517492&page=1 (last accessed 3/8/18).
[6] Oregon Dept. of Human Services, "FAQs about the Death with Dignity Act." Available at: http://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/faqs.aspx#insurance (last accessed 3/9/18).
[7] Sec. 13 (d). (Emphasis added.)
[8] Sec. 13 (b). (Emphasis added.)
[9] Sec. 13 (a).
[10] Sec.1 (4).
[11] Sec. 3 (a).
[12] Sec. 10 (2).
[13] Sec. 3 (b).
[14] For example, statistics indicate, "Only four percent of reported elder abuse cases come from the elder person; 96 percent of the reports come from somewhere else." Gazette.net (Maryland), "A safe place for abused seniors," February 9, 2015. Available at http://www.gazette.net/gazettecms/story.php?id=12049 (last accessed 3/9/18).
[15] Sec. 9 (a) (6) (A).

Patients Rights Council
P.O. Box 760
Steubenville, OH 43952
800-958-5678 or 740-282-3810
http://www.patientsrightscouncil.org