PATIENTS RIGHTS ACTION FUND

Analysis of Connecticut House Bill 6425

The stated purpose of H.B. 6425 is "[t]o provide aid in dying to terminally ill patients." The specific aid the bill provides is physician-assisted suicide.

Section 1 provides definitions used throughout the bill:

Section 1(2) defines "aid in dying" as "the medical practice of a physician prescribing medication to a qualified patient who is terminally ill, which medication a qualified patient may self-administer to bring about his or her death[.]"

Inclusion of lethal medication within medical practice is the first step toward making it part of the standard of end-of-life care. Further, the definition of "self-administer" as "[the] voluntary, conscious and affirmative act of ingesting medication [,]" § 1(19), is sufficiently vague to allow euthanasia since an "affirmative act" can include merely opening one's mouth to ingest the lethal drug.

Nothing in the definition of "attending physician," § 1(3), or of "consulting physician," § 1(5), requires either to have any training or experience in identifying clinical depression. As the Supreme Court recognized when rejecting a constitutional right to physician-assisted suicide, many patients who request suicide withdraw that request when their depression is treated; but, since clinical depression is difficult to diagnose, physicians often fail to address their patients' needs. *Washington v. Glucksberg*, 521 U.S. 702, 730-731 (1997).

Though Section 8(a) provides that either the attending or consulting physician "shall" refer the patient for counseling, the requirement is actually discretionary depending on whether, "in ... [their]medical opinion [,]" the patient may suffer from a condition that is causing impaired judgement. *Id.*

Nothing in the definition of "attending physician," § 1(3), or of "consulting physician," § 1(5), requires them to be independent of each other so that the confirmation of the medical judgement is also independent.

In defining "competent" to include the capacity "to communicate ... [a health care] decision to a health care provider, including communicating through a person familiar with a patient's

manner of communicating [,]" §1(4), nothing prevents such person from having a financial interest in the patient's estate.

Nothing in the definition of "counseling," §1(6), prevents the consultation from being conducted virtually. Nothing in the bill requires the consulting physician to "medically confirm" the attending physician's diagnosis by physically, rather than virtually, examining the patient. *Cf.* § 1(11).

Section 1(9) (D) does not specifically require the attending physician to inform the patient of hospice care as a feasible alternative to lethal medication. *See* also § 6(3)(E). Though the attending physician is required to fully inform the patient about palliative care, §1(9)(D), including hospice care, §1(12)(D), the latter obligation is satisfied if a non-physician health care provider, §1(7), discusses with the patient whether hospice care is an available and appropriate treatment option. § 1(12)(D).

Nothing in the definition of "qualified patient," § 1(18), requires the presence of severe and intractable pain or, for that matter, any pain at all, as a condition for the prescription of lethal medication.

In defining "terminal illness," Section 1(20) only requires the prognosis of death within six months to be within the physician's "reasonable medical judgment [.]" Such standard is satisfied if the physician merely considers it "more likely than not" that death will occur within that time. There is no requirement that such prognosis be with or without treatment. Thus, if a diabetes patient would die within six months without insulin, the condition is terminal under the definition. Further, if death were imminent once treatment were removed, say in the case of kidney dialysis, then such patient is arguably in the "final stage" of the illness.

Under the form set out in Section 4, patients indicate they have been informed of feasible alternatives to lethal medication; but, as previously indicated, this obligation is satisfied regarding hospice care if a non-physician informs the patient of what is considered available and appropriate. Under the form, the patient acknowledges that the attending physician has communicated the terminal diagnosis and prognosis, but not specifically that the illness is in its final stage. *Cf*. §1(20).

Though the form for the written request indicates that the patient is likely to die within one hour from taking the lethal medication, forms in other states, see *e.g.*, O.R.S. § 127.897(Oregon); R.C.W. § 70.245.220 (Washington), set the time at three hours.

Nothing prevents both witnesses to the written request for lethal medication to have a financial interest in the patient's estate.

Nothing requires that the patient's competency be reevaluated before the lethal medication is taken, even though weeks or months have passed since the prescription was written. Nothing requires that an objective witness be present when the lethal medication is taken. Since Section 9(b) requires that the underlying illness be listed as the cause of death, neither the patient's family nor the medical examiner may have any reason to investigate how the patient died.

There is no time interval between the written request and writing the lethal prescription, as required by other states. See *e.g.*, O.R.S. § 127.850(Oregon); R.C.W § 70.245.110(2) (Washington).

Section 13(b) indicates 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 [.]" the term "participate in the provision of medication," however, does not include "informing a patient concerning the provisions of ... [this bill] upon the patient's request; or ... referring a patient to another health care provider for aid in dying [.]" §§ 13(a)(3) & (4). Thus, a health care facility can arguably require its employees to perform such acts even though considered by the employees immoral. Conversely, though a health care facility can prohibit associated health providers' "participation in the provision of medication," § 13(b), the provision of information about the bill and a referral to a willing provider are expressly exempted from such prohibition, § § 13(d)(3) (4), assumedly even if performed on the facility's premises. Further, since such acts are not considered participation, they can arguably be performed even when the associated providers are acting within the scope of their employment or contract. *Cf* § 13(d)(6).

The bill provides a conflicting patchwork of liability. On the one hand, it protects persons from criminal and civil liability and professional sanctions "for participating in the provision of medication or related activities in good faith compliance [." §15(e)(1). On the other hand, Section 16 indicates that nothing in the bill limits civil damages for negligence or intentional misconduct, while Section 17(b) indicates that "[n]othing in ... [the bill] shall preclude criminal prosecution under any provision of law for conduct that is inconsistent with ... [the bill]."

Unlike other States authorizing physician-assisted suicide, *see e.g.*, Oregon Death with Dignity Act: Annual Reports, https://www.deathwithdignity.org/oregon-death-with-dignity-act-annual-reports/#:~:text=During%202019%2C%20the%20estimated%20rate,died%20from%20ingesting

%20the%20medications; Death with Dignity Data: Washington State Department of Health, https://www.deathwithdignity.org/oregon-death-with-dignity-act-annual-reports/#:~:text=During%202019%2C%20the%20estimated%20rate,died%20from%20ingesting%20the%20medications, there is no requirement for an annual report on the administration of the bill to permit the public to monitor its enforcement.

Talking Points for Connecticut House Bill 6425:

People may disagree about the morality of assisted suicide; but all can agree that strict safeguards are imperative. Rather than providing a shield, H.B. 6425 is an open invitation to patient abuse:

It is first worth noting that the bill nowhere requires patients to experience insufferable pain, or any pain at all, as a condition for requesting lethal medication.

Second, someone financially interested in the patient's death (say, the beneficiary of a life insurance policy), who is familiar with the patient's manner of communicating, can serve to communicate the patient's health care decisions to the patient's attending physician. The same interested person can be a witness to the patient's written request for lethal medication.

Third, the same interested person can be the only witness present when the lethal drug is taken since objective observers are not required.

Fourth, the attending physician is not required to evaluate the patient's competency at the time the lethal drug is taken, even though weeks or months have passed since the prescription was written.

Fifth, the attending physician can complete the death certificate on the hear/say of such interested person regarding the circumstances of the patient's death since the physician's presence is not required when the lethal medication is taken.

Sixth, since the patient's death must be listed on the death certificate as the underlying terminal illness, family members would likely never know that the patient died from lethal medication rather than from the underlying medical condition. Further, coroners would not routinely investigate deaths certified from natural causes. Thus, no one will have reason to inquire into the circumstances surrounding the patient's death.

Finally, even though the patient's insurance policy does not cover death from suicide, the same interested person can still recover if named as a beneficiary since death from lethal medication prescribed under the Act is not considered suicide.

Simply put, H.B. 6425 provides a legislative blueprint for crime.