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STATEMENT

3 September 2015

Committee Chair: Kate Hogan

Dear Chairwoman Hogan:

I am pleased to provide my support for the proposed legislative initiative to enact the rights of terminally ill persons who have been diagnosed as likely to die within six month to exercise their choice to end their lives.

The exercise of personal choice is endemic to the ideology expressed in U.S. Constitution provided that such choice does not impinge upon the rights and safety of others. Choice-making is at the heart of life's experiences, and society's current support of personal autonomy undergirds this capacity. Daily, people enjoy and exercise choice-making every aspect of life ranging from accessing the necessities of daily living to their choice in partners, occupations, and how they wish to live. Choice-making extends to the care of the self as well. The Patients' Bill of Rights (a concept initiated at Boston's Beth Israel Hospital in 1966), as well as the Advance Directive model now advanced nationwide are evidence to the importance placed upon individual choice making.

When seeking medical care, we, as patients, are also frequently faced with choice-making based upon the recommendations of medical professionals and our own particular personalities, values and beliefs. Health care professionals and their patients both recognize that making choices is fundamental to their relationship; choice making preserves and respects the autonomous rights of each. There is no logical reason why choice-making rights should not pertain at each stage of human development including life's inevitable end provided that those making choices retain the rational and emotional capacities for such decisions.

Personally, as a Rabbi, clinical psychologist, chaplain, ethicist, teacher, and clinical researcher, I have experienced an evolution in my thinking about this last point. Convinced in the sacredness of life, I initially thought and felt that an individual's choice to end his or her life constituted a cardinal violation of life as a sacred trust. In this context, I viewed anyone's assistance in facilitating a person's death as an agent, even if somewhat distant, from this violation. Over the course of over four decades of caring for persons as a congregational rabbi, chaplain, and mental health care provider, I have been with and held the hands of many people as they died. I have also seen and been with people who suffer physically, psychologically, and emotionally as they die, including a few who were also receiving the best palliative care and support one could ask for. As I see it, there are two domains of human suffering, one physical and the other emotional/psychological and possibly spiritual as well. Even with the advances in medical care that can reduce, even eliminate physical suffering; reducing or eliminating emotional/psychological and spiritual suffering is much more complex and difficult.

Physicians recognize this fact. By tradition and practice, their professional responsibilities are focused in three areas: (1) cure, if possible, (2) maintain and stabilize as indicated, and (3) palliate. The latter option extends from an understanding physician codes in all cultures, “do no harm” and “reduce human suffering”. It is well known that physicians often cause harm in the cause of obtaining clear diagnoses or generating curative outcomes. Today, palliative care and the addition care offered by hospice movement are current models of caring for people whose prognosis is death within six months or less.

Palliative care is provided even when people are not facing immanent death. It represents reasoned compassionate care at all stages of life. Hospice care, though it is formally engaged when people are diagnosed with the likelihood of death within six months. The provisions of both palliative and hospice care are guided by principles of respect for persons. Physicians usually amid a variety of medical options offer choices to patients who, in turn, exercise their rights and choices.

People facing life’s end ought to retain their rights to exercise a variety of choices including a choice to end their lives in a manner that retains their dignity as autonomous choice-makers. Over the years, I have come to respect the emotional and psychological pain and suffering that diagnosed terminally ill patients experience. At core, one of the elements of this suffering is the fear and anger they may feel not only about their mortal condition but over the fact that their autonomy is no longer respected. This feature becomes clear now from experiences in the states that have granted such people the right to choose their deaths. Only a small number who have chosen and petitioned to exercise this right have actually taken this action. This finding supports a feature that the suffering is likely generated by the inability to make choices about how their lives might end was relieved.

In this context, I have become convinced that enabling people to have a legal choice to request assistance in their dying constitutes one of the highest degrees of palliative care that we can offer them. It demonstrates respect for them as individuals who wish to continue their natural capacity to make choices throughout life. Likewise, physicians who agree to assist people in this process also preserve their personal and professional rights as choice makers. The ability to so choose should be a legitimate legal and professional option. They, too, like their patients, can choose whether to offer such palliative care. The proposed legislation that advances both written and verbal statements and corroboration by two physicians and appropriate psychological evaluation serves as a safeguard. I strongly urge the acceptance of this legislation.

Respectfully submitted,

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