Bill Summary:

SB 1076 An Act Concerning Aid in Dying for Terminally Ill Patients

The Legislation Allows:

a terminally ill, mentally capable adult with a prognosis of six months or less to live the option to request, obtain and take medication — should they choose — to die peacefully in their sleep if their suffering becomes unbearable.

The bill is modeled after legislation in authorized jurisdictions, including the Oregon Death with Dignity Act, which has been in practice for 25 years without a single instance of abuse or coercion.

Eligibility Criteria
To be eligible, a person must be:

- An adult, aged 21 or older
- Terminally ill with a prognosis of six (6) months or less to live
- Mentally capable of making an informed healthcare decision

Individuals are not eligible for medical aid in dying solely because of age or disability.

Key Provisions

- The individual must be able to self-administer the medication. Self-administration does not include administration by intravenous (IV) injection or infusion by any person, including the doctor, family member or patient themselves.
- Two physicians must confirm that the person is terminally ill with a prognosis of six months or less to live, mentally capable and not being coerced.
- A terminally ill person can withdraw their request for medication, not take the medication once they have it or otherwise change their mind at any point.
- The attending physician must inform the requesting individual about all of their end-of-life care options, including hospice and palliative care.
- Medication cannot be prescribed until mental capacity to make a healthcare decision is confirmed by a licensed mental health specialist.
- Physicians who participate and comply with all aspects of the law are given civil and criminal immunity.
• Life insurance payments cannot be denied to the families of those who use the law.
• No physician, health provider or pharmacist is required to participate.
• Unused medication must be disposed of according to specified state and federal guidelines.

**Additional Regulatory Requirements**

• Two written requests are required, with a 15-day waiting period between the first and second request. Two people must witness each written request.
• Prescribing physicians must comply with medical-record documentation requirements and make records available to the state department of health.

**Additional Information About the Bill:**

Legislation: **SB 1076**

**For More Information:**

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*The Compassion & Choices family comprises two organizations: Compassion & Choices (the 501(c)(3)), whose focus is expanding access, public education and litigation; and Compassion & Choices Action Network (the 501(c)(4)), whose focus is legislative work at the federal and state levels.*

Paid for by Compassion & Choices Action Network
75% of Connecticut Voters Support Medical Aid-in-Dying Legislation

Legislation to allow medical aid in dying, an option for mentally capable, terminally ill adults to peacefully end unbearable suffering, is supported by a wide majority of Connecticut voters regardless of race, religion, age, gender identity, political affiliation or whether they have a disability.

AGE
- 80% 18-49
- 73% 50+

RACE
- 77% WHITE
- 72% PEOPLE OF COLOR

GENDER
- 72% MEN
- 78% WOMEN

RELIGION
- 69% CATHOLIC
- 70% PROTESTANT
- 68% TOTAL CHRISTIANS
- 89% NO RELIGIOUS AFFILIATION

POLITICAL AFFILIATION
- 84% DEMOCRATS
- 64% REPUBLICANS
- 74% INDEPENDENTS

VOTERS RATED THEIR PERSONAL DOCTORS OVERWHELMINGLY SUPPORTIVE


CompassionAndChoices.org/Connecticut
Fact: There is NO Connection Between Denial of Insurance Coverage and Medical Aid in Dying

As a board-certified physician in family medicine, hospice and palliative medicine for 30 years in Montana, where medical aid in dying has been authorized since 2009, I can say with certainty that there is no connection between the availability of this end-of-life care option and the denial of treatment by insurance companies. Insurance companies won’t cover unproven or experimental treatments — regardless of whether or not a state has authorized medical aid in dying. Using insurance companies as a justification to prevent dying patients from accessing this humane palliative care option to peacefully end unbearable suffering is cruel and mean-spirited.

– Eric Kress, M.D., family, hospice and palliative care physician in Missoula, MT

FIVE FACTS YOU NEED TO KNOW

1. It is illegal for anyone, including an insurance company, to coerce an individual to request or use medical aid in dying.

2. Regardless of whether a state has authorized medical aid in dying, insurance providers cover treatments that are deemed effective and proven, and not those considered unnecessary, experimental or below the standard of care.

3. A research article published in the New England Journal of Medicine and coauthored by Dr. Ezekiel Emanuel, a public opponent of medical aid in dying, concludes that insurers have no financial incentive to pressure patients to accelerate their deaths.

4. The vast majority of people who choose medical aid in dying are enrolled in hospice services. They have already discontinued expensive, curative treatments, so an insurance company is not saving money by approving a request for medical aid in dying.

5. In a combined 40 years of experience with medical aid in dying across authorized jurisdictions, there has not been a single proven incidence of an insurance company denying treatment because of the availability of medical aid in dying.

For more information, visit CompassionAndChoices.org

Updated: 4.04.18
When people face life’s inevitable end, they deserve to have autonomy and a full range of medically appropriate options for care at the end of life. One of those options is medical aid in dying.

Support for medical aid in dying has grown rapidly, 72% of United States voters support this end-of-life care option. This legislation has gained support from a broad base of voters, including those living with disabilities.

Years of Evidence, No abuse.

Nearly ten years after the first law authorizing medical aid in dying went into effect in Oregon:

“Rates of assisted dying ... showed no evidence of heightened risk for the elderly, women, the uninsured ... people with low educational status, the poor, the physically disabled or chronically ill ... people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations”^2

Across the country, an increasing number of disability rights groups have taken a neutral or supportive position on medical aid in dying.

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2 Margaret P Battin, Agnes van der Heide, Linda Ganzini, Gerrit van der Wal, Bregje D Onwuteaka-Philipsen. Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in “vulnerable” groups. Journal of Medical Ethics, Volume 33, Issue 10, 2007, available at http://jme.bmj.com/content/33/10/591
People with disabilities are speaking out in support for medical aid in dying.

“ I think those who have a terminal illness and are in great pain should have the right to choose to end their lives and those that help them should be free from prosecution.”

– Stephen Hawking, (1942 – 2018), Renowned Cosmologist and theoretical physicist, who lived with Lou Gehrig’s disease

“ I’ve always felt that one should have a choice at the end of their lives. That has not changed because I have an ALS diagnosis. What’s more important for a dying person than to have control at the end of their life?”

– Sara Myers, (1954 – 2016), Terminally Ill person with disabilities and an ALS patient, New York City

“ Based on my 23 years of clinical practice, as a person with a disability, and as an individual whose family members have experienced very difficult end-of-life challenges, I am in strong support of authorizing medical aid in dying.”

– Dr. Seth Morgan, Board-Certified fellow of the American Academy of Neurology, leader for the National Multiple Sclerosis Society, and chair of Montgomery County’s Commission on People with Disabilities

The movement to expand end-of-life care options and the disability rights movement share important core values:

AUTONOMY INDEPENDENCE SELF-DETERMINATION

For more information, visit CompassionandChoices.org/disabilityrights
ZERO: The number of complaints Disability Rights Oregon has received in the 20 years since Oregon’s medical aid-in-dying law was implemented

“Disabilities Rights Oregon has never to my knowledge received a complaint that a person with disabilities was coerced or being coerced to make use of the Act.”
– Bob Joondeph, Executive Director, Disability Rights Oregon (DRO)

“One of the, probably the most fundamental right that we support as an agency is the right to make your own decisions whenever you’re competent to do so. And that leads us to stand here in support of this bill.”
– James Jackson, Disability Rights New Mexico

NINE FACTS YOU NEED TO KNOW

1. The medical aid-in-dying and disability rights movements share important core values: autonomy, independence and self-determination.

2. Medical aid-in-dying laws protect people with disabilities from coercion and exploitation through strict eligibility requirements and safeguards. In states where medical aid in dying is not authorized, people with disabilities are actually more vulnerable to coercion and abuse.

3. A person with a disability is only eligible for medical aid in dying if they are terminally ill with six months or less to live. In addition, the person has to be an adult, able to make informed healthcare decisions, and able to take the medication themselves.

4. No one can get a medical aid-in-dying prescription unless and until two doctors and two independent witnesses confirm that the person requesting it is not being coerced to do so.

5. Coercing someone to use medical aid in dying is a felony punishable under state criminal laws.

6. Medical aid in dying is a medical practice proven by decades of experience in authorized states. In more than four decades of practice, there is not a single substantiated case of abuse or coercion nor any civil or criminal charges filed related to the practice. Not one. Currently medical aid in dying is authorized in 11 jurisdictions.

7. Two out of three people living with a disability support medical aid in dying according to surveys in Connecticut, New Jersey and Massachusetts.

8. The Disability Rights Legal Center has declared that medical aid in dying “poses no threat to people with disabilities.”

9. Activists in the disability community — like Dr. Steven Hawking, among others — are some of the strongest supporters of medical aid in dying as an option.

For more information, visit CompassionAndChoices.org

Updated: 3-24-21
Medical Aid in Dying is fundamentally different from euthanasia. While both practices are designed to bring about a peaceful death, the distinction between the two comes down to who administers the means to that peaceful death. Euthanasia is an intentional act by which another person (not the dying person) administers the medication. By contrast, medical aid in dying requires the patient to be able to take the medication themselves and therefore always remain in control. Euthanasia is illegal throughout the United States.

State legislatures and courts in states where the practice is authorized recognize medical aid in dying as differing from suicide, assisted suicide or euthanasia. Euthanasia and assisted suicide are both illegal in jurisdictions where medical aid in dying is authorized. Medical aid-in-dying laws on the books in California, Colorado, the District of Columbia, Hawaii, Maine, New Jersey, Oregon, Vermont and Washington expressly state: “Actions taken in accordance with [the Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide.” And in Montana, where assisted suicide is specifically illegal, the Montana Supreme Court ruled in Baxter v. Montana that medical aid in dying provided to terminally ill, mentally competent adult patients in no way violates established state law [including Montana’s assisted suicide statute] or the principles of public policy.

The American Association of Suicidology (AAS) recognizes that the practice of medical aid in dying is distinct from the behavior that has been traditionally and ordinarily described as “suicide.” People who seek medical aid in dying want to live but are stricken with life-ending illnesses. They feel deeply offended when the medical practice is referred to as suicide or assisted suicide.

Leading medical organizations reject the term “physician-assisted suicide.” The American Academy of Hospice and Palliative Medicine, American Medical Women’s Association, American Medical Student Association, American Academy of Family Physicians and American Public Health Association have all adopted policies opposing the use of the terms “suicide” and “assisted suicide” to describe the medical practice of aid in dying. The American Association of Suicidology, a nationally recognized organization that promotes prevention of suicide through research, public awareness programs, education and training comprised of respected researchers and mental health professionals, documents 15 ways medical aid in dying is fundamentally distinct from suicide and “a matter outside the central focus of the AAS.”

The most prominent professional society in the United States addressing issues that arise at the interface of law and medicine rejects the term “physician-assisted suicide.” The American College of Legal Medicine filed an amicus brief before the United States Supreme Court in 1996 rejecting the term and adopted a resolution in 2008 in which they “publicly advocat[ed] the elimination of the word ‘suicide’ from the lexicon created by a mentally competent, though terminally ill, person who wishes to be aided in dying.”
Opinion: Medical aid in dying should not be proscribed by society’s laws or condemned by its mores

By George F. Will
Columnist

Today at 8:00 a.m. EST

Late last year, at 3 a.m. in what is a now-normal night, Kim Hoffman awoke with “an unbelievable headache.” These are related to the 30 brain lesions, and the steroids needed to reduce the swelling of the brain. After dawn that day, she said, speaking by phone from her home in Glastonbury, Conn., “I felt a new neck lesion.” She has so many skin lesions that “it feels as though my skin is being torn like someone has a serrated knife.” What began as ovarian cancer has, she said, metastasized to “both breasts, my right lung, the lining of my spine, and many lymph nodes.” She says, “I’m a pretty sick puppy.”

When she was 16 and “a car brosided me while I was on my bike,” her injuries were “really, really painful.” Then, however, “I knew I was going to live. The difference here is I’m not going to get better. And the pain is indescribably worse.”

A few days before her initial diagnosis in June 2013, she ran a three-mile, 20-obstacle race through mud. For years, the arsenal of modern oncology has been unable to defeat her disease, and has left her debilitated by constant fatigue and pain. In November, she was told she had two to four months to live. She turned 59 on Dec. 27. She and her wife — “It hurts her so much to see me suffer so deeply” — and other loved ones hope she won’t live far into her 60th year.

While resisting her disease with surgery, radiation and chemotherapy (one treatment she likens to “injecting your body with Agent Orange),” she has twice testified to Connecticut’s legislature in support of legalization of medical aid in dying (MAID). Although 75 percent of Connecticut voters favor MAID, the legislature tabled the measure this past year without debating this question: What is Connecticut’s compelling interest in preventing Hoffman from receiving such assistance?
Writing in the London Review of Books, Stephen Sedley, a former judge and current Oxford University professor, notes that in the 19th century the law “got itself into such a tangle” that a person who injured himself or herself in a suicide attempt “could be indicted for wounding with intent to kill,” a capital offense. Some believers in an interventionist deity argued that terminal suffering, being God’s will, should not be curtailed, an objection they could also lodge against anesthesia. The British common law of “trespass to the person” entitles a mentally competent adult to refuse invasive treatment even if it is painless. “Yet,” Sedley writes, “the ability of a rational individual in unbearable and untreated distress to opt for terminal medication remains beyond the pale of the law.”

Increased life expectancy, increased medical competence, increased secularism, and increased insistence on privacy and autonomy are producing increased support for legal regimes that respect the right of mentally capable and terminally ill individuals to protect themselves from lingering intense pain and mental decrepitude. A November survey by Susquehanna Polling and Research found that 68 percent of likely voters believe that a mentally sound person with no more than six months to live should have access to a prescription medication that will produce a peaceful death while asleep. Ten states and the District of Columbia, with a combined 22 percent of the U.S. population, have comparable laws.

Compassion & Choices, which advocates for medical aid in dying, sensibly insists that this terminology, not “assisted suicide,” is proper. Suicide connotes despair and perhaps derangement. Dying is a facet of every life. An anticipated death, in the presence of loved ones, a death chosen after reflection about predictable, unavoidable pain, should not be proscribed by society’s laws or condemned by its mores.

“I do want to live,” Hoffman says. But not in her increasingly, irreversibly “whittled down” condition.

She is a tad testy about the legislature ignoring her cause but making pizza the state’s official food. Before she was incapacitated, she was a social worker in local high schools. “My God,” she says, humorous even in extremis, “I worked with teenagers for 30 years. If that’s not paying my dues …” She is speaking, she says, “tongue-in-cheek,” but pointedly: What does she owe, and to whom, that justifies the state government’s standing between her and consensual measures that would stop the prolongation of her agony?

A subsequent column will consider the qualms that many thoughtful people have concerning MAID. And the accumulating data pertinent to the serious issues involved.

Opinion by George Will

George F. Will writes a twice-weekly column on politics and domestic and foreign affairs. He began his column with The Post in 1974, and he received the Pulitzer Prize for commentary in 1977. His latest book, "American Happiness and Discontents," was released in September 2021. Twitter
OPINION

Letter: CT’s ‘aid-in-dying’ bill is about me. ‘Time is running short’

Lynda Shannon
April 4, 2022

To the editor,

This ‘aid in dying’ bill is about me: I am a patient with a life-limiting diagnosis. A year ago, I was diagnosed with late-stage Fallopian tube cancer, my third cancer diagnosis. Time is running short for me too and I do want this bill to make it out of committee this year.

In 2021, Connecticut’s aid-in-dying bill passed the Public Health Committee, but when referred to the Judiciary Committee it died. State Rep. Steve Stafstrom, co-chair of the Judiciary Committee, said there “wasn’t enough support to bring it to a vote” and it’s starting to look like that might happen again. Seriously?

Why is it so hard to pass a bill that lets people decide for themselves about their end-of-life care? In 1997 Oregon became the first state to pass a Death With Dignity Act and polls have consistently shown widespread support for medical aid in dying among Connecticut voters in all demographics including younger people (80 percent), older people (73 percent), Catholics (69 percent), Protestants (70 percent), those with no religious affiliation (89 percent), white men and women (77 percent), people of color (72 percent) and people who have a disability (65 percent).

The Connecticut State Medical Society has a stated position of “engaged neutrality” and the AMA has acknowledged that providing medical-aid-in-dying in no way violates the Code of Medical Ethics. So, what’s the problem? Are our legislators voting their personal beliefs, rather than representing the people who elected them?

My choices may not be what others would want given similar circumstances, but they are mine, personal, private, precious, and sacred.

Lynda Shannon
Bridgeport