January 28, 2016
Honorable Congressmen and Congresswomen:
I have been a physician member of Pueblo County Medical Society and Colorado Medical Society (CMS) for 30 years. I served on the CMS Committee on Professional Education and Accreditation for 4 years. I am doubly boarded in two specialties and in full-time practice in Pueblo, Colorado. I recommend that you vote AGAINST all upcoming Physician Assisted Suicide bills.

Consent and Communication Challenges
Let me begin by stating that you cannot possibly craft legislation that will be airtight in protection against unintended consequences from (1) biased professional guidance misconstrued as "informed" consent and (2) the inherent imperfections of communication.

In day-to-day practice of medicine, the physician must be careful not to bias the patient when getting consent. But invariably, the patient turns to the doctor and asks, "What would YOU do, in my situation, doc?" Now, in the case of physician-assisted suicide, the gravity of the doctor's response, either actual or implied, is obvious. If the doctor's bias is that quality of life appears to be poor for the frail elderly or the disabled spastic paraplegic or the chronically mentally ill or the cancer patient facing rounds of chemotherapy, then the doctor's counsel may reflect that bias.

Let me give you a real-life example of how a doctor's own bias about life-worth does weigh in. An elderly man in his early eighties, mowing the lawn one day, found himself the next day suddenly in the intensive care unit (ICU) with triple organ failure (heart, lungs and kidneys) intubated and on a respirator, facing kidney dialysis within a day or two. The ICU doctor immediately proposes that all measures be stopped, because the man is very old and his likelihood of surviving is remote and he surely must have "lived a full life", and this would "prevent him from suffering". The family resists, insisting that everything be done, especially since the old man is still communicating on a chalkboard despite the dire situation with him on a ventilator. Each day, three days in a row, the ICU nurse relays to the family that the ICU doctor says that this seems "hopeless" and "they need to make a decision to stop the machines and see if he can make it". The old man meanwhile, remains hanging on, semi-alert, still squeezing everyone's hands when he arouses. On the fourth ICU day, the ICU nurse triumphantly enters the ICU waiting room and greets the family with, "Well, your father wants to go. He's said so himself. Here it is" and she holds up the old man's chalkboard where he has written shakily, "NO SUPPORT". The family cringes reluctantly, believing suddenly that Dad really wants to die. But one daughter says "What?! That doesn't sound like Dad", and races to the bedside with the chalkboard frantically begging Dad to try to explain what he means by "no support". His hands still tied to the bed, he points to his feet and wiggles his toes, unable to talk because of the tube in his throat. Hesitating, the daughter says, "No support?... No support stockings? Do you mean *take off the support stockings*?" and the father's entire body groans with relief and he nods his head to the limit of the apparatus holding him down. The old man wanted his support stockings off! That day the ICU doctor and nurse witnessed their dangerously flawed communication. They also made a

grave error in judgment about the length and quality of the old man's life, for ultimately he survived the entire ICU episode, got off all the machines, and after an aortic valve replacement and triple cardiac bypass, he enjoyed his grandsons' high school and then their college graduations before he died of injuries from a fall at nearly 90 years of age. To this day, I remain demoralized and disillusioned at how quickly medical colleagues wrote my dad off because of his advanced age and the critical nature of his sudden illness, and how they were willing to accept a chalkboard communication as a death sentence---even understanding that I, his doctor daughter, was watching the medical situation closely.

Fear No Pain

On a positive note, my father's ICU experience reflects our ability to make people very comfortable at the end of life, for he never had any negative recollection of having been on machines and tubes, nor did he recall being in the ICU near death for those weeks. This speaks against one of the reasons people think they want assisted suicide: their fear of "the end" or their fear of "pain" or of "being on all those tubes". Simply put, their recollections of what they saw happening 30 years ago does not accurately portray the effectiveness of current pain control regimens. Medicines used nowadays do keep people comfortable at the end of life.

Physician Assisted Suicide is Not Passive

It is important to clarify that physician assisted suicide is not withdrawing life-support and allowing a person to die, nor is it making a patient a "no code" and thereby not resuscitating, ie. it is NOT being a passive observer in a natural process. Physician assisted suicide means helping the patient to kill him or herself. Physician-assisted suicide is a **euphemism** for one person assisting another in a premeditated murder. An even more misleading euphemism is the latest misnomer, "doctor assisted dying".

Your Doctor is not your Pet's Vet

Doctors are supposed to be healers and bring hope to the hopeless: Hope for a life with termination of suffering NOT termination of suffering by termination of life. It is not our role, nor the role of anyone in our society, to be the provider of the ultimate "mercy killing" as though a fellow human being was our dog or cat. We do console ourselves that we put our pets "to sleep" to prevent their suffering. However, that is never done without asking the vet (1) Could anything be done to keep "Rover" alive? AND, (2) How much would it cost to keep "Rover" alive?? In reality, we animal lovers are making a cost-effective decision at the apparent end of our pet's lifespan. However, animals are not human beings. This is a critical point. Our respect of a human life is ultimate: we would pay any price to keep our loved ones alive and comfortable; that's why people fought for health care coverage and that's why families hold spaghetti fundraisers for cancer treatments. When our loved ones are dying, we want to make them comfortable, tenderly holding hands as we sit at the bedside. Patient's families are disappointed if their loved one dies just after they had left the bedside, for they had wanted to be there "with him" at the last breath. Already a "death with dignity" occurs regularly in homes, hospices and hospitals, with loved ones in attendance and *without* having the doctor help them commit suicide.

No Hopeless Case

When a person expresses the death wish, it is the ultimate cry of hopelessness. Our role as physician healers is to value that person's life so much that even in the face of despair we stand by and assist as we can, as though they were one of our loved ones. The first time that a doctor witnesses a patient who appears to be a hopeless case who then suddenly rebounds inexplicably, the doctor learns that ultimately, NO situation can ever be presumed to be hopeless. Situations do sometimes change and people may unexpectedly recover or live far longer than expected. That is why a physician cannot be allowed to expedite a death because of it's apparent hopelessness.

Two Thousand Years Protection: The Hippocratic Oath

The Hippocratic Oath was written in the 5th century BC, purposely to define the ethical-moral code of conduct for physicians towards their patients, crystal clear: *"...With regard to healing the sick, I will devise and order for them the best diet, according to my judgment and means; and I will take care that they suffer no hurt or damage. Nor shall any man's entreaty prevail upon me to administer poison to anyone; neither will I counsel any man to do so..."*

The problem that our society is facing in 2016 is that while ALL physicians for two millennia held to the Oath of Hippocrates, many current physicians have NOT taken the oath. Did you know that it is no longer a requirement upon receiving the medical degree? Other far less rigorous oaths have supplanted it at many medical schools. Unfortunately, this means that there will be physicians who will too readily comply to act as "Dr Death" and these killings will NOT be rare and isolated situations, and our most vulnerable will be at risk.

NO Justification for Involving the Physician in a Suicide

Dr Karl Brandt, in charge of the Nazi program that was instrumental in euthanizing thousands of people, testified at his Nuremburg trial, "The underlying motive was the desire to help individuals who could not help themselves and were thus prolonging their lives of torment." Please consider carefully that assisting a suicide is assisting a killing and that **killing is always in some way justifiable in the killer's eyes, but the killer's justification does not make killing the right thing to do**. Never should anyone else be required to assist the act.

The mammoth responsibility now comes before you as to whether or not you will allow the naïve and dangerous House Bills to move forward. I implore you to kill all such bills; it is critical that you protect individuals and society from them.

Most sincerely,

Kim K Dernovsek MD FAAD
1925 E. Orman Ave, Ste. 115
Pueblo, CO 81004
PHONE 719-564-4500
FAX 719-564-0304