Statement by Patrick R. Brannigan in Opposition to A3328
Before the Assembly Health and Senior Services Committee

February 7, 2013

Thank you Doctor Conaway and members of the Committee for the opportunity to testify before you in opposition to Assembly Bill 3328 which we think has serious flaws. Let me focus on just two.

First, a six-month prognosis for a terminal illness can be wildly inaccurate. I have submitted to the committee a letter from Bernard Ernst, a Toms River resident who was severely injured by toxic fumes while evacuating people from an arson fire in a homeless shelter. In 1992, Mr. Ernst was confirmed as "terminal" with a short expectancy to live. Twenty plus years later Mr. Ernst is still fighting for life. He would have come here today but as his letter indicates, he is receiving medical treatment as we speak.

Second, Section 6(10) c states that "The attending physician may sign the patient's death certificate, which shall list the underlying terminal disease as the cause of death." That statement legalizes a misstatement that borders on a fraudulent report. The cause of death should be listed as self-administered drugs that ended life. Why not tell the truth – this is assisted suicide.

Members of the Committee, in 2012, more active duty military members committed suicide than were killed in combat. The US Department of Defense cautions people about over reacting to those numbers because of the robust programs the Department has put in place to prevent suicide. What message would New Jersey be sending to our military if as a state we passed a bill encouraging troubled individuals to take the path of suicide?

The Catholic Church teaches that life is the most basic of all human goods but not that it should be extended at all costs. There comes a time when it would be unreasonable and even cruel to prolong the dying process.

The sick and the elderly deserve our special care. Medical science is called on to eradicate the illnesses from which we suffer; it is not called on to eradicate the patients who suffer the illnesses. The humane approach to dealing with suffering of the dying is not to kill the one who is suffering. Our duty is to assist those who are dying- not kill them.

Some who promote physician assisted suicide claim they want to help those suffering from intractable pain. However, today medical specialties in pain management allow us to deal with almost all pain effectively.

Patients have a right to receive adequate pain control and their families should assist them in obtaining such compassionate care.

Let me point out that opposition to euthanasia and physician assisted suicide is not simply a Christian position. Hippocrates some 2500 years ago said, "I will give no one a deadly medicine even if asked, nor counsel any such thing . ."

Physicians receive extensive training to put their skills at the service of those who are ill. To use their skills to help people kill themselves would violate their sacred oath.

We are not insisting that a person be kept alive as long as possible using every technical means available. There comes a time when the use of machines to keep people alive is not compassionate or reasonable. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human **dignity *if* death is not willed as either an end or a means**, but only foreseen and **tolerated as inevitable**. Palliative care is a special form of disinterested charity. As such it should be encouraged.

The Catholic Church teaches that there is a moral obligation to use a medical intervention to prolong life ***only*** if it holds out a reasonable hope of benefit without imposing an excessive burden on the patient.

Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate. Doing so is just refusing "over-zealous" treatment in which one **does not will to cause death**. Rather, one's inability to impede death is merely accepted. Those decisions should be made by the patient if he/she is competent and able or, if not, by those legally entitled to act for the patient.

Mr. Chairman, last year, with your leadership the Committee considered legislation clarifying a patient's right to designate a decision maker for them if they are unable to do so themselves. Doctor Conaway, I commend you for your leadership and for the thoughtful and thorough process that you established that brought together a wide spectrum of people with varied opinions to discuss and debate that important end of life issue. Rather than moving quickly, a similar process on A3328 would be beneficial for the State.

Thank you, I urge you to vote no on A3328.