

LATE

HB-2739-HD-1

Submitted on: 3/15/2018 8:15:26 AM

Testimony for CPH on 3/16/2018 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Karen Ginoza	Individual	Support	No

Comments:

My name is Karen Ginoza and I am testifying as an individual. Please pass HB2739 HD1 as written. This bill is long overdue.

LATE

HB-2739-HD-1

Submitted on: 3/15/2018 3:01:02 PM

Testimony for CPH on 3/16/2018 8:30:00 AM

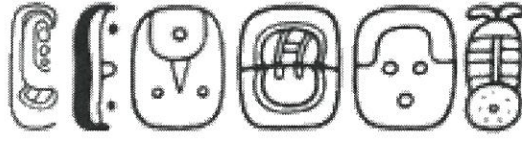
Submitted By	Organization	Testifier Position	Present at Hearing
CW Lee	Individual	Oppose	No

Comments:

While this bill may seem good business regulation of medical and drug practices, please get out of way of the physician-patient relationship. Hawai'i has more traditional believers and practitioners than most states in the union I'm sure. Traditional families and communities understand that dying is inevitable and however heart wrenching, has protocol to meet this event on an individual, personal basis. No more regulation or prescriptions are needed.

My experience: a beloved sister-in-law face courageously faced death by placing her bed in the middle of her living room and welcoming family and friends to spend time with her for almost a year. Her 20 month old grandson crawled up to her bed to kiss and hug her often. Yes, she decided when her pain was beyond unbearable to self-administer her fatal dose of morphine. We all understood what she would do, hence her passing, though sad was acceptable.

For non-traditional individuals and families, death is academic, abstract and an intrusion, to be fought, and to spare others from. I recommend that a series of classes about death and dying be added to this bill if it is approved.



LATE

Juliet A. F. Begley
67-5111 Yutaka Pen Place,
Kamuela, Hawai'i 96743

February 27, 2017

Senator Keith Agaran, Chair
Senator Karl Rhodes, Vice Chair
Senate Judiciary and Labor Committee

SUPPORT SB 1129 - Relating to Health, establishing a Death with Dignity Act

Dear Senate Members of the Senate Judiciary and Labor Committee:

In 2002 I testified for Death with Dignity legislation due to my friend who died with great suffering in 1998. Her death caused me to ask Governor Cayetano if we could put forth a bill to address the hastening of death in the Governor's legislative package that year. He agreed, and Death with Dignity legislation almost passed on the floor of the Senate on the last day of the 2002 Session. Since that time I have been involved with this issue. I do end of life care. So I want to impress upon you that my opinion is not purely intellectual, I have hands on experience with the daily care of dying people.

I fully support legislation to allow for a legal venue for terminally ill people of sound mind to be able to choose when they die. I have cared for over a dozen people in the final stages of life – and all of my patients have asked me why we do not have a safe and reasonable manner of addressing death, that would allow them a peaceful exit, one where they were able to exercise a level of self-control. A death with dignity law in Hawaii, that adheres to the safeguards that Oregon has, is a reasonable response to this need, and will address needless suffering at the end of life.

It has been fifteen years since people in Hawaii started to push for a law to mirror the Death With Dignity law in Oregon for Hawaii. Since that time the entire West Coast of the United States has put in place legal options for people who are terminally ill and of sound mind to be able to end their lives. Please allow the residents of Hawaii to be able to have this same choice. It is the ultimate act of personal autonomy.

Sincerely,

Juliet Begley

HB-2739-HD-1

Submitted on: 3/15/2018 3:24:32 PM

Testimony for CPH on 3/16/2018 8:30:00 AM

LATE

Submitted By	Organization	Testifier Position	Present at Hearing
Taylor Schultz	Individual	Support	No

Comments:

LATE

HB-2739-HD-1

Submitted on: 3/15/2018 3:27:47 PM

Testimony for CPH on 3/16/2018 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Javier Mendez-Alvarez	Individual	Support	No

Comments:

HB-2739-HD-1

Submitted on: 3/15/2018 3:56:08 PM

Testimony for CPH on 3/16/2018 8:30:00 AM

LATE

Submitted By	Organization	Testifier Position	Present at Hearing
Steve Franks	Individual	Oppose	No

Comments:

This has nothing to do with Death with Dignity, since in the Netherlands, after this passed, a doctor was cleared of murder when he asked the family to hold the old person down (who was NOT termally ill) to give lethal injection.

<http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/assisted-suicide-from-voluntary-to-involuntary-edits.pdf>

In Oregon they are trying to make it possible to starve people to death. How is that humane or dignified?

<https://conservativedailypost.com/assisted-suicide-just-the-beginning-oregon-may-approve-starving-mentally-ill/>

There is also a story of a mother who has asked to terminate her child simply because the child is mentally difficient and she is using this law to push for a hearing.

If you read history there was one other country in 1939 who passed similar laws to terminate the old, infirm, and mentally ill. I would have never dreamed the Hawaii government known for it's compassion and aloha would even consider aligning itself with Nazi Germany...but here we are.

LATE

CCPH Senate Hearing HB2739
HD13/16/18 8:30 #229

LATE

To Health Committee

From Brian Delara

HB2739 HD1 has been introduced. I want you to know that we don't need so called 'aid in dying' in Hawaii. What we need are increased services for those of us with medical challenges. I have been fortunate to be receiving medical care for chronic infections-I am writing you from the hospital. I appreciate that no one has offered me assisted suicide as my life is difficult and challenging. (If someone offered it to me I would think they just don't want to struggle to care for me). I have problems keeping my scooter in good repair and can't get around without it. I have been trying for months to find a place to live as few want to rent to someone bedbound with a scooter and who just wants a room big enough that my daughter can come and visit me occasionally. However, I appreciate that I am alive and have people in my life who love me. What about those who don't have anyone? Please don't make this bill real.

Brian Delara of Maui -current address Maui Memorial Medical Center Maui East Unit

LATE

Patrick Boland

45-665 Uhilehua Street
Kaneohe, Hawaii 96744
808 235-1562
e-mail: boland@lava.net

CPH Senate Committee HB2739 HD1 3/16/18 Room 229 hearing at 8:30 AM OPPOSITION

Honorable Members of this committee,

I am against HB2739 HD1

I've been there.

I am Patrick Boland, and in 1998 my wife of 31 years, Carolina, died after a 6 year struggle with a neurodegenerative disease. The last year she was bedridden and nearly helpless. With the assistance of St Francis Hospice she died in comfort and in dignity.

I could give you pages of testimony about why 'death with dignity' (physician assisted suicide) is a bad idea. You do not have time to hear it, and others will have presented the arguments more articulately than I.

I will emphasize one point. If this bill is enacted, some people will feel pressured to take the lethal dose. I know. From time to time Carolina would be quite depressed about 'being a burden' to me and my family. It was hard to reassure her that she was not a burden. I am glad the suicide alternative was not available to her. It would have placed more distress on all of us as, with love for her family, she considered relieving us of the 'burden' of her existence.

Please hold this bill. Thank you.

LATE

Hi

I am Clayton Kanae, born and raised on Maui Hawaii. I am a father, currently unsheltered and have a disabled child who I love. I heard about this assisted suicide thing that officials are going to vote on and I want to tell you not to do it. It is too risky and opens a door to bad things—like they might want to live by don't have enough money.

I know lots of VA friends who have benefits getting cut and they are bummed. Some have PTSD and might think they should take those pills cause life is just too difficult. We need more programs and support for those guys—they fought for us and now are having a hard time—don't even suggest a death pill because they might take it and they don't deserve to have that happen to them.

Clayton Kanae
471 Lipo Place
Wailuku 96793

Sometimes I get my mail at this address. I would be happy to meet you and discuss this any time.

THE SENATE
THE TWENTY-NINTH LEGISLATURE
REGULAR SESSION OF 2018

COMMITTEE ON COMMERCE, CONSUMER PROTECTION, AND HEALTH

Senator Rosalyn H. Baker, Chair
Senator Jill N. Tokuda, Vice Chair

NOTICE OF HEARING

DATE: Friday, March 16, 2018
TIME: 8:30 – 11:25 a.m.
PLACE: Conference Room 229
State Capitol
415 South Beretania Street

HB 2739, HD1

CPH Senate Committee HB2739 HD1 3/16/18 Room 229 hearing at 8:30 AM OPPOSITION

LATE

Honorable Chair Bellatti and members of the House Health Committee,

As an oncology nurse manager for 13 years of my career I am writing to hopefully put some perspective on the assisted suicide issue. During my 13 years as an oncology nurse I have known only 2 patients who took their own life. Most patients who were terminal passed away peacefully with their loved ones at their side. The common theme among those with terminal cancer was to live out their last days with their family and spend every moment in which they still have breath with their loved ones. The two who took their own life were able to do it without a physician assisting.

I have treated hundreds of cancer patients, and when they no longer respond to chemotherapy, they are given compassionate care from Hospice and from their families. Every measure is taken to keep a patient comfortable. People "suffer" every day, whether it is from terminal illness, short term illness, abusive relationships, trauma, or overwhelmed with life. Would we allow a physician to prescribe a pill to end their life? To allow assisted suicide for terminal illness will only open the doors to allow psychiatrist to prescribe medication for suicidal patients so that they won't have to hang themselves and traumatize the person who finds them. It will open the doors to allow those who are paralyzed and unhappy with their loss of independence to end their life.

Even with the safeguards described in the bill, it can easily be worked around by patients or families who go doctor shopping.

Thank you for your consideration. Assisted suicide is not true compassion.

Marny Hall-Moriyasu





LATE

New Hope Christian Fellowship

CPH Senate Committee HB2739 HD1 3/16/18 Room 229 hearing at 8:30 AM OPPOSITION

I am opposed to Physician Assisted Suicide

Thank you for this opportunity to express my strong opposition to HB2739 HD1

People can commit suicide at will, but by having a physician endorse it will communicate a message this is incorrect and destructive. I am opposed to the PAS bill first because:

1. It gives an inordinate amount of authority to an attending physician (or to two physicians) to make final determination that a person will die within six months. There are several in our congregation who were given three to six months to die, and they are still in our congregation five years later. A physician will have to play to the role of God to conclusively determine the timeline of a person's life, regardless of how conclusive a diagnosis may seem at a given time.
2. Secondly, they will need to conclusively determine that a person is of "sound mind". When persons are diagnosed with a terminal illness, they will many times go through a season where they feel resigned to dying. Then with a lost hope, they have suicidal tendencies. However, once they get through this period, their lives can regain momentum and oftentimes they beat the odds.
3. Physician's assisted suicide preempts this possibility of health. It also might be so premature that we can erroneously make a permanent decision based on a temporary health situation.

Thank you for your consideration and I ask you to vote "NO" on SB1129.

Dr Wayne Cordeiro
Sr. Pastor New Hope Christian Fellowship
ohana@enewhope.org

LATE

Leslie Williams
318 Makea Street
Makawao, Hawaii 96728
[practical.dog@gmail](mailto:practical.dog@gmail.com)
283-1887

CCPH Senate Hearing HB2739 HD1 3/16/18 8:30 #229

Honorable House Chair Bellatti and Members of the House Health Committee:

Please don't pass assisted suicide- discrimination against the disabled is not obvious but is very real. I am now 70 years old and as I have gotten older medicine has progressed. I am a Maui resident but when I was on Oahu I found new treatment for Multiple Sclerosis and after 7 years of daily injections my pain subsided enough for me to begin the long road of rehabilitation. I now work part time with the help of vocational rehab as a substitute teacher on Maui. My family and friends tell everyone what a miracle my life has been. With medicine progressing so fast all I can say is don't give up hope.

If you have any questions, about my life story or if you would like to talk with me personally, please feel free to call anytime. I can even suggest a book you might want to read about the disability movement named, "No Pity: People with Disabilities Forging a New Civil Rights Movement" by Joseph Shapiro.

That said, I really wanted to come and deliver this testimony in person but I could not get an airline flight out in time to be there. I would like to make a request for accommodation. Could you do it through Akaku here or Skype or at least call me and let me say my testimony from Maui during the hearing? Looking forward to a response. I have always felt it was so unfair to the disabled who are large stakeholders in the issue and cannot get to Oahu to have their testimony heard.

Sincerely,

Leslie

LATE

Jason Kiaffas APRN

221 Mahalani Street
Wailuku Hawaii 96793

jkiaffas@hotmail.com

CCPH Senate Hearing HB2739 HD1 3/16/18 8:30 #229

I am in **strong opposition** to this bill and hope you do not pass it out of committee.

Turning to killing as a way of addressing one of life's greatest and most difficult challenges betrays the power of the human spirit to overcome adversity and find meaning in life.

LATE

CPH Senate Committee HB2739 HD1 3/16/18 Room 229 hearing at 8:30 AM OPPOSITION

My name is Dr. Vivien Wong. I am a board certified diagnostic radiologist with medical license to practice in the State of Hawaii and California.

I oppose HB2739 because it is asking a physician to treat an individual for the purpose of accelerating his or her death. Physicians are trained to provide the best of medical care available (standard of care). This includes offering various options in treatment with thorough discussion of the benefits and risks of each treatment. A physician always respects each individual rights to choose not to undergo treatment even knowingly that he or she may die without such treatment. However, I do not believe that any physician can predict when the patient would die with or without treatment. Even with incurable and irreversible disease, it is impossible for a physician to medically confirm that a disease will produce death within 6 or fewer months.

If this bill is passed, close oversight and monitoring are needed to assure that all the steps are followed as outlined in the bill. Once the prescription is given to the requested patient, the physician is not required to be present when the patient takes the medication or to monitor the effect of the medication if taken. What if the medication was not effective and death is prolonged? Won't this be more inhumane and undignified? The bill also allows the patient the option of not notifying the next of kin. What if, while the patient self-administered the medication, a next of kin walks in and discovers the status of the patient? The next of kin, not knowing the patient's intent, may immediately seek emergency medical care. Without third party observer, how can we be sure that the requested patient has free will to self administered without coercion from another individual? When the prescription is filled but the patient decided not to take the medication, how can we be sure that the patient will discard the medication properly so that it is not accessible for abusive use by another individual? How can we be sure that it is not accessible to children?

Please oppose. Otherwise, place more safeguards to this bill to ensure that the questions and concerns stated above are addressed.

Respectfully,

Vivien C. Wong, MD, MPH

LATE

CPH Senate Committee HB2739 HD1 3/16/18 Room 229 hearing at 8:30 AM OPPOSITION

I am a palliative medicine physician.

The questions we should be asking today are the following:

What is the quality of health care provided to the seriously and terminally ill in Hawai'i, and what can the legislature do to improve it?

It is a misguided effort to create public policy that allows the terminally ill to commit physician assisted suicide. It does not serve the general public. The idea is tempting because of everybody's desire to avoid illness, suffering, and dependence at the end of life. The idea is tempting because of all these heartfelt testimonies you are hearing from the proponents. However, this is not about our own fears, experiences, or painful personal tragedies. Having the responsibility to create good public policy, you should be asking the following:

What is the best possible way to assist the growing number of people living with serious, chronic, and terminal diseases?

What are our options? One is to feel overwhelmed and declare that there is no good solution. Some of the supporters of legalizing PAS are probably coming from that position. Alternatively, we can build a system of health and social services that will not leave such people and their families in a state of suffering, pain, helplessness, and abandonment. There are many new and effective ways of making a difference in the lives of those with severe illness. However, not all possibilities are equally known, available, or understood by the general public.

Everybody knows what physician assisted suicide is.
Not everybody knows what palliative medicine is.

It is a new medical specialty. It focuses on alleviating the suffering, and improving the quality of life of those living with serious, chronic, and fatal illness. It is combined with efforts to cure disease, as long as the disease is curable. Skilled palliative medicine practitioners are highly successful in relieving the physical and psychological suffering that illness can bring.

If given the choice for a legal PAS, what do people choose? We have some idea based on the Oregon experience. Approximately 0.1% will choose PAS. In Hawaii that would translate to 8 out of 8000 deaths every year. The other 99.9% of terminally ill people and their families will decide not to exercise that choice.

What are the choices we should offer to the 8000 people among us who die every year? Should they have the choice of getting decent medical and personal care up to their death? Isn't that the most important choice they should have?

LATE

Just think about it. When somebody close to us becomes ill, what do we do? Are we more likely to offer them quick death in a bottle, or are we more likely to stop short of ending somebody's life, and instead do the best we can in order to relieve their suffering?

Doing our best in these situations is not easy. It takes commitment to relieve somebody's suffering, to put their needs above our own, and to advocate for them. It takes learning, creativity, and the wise use of material resources. Many of us do it. We do it as individuals for our parents, friends, children, and patients. However, there are limits to what we can do as individuals.

It is time to demonstrate a larger commitment.

We need to create effective, easily accessible systems of care for the seriously ill. In Hawai'i a solid foundation has been already established for the building of such systems. Many dedicated organizations and individuals have spent the past 10-20 years working on it. I know for a fact, that we have the potential to do an excellent job taking care of the seriously and terminally ill in Hawai'i, especially if strengthened by legislative support.

Compassion and Choices, a Mainland organization, the money and push behind this bill, has already publically announced they are coming to Hawaii to provide us with good resources and support as we struggle with providing good end of life care. They want to make us the next State that allows assisted suicide for our own good. As they do in all States, they expect to be the lead organization to which people turn for advice about how to get it right- including the option of killing you if things get too bad.

We have no need for their organization around end of life care because we have an excellent resource here in Hawaii: Kokua Mau. Kokua Mau is the organization we trust in Hawaii to know our culture and values and to help us and guide us during the end of life process. Expansion of our own local solution to the challenges of end of life care should not include a Mainland organization and philosophy that openly admits to wanting to imprint a cookie-cutter solution for our patients in Hawaii.

Just like the doctors who don't truly know the patient prescribing the medicines.

My hope is that the legislature will refocus on creating policy that will support the development of improved systems of care for the seriously and terminally ill.

The legalization of PAS might serve a tiny minority, and for that reason it *should not* be our first priority. Our moral and legislative obligation is to do first what will serve the majority.

This is the reason why I say a compassionate NO to the legalization of physician assisted suicide.

Thank you,
Dr. Somogyi-Zalud

CPH Senate Committee HB2739 HD1 3/16/18 Room 229 hearing at 8:30 AM OPPOSITION

LATE

I am a physician who opposes HB2739 HD1 before you today.
NCTERMULO@aol.com

This bill is unnecessary and potentially harmful to our patients in Hawaii. Advocates of suicide are misleading when they tell their old stories and claim that pain is a significant reason for requesting. Even in Oregon where it is legal 92% of reasons given are social concerns such as being a burden.

There has been no documented case of assisted suicide being used for untreated pain.

Why would we want to put our underserved patients at risk for such a few? This bill would radically change medical practice in Hawaii. We are already understaffed especially in our rural areas and here in Maui it is difficult to recruit and keep physicians.

Now we propose letting physicians AND Aprns who have never been trained in the Art of caring for our elderly at end of life-- offer them death rather than ease the feelings of worthlessness and/or hopelessness they may feel? How can you reassure them we will be with them through whatever they are going through when we also say we will kill them if they want that? It is a mixed message and actually coercive to ask a possibly lonely, unfriended, ill person if they want you to kill them rather than wrestle with whatever it takes to have them feel valued and respected.

Thank you,

Dr. Termulo

LATE

CHENG-HOCK SEAH M.D.
j.seah@aol.com
Honolulu, Hawaii 96813

CCPH Committee HB2739 HD1 3/16/18 Room 229 hearing at 8:30 AM OPPOSITION Senate

I was the past director of the Queens Medical Center, Obstetric Anesthesia. SB1129 on the surface is for physician assisted suicide but if you listen closely to the proponents is about euthanasia for the terminally ill person. In Taber's...

1. Dying easily, quietly and painlessly.
2. The act of willfully ending life in individuals with an incurable disease.

In Dorland's

1. An easy or painless death
2. Mercy killing; the deliberate ending of life of a person suffering from an incurable and painful disease.

In my opinion, euthanasia or mercy killing for the deliberate ending of life of a person suffering from an incurable and painful disease is ethically and morally wrong.

If we legalize euthanasia (i.e. permit a licensed physician to deliberately assist in the dying or killing of a terminally ill patient) we are going against the very basic principle of the practice of medicine. It demeans the oath that all physicians take as healers in our society, before practicing the art of medicine.

In essence that oath commits physicians to cure the sick, alleviate pain and prolong life. We must seriously ask ourselves, "Is legalizing euthanasia or willfully assisting in end the life of a patient a necessity in our society?" Is mercy killing different from killing someone who has committed a murder? Is mercy killing different from assisting someone to commit suicide? Does a convicted criminal with an incurable psychopathic disorder who is a danger to society and no more and asses to society deserve mercy killing by a physician?" The obvious answer to the above is NO. A physician's role is to save and respect life; not to take life away.

Dying with dignity and with respect is what every human being deserves. If the patient dies because we literally are trying to hasten death by not feeding them or depriving them of essential human needs that is one thing and to me wrong.

Is this dying with dignity? Mercy killing can be injecting an overdose to stop the heart of a convicted killer as with the death penalty. Is this a dignified way to die, even if the person is already dying from an incurable disease and in a 'terminal state'?

Should the State of Hawaii legalize this permitting of physicians (requiring physicians) to do this for the terminally ill patient who requests it?

My response is an emphatic NO. I say NO on humane, ethical, and moral grounds. I say NO from a public policy viewpoint. I say NO for the conscience of the physician who did not take up medicine to kill people.

Thank you for allowing me to express my deeply held conviction.

LATE

Lorene Siaw M.D.

Hospitalist
Wailuku, Hawaii 96793

CPH SENATE COMMITTEE HB2739 HD1 3/16/18 ROOM 229 AT 8:30 AM OPPOSITION

As a long-time Hawaii hospitalist, I am writing to express some very specific concerns regarding this proposal to allow physician assisted suicide in Hawaii.

I was the chief medical resident of the UH Medical Residency Program under Dr. Max Botticelli. S.Y. Tan MD was my mentor and head of medical ethics at the time. I did a one year project surveying all physicians in the State about their thoughts and comfort level with euthanasia and physician assisted suicide, published in the Hawaii Medical Journal in 1996. If you would like a copy, let me know.

The bill will irreparably harm the medical profession and compromise the physician-patient relationship of trust.

So-called 'controls', 'safeguards', have been tried elsewhere and do not work. Regulations to restrict physician assisted suicide are easily violated and inevitably lead to ever wider qualified candidates for "suicide". Oregon this year seeks to expand the 6-month terminal illness to 1 year prediction. Belgium expanded it to children. The Netherlands has allowed it for being tired of living. A patient's family member in Oregon registered a complaint that his brother was allowed the medicine but wasn't able to swallow at the end, so the bill discriminated against him. In Oregon, two nurses openly admitted to giving a patient a deliberate drug overdose; because she asked for it; even though the family said she had turned down the assisted suicide offer. No charges were filed and the nurses still practice.

We have a wife writing us from Washington that while waiting for her husband in the waiting room she overheard the nurse offering assisted suicide to her husband as he could be a burden on his wife. She had to stay glued to him every doctor visit thereafter. How can a nurse convey to a patient the wife's feelings without knowing them? Isn't this coercion?

Barbara Wagner received a letter at her home denying her the cancer medications prescribed by her physician but offering her the pills to kill herself. Do you want this to happen to a family member of yours?

Please do not pass this dangerous bill. At the very least, wait a few years until we can see what happens in California as they try to implement it. They are having lots of difficulties.

Thank you for your consideration in allowing me to submit this testimony.
Lorene Siaw M.D.

LATE

**Michael R Savona M.D.
Internal Medicine, Oncology**

**1721 Will Pa Loop
Suite 101/P. O. Box 1977
Wailuku, Hawaii 96793
Telephone: 808-242-5599
Fax: 808-242-2838**

Regarding: HB2739 HD1

Position: Opposition

My name is Michael Savona from Maui representing myself. I am a physician who practices in the specialties of Internal Medicine and Oncology, the latter specialty involving the diagnosis and treatment on cancer. I have been in practice here on the Island of Maui since my arrival in Hawaii in July of 1976, and prior to that at Columbia Presbyterian Medical Center in the City of New York from July of 1973 until July of 1976. I would like to first state that the statements that we are hearing concerning the majority of Hawaii's patients favor assisted suicide- is in my experience not true. I believe that I can attest to this fact since I am involved in the care and treatment of many patients with the diagnosis of cancer which in the eyes of many is considered to be the most terminal illness. It exemplifies the confusion over the difference between providing comfort care and palliation of pain, and thereby improving the quality of life, and assisting loved ones to commit suicide.

The Hawaii Medical Association does not actively support a deliberate act of precipitating the death of any human being. It does support and advocate the for the alternative stance of compassionate palliative care at the end of life for terminally ill patients. It is also clear that physicians are not accurate in their predictions concerning length of life in patients with terminal illnesses. Quite frankly, if I were capable of predicting the future, I would be at the race track or in Las Vegas rather than working in my office. Grim prognoses are often wrong. I currently have several patients who have severe cardiac disease or cancer who were informed that they had "months to live", and are still alive with good quality of life 10 years later. Statistical analysis with the probability of dying within a certain time frame is based

on data compiled from large numbers of patients with similar diagnoses. The life expectancy of countless individuals far exceeds their statistical probability life span.

In my opinion, HB2739 HD1 is an invitation for abuse. Safeguards protect no one. It will not and cannot ensure patient control, and physician competence in end of life matters.

Sincerely,

A handwritten signature in black ink that reads "Michael R. Savoná M.D." with a stylized flourish at the end.

Michael R. Savoná M. D.

LATE

CPH Senate Committee HB2739 HD1 3/16/18 Room 229 hearing at 8:30 AM OPPOSITION

I came to Hawaii and testified in person before your Senate Health Committee and though I can't be there in person this time, would like to share my opposition to HB2739 HD1

My Experience with Assisted Suicide in Oregon

by Dr. Kenneth R. Stevens, Jr. MD, Radiation Oncologist,
Professor Emeritus and former Department Chair, Radiation Oncology
Oregon Health & Science University, Portland, Oregon

President, Physicians for Compassionate Care Education Foundation www.pccef.org

I have been following the experience with legalized physician-assisted suicide in Oregon since 1994. I have been a cancer doctor for 59 years in Oregon, where physician-assisted suicide is legal. I am Professor Emeritus and former chair of the Department of Radiation Oncology at Oregon Health and Science University. I continue to care for patients.

My Personal Story – The importance of trust between patient and doctor

I first became involved with assisted-suicide in 1982, shortly before my first wife, Shannon, died of cancer. We had just made what would be her last visit with her doctor. As we were leaving the office, he said that he could provide her with an extra-large dose of pain medication. She said she did not need it because her pain was under control. As I helped her to the car, she said "Ken, he wants me to kill myself."

It devastated her that her doctor, her trusted doctor, would suggest that she kill herself. Six days later, she peacefully died in our home without pain, and with dignity. I learned how assisted suicide destroys the trust between patient and doctor. Patients want support from their doctor, not encouragement for them to take their life, or have the doctor or others cause their death.

Physician's Role

Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. [AMA Principles of Medical Ethics.]

Dr. Leon Kass, MD, wrote: "Even the most humane and conscientious physicians psychologically need protection against themselves and their weakness and arrogance, if they are to care fully for those who entrust themselves to them. A physician-friend who worked many years in hospice caring for dying patients explained it to me most convincingly: 'Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately

into caring for them as they lay dying.' My friend's horror at the thought that he might be tempted to kill his patients, were he not enjoined from doing so, embodies a deep understanding of the medical ethic and its intrinsic limits." [Cass, LR: "I will give no deadly drug": Why doctors must not kill. In *The Case Against Assisted Suicide, For the Right to End-of-Life Care*, Edited by K Foley and H Hendin, Baltimore, Johns Hopkins University Press, 2002, p 30.]

Suicide

When a person expresses a desire to take their own life, society generally acts to protect him/her from committing suicide. However, when assisted suicide is legalized, society acts to assist that person in committing suicide. This is especially true for those who are seriously ill or have disabilities – they have lost society's protection against suicide. The legalization of assisted suicide legally protects doctors who write prescriptions for lethal drugs, and family members who are involved. It is not designed to protect patients from others causing their death.

Assisted Suicide is Suicide – Beware of Deceitful & Dishonest Euphemisms

The strategies and methods of pro assisted suicide organizations are to use euphemisms. But assisted suicide is suicide. Both the Connecticut State Superior Court (June 2, 2010) and the New Mexico Supreme Court (June 30, 2016) have clarified that so-called "physician aid in dying" is assisted suicide and euthanasia.

Assisted suicide death certificates are falsified by assisted suicide doctors

In Oregon, doctors are instructed to put the underlying disease as the cause of death. But the reality is the person died from an overdose of drugs resulting in an assisted suicide. Doctors are directed to falsify the death certificate. This undermines transparency in the record and the ability to investigate suspicious overdose deaths.

Pain is Not the Issue

Both opponents and proponents of legalization of assisted suicide agree that pain is not the issue. Pain can be controlled. Uncontrolled pain in the terminally ill rarely occurs. In Oregon only a very small minority of patients dying of assisted suicide chose it because of fear of pain in the future. This was not because they were having current pain.

Assisted suicide encourages patients to throw away their lives. Assisted suicide is not necessarily for only those who are dying. Some patients with a prognosis of living less than six months may live much longer.

Photo of me and my patient Jeanette Hall in 2015, 15 years after I talked her out of assisted suicide in Oregon



In Oregon, the assisted suicide law applies to patients predicted to have less than six months to live. This does not necessarily mean that they are dying.

In 2000, Jeanette Hall was my cancer patient. At our first meeting, Jeanette told me that she did not want to be treated, and that she was going to "do" our law, i.e., kill herself with a lethal dose of barbiturates. She had previously voted in favor of the law, and that was what she had decided. I informed her that her cancer was treatable and her prospects were good. She was not interested in treatment; she had made up her mind for the assisted suicide.

Her surgeon had previously informed her that without cancer treatment, she had only six months to a year to live, making her eligible for Oregon's law. I asked her to return for weekly visits. On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel about her plan. A short time later she decided to be treated.

Five years later, Jeanette and I happened to be in the same restaurant. Excitedly, she came over to my table exclaiming, "Dr. Stevens you saved my life." She is still alive and grateful 17 years after her cancer diagnosis.

For Jeanette, the mere presence of legal assisted suicide had steered her to suicide. She has now told me repeatedly that if I had believed in assisted suicide, she would be dead.

<http://dailysignal.com/2015/05/18/assisted-suicide-how-one-woman-chose-to-die-then-survived/>

Patients may become eligible for assisted suicide by discontinuing treatment. For instance, a person with insulin-dependent diabetes may become eligible by discontinuing taking insulin.

I have treated many cancer patients who were told they had only a few weeks to a few months to live, who have lived much longer; some patients as long as 20 years after a "terminal" brain tumor diagnosis.

See my paper: "Terminal Illness, What Does it Mean?"

http://www.pccf.org/resources/documents/PRCUupdate_2011_4pg4-5.pdf

Financial Incentive for Assisted Suicide

Barbara Wagner – "They will pay for me to die but won't pay for me to live."

In Oregon, the combination of legal assisted suicide and prioritized medical care based on prognosis has created a danger for my patients on the Oregon Health Plan (Medicaid). First, there is a financial incentive for patients to commit suicide: the Plan will cover the cost of assisted suicide. Second, the Plan will not necessarily cover the cost of treatment. The story of Barbara Wagner was publicized in Oregon in 2008. She was informed that the Oregon Health Plan Insurance would not approve and pay for her lung cancer medication, but they would pay for Comfort Care, which included assisted suicide. She told the TV reporters, "Who do they think they are? They will pay for me to die, but won't pay for me to live." See

<http://abcnews.go.com/Health/story?id=5517492>.

As medicine becomes more politicized, you will lose your choice. Insurance companies and government bureaucracies will decide what treatments you may receive. You may not qualify for the treatment that you want and that may benefit you.

Depression is the leading cause of suicide

Depression is the leading cause of suicide. Depression needs to be diagnosed and properly treated with counseling and medications. Oregon researchers (Ganzini – British Medical Journal) in 2008 reported that 25% of Oregonians requesting assisted suicide were depressed. Yet, in the past 7 years less than 2% (14 of 574) of Oregonians dying of assisted suicide had a psychiatric evaluation.

Oregon has a real problem with its High Suicide Rate

Oregon government pays for assisted suicide, but does not pay for adult suicide prevention

Oregon has a regular suicide rate that is 140% of the national average, and has increased 20% since 2000 (assisted suicide started in 1998). In spite of a recognized need in prior years for an adult suicide prevention program, the Oregon Health Authority reported in 2015 that they do not have funding for, or support for, an adult suicide prevention program. Oregon state government is paying for assisted suicides (like Barbara Wagner), but is not paying for adult suicide prevention. How do you justify suicide prevention in a state that has legalized assisted suicide?

What message does legalization of assisted suicide send to those who are considering suicide because of life's problems?

See:

<http://www.pccef.org/pressreleases/documents/AbsenceofresponsetoOregonssuicideproblem6115pressrelease7v000.pdf>

Legalization of physician-assisted suicide does not result in a decrease in regular suicides.

Researchers have recently reported that "legalizing physician assisted suicide has been associated with an increased rate of total suicides relative to other states and no decrease in nonassisted suicides.

(Jones DA, Paton, D. How does legalization of physician-assisted suicide affect rates of suicide?, South Med J. 2015; 108(10):599-604)

Lack of Oversight by Oregon Health Department

There is a serious problem with the Oregon Department of Health's oversight of assisted suicide. Following a failed assisted suicide attempt in 2005 (David Pruiett), the Department of Human Services (DHS) stated that they had "no authority to investigate individual Death with Dignity cases – the law neither requires nor authorizes investigations from DHS *"Press Release from DHS on 3/4/2005"*

The problems with the Oregon information is exemplified by the following: The 2011 year report (released in 2012) listed the underlying illness as "Unknown" for 3 patients. How can an "Unknown" diagnosis be terminal? Residence was "Unknown" for 3 patients. How can two doctors confirm that a patient is terminal when the diagnosis is "Unknown". In the past 5 years (2009-2013) the prescribing doctor has been present for only 65 of the 574 (11%) assisted suicide deaths in Oregon. Yet, doctors are asked to describe what happened at that time. They have no knowledge. Doctors are not required to care for the patient once the prescription for lethal overdose has been written.

Abuses and Complications

When it is reported that there are no or few complications from assisted suicide in Oregon, the truth is that we don't know the complication rate. The Oregon Health Department reported that of the 132 assisted suicide deaths in 2015, the complications were "unknown" for 105, two patients regurgitated (vomited), two had other complications (type not stated), and 23 had no complications. But complication information was "unknown" for 105 of those who died, because the physician or other health care provider was not present at the time of death.

A paper in Journal of American Medical Association, October 18, 2016, by Dr. William Toffler and me described the failure in Oregon and Washington to track data regarding assisted suicide abuses and complications. see <http://jamanetwork.com/journals/jama/fullarticle/2569774>

We do not know the rate of abuses or complications of assisted suicide. For instance, the Oregon Health Authority Annual Reports show that in the past seven years, doctors were not present for 89% of those dying from assisted suicide, so there is not information regarding the complications that occur at that time among the majority of patients. Clearly abuses and complications exist although the rate is unknown. The reporting system is flawed in failing to document what is happening with assisted suicides

Coterie of Insiders Runs the Program

The Compassion & Choices organization are associated with three-fourths of Oregon's assisted suicide deaths. In Oregon in 2009, 57 of the 59 assisted suicide deaths were their clients. They know and control the information released to the public. The Oregonian newspaper editors correctly stated "A coterie of insiders runs the program with a handful of doctors & others deciding what the public may know." *The Oregonian newspaper editorial 9/20/2008.*

As reported in *The Oregonian* newspaper in 2008, "The group promoting assisted suicide, so-called Compassion & Choices, are like the fox in the proverbial chicken coop; in this case the fox is reporting its version to the farmer regarding what is happening in the coop", (Stevens, KR, Toffler, WL, Assisted Suicide: Conspiracy & Control, *The Oregonian* newspaper, 24 September 2008)

In Oregon patients are not getting the lethal prescriptions from their own doctor. They usually obtain the doctor information from Compassion & Choices doctors. Most of the prescriptions are concentrated in a small number of doctors.

From 2001 to 2007, 109 doctors (1% of Oregon doctors) wrote 271 fatal prescriptions for assisted suicide. Three doctors wrote 62 of those prescriptions (23% of prescriptions). Seventeen doctors wrote 165 of the 271 prescriptions (61% of prescriptions).

Hedberg, J Clin Ethics 2009;20:123-132

George Eighmey, C&C Exec Director, reported in *The Oregonian* newspaper in 2007 that he had been present and involved in over three dozen assisted suicide deaths; he is an attorney, he is not a doctor.

No safe harbor for patients

What is ahead for assisted suicide? What do proponents want? One of the things they want is no safe harbor for patients. They believe that doctors should be required to participate, or to have a duty to refer a patient to a doctor who will write a lethal prescription. They want no choice for doctors. Sue Porter, a leader of Compassion & Choices, has written in support of this policy. When I asked her why that "duty to refer" requirement was not written into the Oregon or Washington assisted suicide laws, she told me that the voters would not have voted in favor of the assisted suicide law. They use language to get the law passed, then they campaign to have the language changed to require doctors to participate, or to require them to have a "duty to refer" to a doctor who will write a prescription for lethal drugs.

In Summary

Physicians who care for patients should not order and direct their death through assisted suicide.

- It is against medical ethics: "Give no deadly drug".
- It is too dangerous to give the power to kill patients to the medical profession
- It is dangerous because of insurance company and government financial incentives.
- It destroys the inherent trust between patient and physician.
- It devalues the inherent value of human life.
- It desensitizes us towards any type of suicide.

I urge the Hawaiian state House and Senate to oppose the legalization of assisted suicide in your state.

Thank you for the opportunity to testify in opposition to the legalization of assisted suicide.

Dr. Kenneth R. Stevens, Jr., MD
13680 SW Morgan Rd, Sherwood, OR 97140
503-625-5044
503-481-8410

Harriet H. Pien MD
1609 Laukahi Street
Honolulu, Hawaii 96821

LATE

Physician opposition to assisted suicide bill before you.

CPH Senate HB2739 HD1 3/16/18 Room 229 hearing at 8:30 AM OPPOSITION

As a physician, I am testifying against this proposal to expand medical treatment to include suicide. Suicide is not healthcare in any sense of the word and death is not a 'treatment' to be offered to a patient.

It will sow doubt between a doctor and her patient. Stories are coming out of Oregon and Washington State where this practice is allowed of patients needing to ask their physicians whether they are one of those "death doctors". This was never an issue before this proposal for assisting them to commit suicide. Hawaii law already allows you to direct your end of life care and have your final wishes honored, including refusing any treatment.

This proposal actually devalues a patient's dignity. Everyone wants a dignified death but calling assisted suicide dignified does not make it so. Legalization will open the door for cost-conscious health care manager to push for its use because it is cheaper than good care.

We should extend care and aloha to all patients and not be assisting them in suicide.

Thank you,
Dr. Harriet Pien

George Powell, MD
Neurology
2180 Main Street
Wailuku, HI 96793 (808) 242-6464.

LATE

CPH Senate HB2739 HD1 3/16/18 Room 229 hearing at 8:30 AM OPPOSITION

I am in strong opposition to HB2739 HD1

I was recently in Washington DC and I visited the National Holocaust Museum for the second time. I feel it is part of my duty to bear witness to the Nazi inhumanity. What is most disturbing to me is that Germany was supposedly one of the most civilized and modern regions of the world and look what happened so rapidly. And it began in the medical community with physician abuse of power.

Physicians have the duty to safeguard human life, especially life of the most vulnerable: the sick, elderly, disabled, poor, ethnic minorities, and those whom society may consider the most unproductive and burdensome. Physicians are to use all knowledge, skills and compassion in caring for and supporting the patient. Medicine and physicians are not to intentionally cause death. The patient-physician trusting relationship is the most important asset of physicians and is for the protection of patients.

- Doctor assisted suicide undermines trust in the patient-physician relationship
- Doctor assisted suicide changes the role of the physician in society from the traditional role of healer to that of the executioner
- Doctor assisted suicide endangers the value that society places on life, especially for those who are most vulnerable and who are near the end of life.

I am an HMA member and the HMA does not support assisted suicide or euthanasia. The AMA opposes assisted suicide and euthanasia. This HMA neutrality stance means nothing more than an appearance of approval where there is none. Thank you for the opportunity to testify.

George Powell, MD

LATE

Peter Muthard MD
221 Mahalani Street
Wailuku, Hawaii 96793

CCPH Committee HB2739 HD1 3/16/18 Room 229 hearing at 8:30 AM OPPOSITION Senate

My name is Peter Muthard and I am a practicing intensivist in the intensive care unit at MMMC.

There is no good moral rationale for this unnecessary and potentially harmful bill.

Please stop this bill from moving out of your committee.

Thank you for this opportunity to testify.

Pete Muthard, M.D.

Fernando Ona, MD, FACP, PACG
Retired from the VA
Board Certified - Internal Medicine and Liver Disease
fvonamd@yahoo.com

LATE

CCPH Senate Hearing HB2739
HD1 3/16/18 8:30 #229

Madame Chair and Members,

Thank you so much for this opportunity to attend the hearing and to testify about this important issue.

My name is Fernando Ona and I have been a physician for over 47 years and 18 years here in Hawaii. I am retired from the VA and spend my free time on medical missions and teaching medical students at the University of Hawaii.

My opposition is from a human rights perspective. It is founded on the fact that physician assisted suicide is killing and the best antidote to killing is compassionate care.

The proponents statements that this is the will of the people only shows us how confused people are over the difference between providing palliation of pain—and assisting patients to kill themselves. There is a big difference.

I adhere to the culture of life and oppose strongly the culture of death environment emerging in recent years. I am against the disposable culture for human persons. Legalizing PAS is dangerous for the dying, dangerous for their families, dangerous for medicine and dangerous for society. Killing is not caring. We need to offer alternatives and we can't do that if we take this simple "fix" to the problem rather than serious consideration of its 'downsides'. There will be new victims and unintended consequences.

The American Medical Association does not condone the deliberate act of precipitating the death of a patient. Neither does the Hawaii Medical Association who has in no way admitted to support of this bill.

As one of the co-founders of Mount Carmel House In Rochester, NY in 1984, dedicated to provide a Home for the Dying and the Poor, my experience highlights the role compassionate care can play in a patient's life. I have observed patients who actually lived beyond the expected date of death with comfortable life and eventual discharge home. For this reason, you could be the cause of a cancer patient not receiving potentially lifesaving treatments and participating in healthy family, spiritual, and social interactions. Once the patient is dead, there is no chance for any recourse.

The AMA states the "social commitment of the physician is to sustain life and relieve suffering. A physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient whose death is imminent to die. However, he should not intentionally cause death". What is more rational and dignified to have the patient killed who is suffering with pain or to more effectively ease that patient's pain?

Elder abuse is already a huge problem. You have heard that pointed out by others. Suicide is also a problem for teens and others. This bill cannot help those social problems and indeed will exacerbate them. This bill cannot protect patients from all manner of coercion. It cannot ensure patients or physicians competence. There is no oversight, no witness and it would allow medical professionals to lie on death certificates by instructing them to list the cause of death as the underlying disease, not the lethal drugs as we already see happening in other states who enacted this.

This bill gravely endangers civil liberties. Let's learn from those who have tried it and defeat the bill so residents of Hawaii never have to say 10 years from now...."Please Doctor, don't kill me".

Dr. James McKoy
Rheumatology and Pain Medicine
94-326 Pauwala Place
Mililani, Hawaii 96789

LATE

CCPH Senate Hearing HB2739
HD1 3/16/18 8:30 #229

Care and compassion offer the alternative to suicide. As a board certified pain management specialist I know that no one will want to die if they are getting the kind of care necessary for their pain and suffering. Maybe that kind of care was not available 5 years ago but it is most definitely available today. Both depression and pain can be treated, providing the patient with great relief. Hospice and palliative care offer dying with dignity, fulfilling the true meaning of compassion coming alongside the sufferer. The loving care of friends and family bring true dignity and immeasurable value to the lives of terminally ill patients.

Some people falsely believe that assisted suicide means refusing artificial life support. They think it will help someone decide they don't want to be hooked up to tubes and machines just to keep a heartbeat going when they would otherwise simply die. In existing law patients and their designated decision makers can refuse the artificially prolonging of life. No one has to linger on indefinitely when natural causes would just lead to death.

This bill goes a giant step beyond allowing a natural death. It actively causes a premature death. Legalizing assisted suicide means giving someone the legal power to help kill another person. Treat the pain and suffering or kill the patient. This is a bitter pill to swallow when we have pledged to do no harm. Dr. Thomas Beam, Medical Ethics Committee chair points out, "While the act of physician-assisted suicide seems compassionate on the surface, it is often the abandonment of the patients in their most needy time."

This proposal is just a bad public policy for the State of Hawaii or anywhere and I am against it.

Thank you,
James McKoy, MD

Testimony of Benjamin B. Massenburg MD

Post Office Box 1565

Kahului, HI 96733

CCPH Senate Hearing HB2739
HD1 3/16/18 8:30 #229

LATE

Thank you for this opportunity to testify about this important issue. I am a physician and I OPPOSE this bill.

This bill is not about choice as you hear all the testifiers claiming. At least not choice in the regular sense that we use it – just like it isn't about medical treatment in the regular way we use it.

An individual's choice does not always trump public good. We have laws for reasons. From the time of the Mayflower compact groups of individuals wishing to survive in a challenging world had to put the public good over any private gain for the group to survive. Though we are not in those primitive times the same principle holds true—we have to be careful that we don't make public policy that would put innocent individuals at risk, as this bill does.

And we have to acknowledge the doctor patient trust relationship so important to medicine which will be broken with this HB2739 HD1

More learned bodies than ourselves, including the Supreme Court, have opined that there is no intrinsic right to die in our Country. Though this issue of assisted suicide was opened to states views the caveat given at the time was to remember that government does have a vested interest in preserving life, protecting the unprotected, poor, elderly and less fortunate. When you offer someone a choice, you need to look to see whose choice you may be denying. We see more than enough abuse already, we don't want to create an environment making it any easier.

Treatments in medicine are used to alleviate pain and suffering. Suicide at no time in our history has been considered a treatment for anything. Now the legislature seeks to define suicide as medical treatment and leave it in the hands of the physicians to watch over themselves. No physician wants to be a policeman and very few physicians want to kill their patients. Will you advise your friends to ask their physicians if suicide is a good option for you?

It seems an abrogation of responsibility to put this in the physician's hands. If you truly want assisted suicide, appoint yourselves as the decision makers when people want to die. You might then understand our aversion to being involved in this whole issue.

Please remember to be careful what you wish for...you may be the next one that is left alone in the world at the time they need your hospital bed for a productive patient. It has happened before.

LATE

John T. McDonnell, M.D., Ltd.

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Telephone: (808) 247-6070

CPH Senate Committee HB2739 HD1 3/16/18 Room 229 hearing at 8:30 AM

Thank you for the opportunity to express my opposition and testimony on this important matter.

"Physician Assisted Suicide" is not "Death with Dignity", "Medical Aid In Dying", it is an "Easy Way Out" for both patients and others, caregivers and families alike, who do not understand the dying process. Suicide, assisted or not, is a permanent solution to what is usually a temporary problem: either pain, depression or frustrations, each of which can be, and must be, dealt with appropriately. In the context of a terminal illness, all this is part of the process of coming to terms with one's own mortality, and imminent death.

The American Medical Association (AMA) strongly oppose any bill to legalize physician assisted suicide or death. The Hawaii Medical Association (HMA) does not support physician assisted suicide. Physician assisted suicide is fundamentally inconsistent with the physician's role as a healer.

The power to assist in intentionally taking the life of a patient is counter to the physician's central mission of healing. It is power that the physician's do not want and could not control if they had it.

We continue to support the concept that physicians preserve life as long as possible, while at the same time prevent suffering. If by giving a dose of a pain reliever adequate to relieve pain, a physician causes respiratory failure, then so be it. The patient's disease has been the essential reason for the death, not the physician's action. On the other hand, if a physician injects a lethal dose of Potassium chloride (KCL) or knowingly prescribes a lethal dose of barbiturate for a patient, then the physician is the primary cause of the death of the patient. It is the intention for our actions that determines their ethical nature. If the state wishes to provide a methodology so that people can voluntarily end their own life for whatever reason, please leave medicine out of it. If it is execution or elimination of a sick or elderly family member who is no longer productive, or who may be becoming burdensome, and costly, let's call it what it is, but we should remember that we have gone to great lengths in our State to create laws to protect against "Elder Abuse" and abuse of children and invalids. In Hawaii, we

LATE

Reginald G Buesa MD
811 Kolu Street Suite 101
Wailuku, Hawaii 96793
808 242-0023

CCPH Senate Hearing HB2739 HD1 3/16/18 8:30 #229

From Dr. Reginald Buesa

Regarding HB2739 HD1

I am opposed to this bill, please do not move it forward.

Honorable Chair Della AuBellatti, Vice Chair Bert Kobayash, Andrea Tupola,
Marcus Oshiro, Sharon Har and Dee Morikawa,

I have been a practicing primary care Internist on Maui for over 30 years. I have
continuity of care for most of my practice. I have taken care of dying patients in
the hospital, nursing home and patient's homes.

I have managed and treated both acute and chronic dying patients and their
beloved families.

Personally, I am strongly opposed to assisted suicide mainly because of my moral
beliefs and it is against my medical ethics.

I do not recall in the Hippocratic Oath anything that tells physicians to administer
medication with the intention of ending his or her life.

I know we all have rights but on this one right I am strongly opposed.

Yours truly,

Reginald G. Buesa MD

LATE

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Bannerhawaii@gmail.com
808-781-2023
Aina Haina, Hawaii

TO: Commerce, Consumer Protection, and Health Committee

CCPH Senate Hearing HB2739 HD1 3/16/18 8:30 #229

I am testifying against HB2739 HD1

Please do not pass this bill which promotes physician assisted suicide. No matter how dignified and nice sounding a name it may be given, it is a frightening change to Hawaii's values and diminishes respect for life! Though well-meaning, the advocates for this fundamental change in public policy fail to recognize that there is great harm in store for the vulnerable among us. Physician assisted suicide is not necessary. Advocates mislead when they claim that pain is a significant reason for requesting physician assisted suicide. In Oregon, the great majority of reasons cited for physician assisted suicide are social concerns such as not wanting to be a burden.

No longer is suffering necessary. Comfort care services are in place throughout our state and physicians and the many other care givers, so important to each of us, continue to improve our sensitivity and skills for our patients.

As a practicing physician in Hawaii for more than 20 years, I know that true compassion for my patient at the end of life's journey is to care, to relieve pain and promote comfort, and to help my patient to take care of "last concerns." The moment I suggest that such an action as physician assisted suicide is an option, (and would not "Informed Consent" require that I do so?) I have begun to abandon my patient and replace our mutual trust with anxiety and doubt.

I am particularly concerned about safeguards. There is evidence of lapse of ethical standards. In Oregon, when the Medical Officer of a major HMO was unable to find one of the practicing physicians in the HMO network of physicians to certify that a requested suicide was appropriate under the rules of law, the HMO Medical Officer himself wrote the prescription for the lethal dose of drug. This is a clear conflict of interest and under Hawaii's law such an action is illegal as the insurance company physician does not have a relationship with the patient which would entitle the physician to treat the patient. This example I believe illustrates the deterioration of the ethical climate which follows such a deleterious change in public policy found in SB1129.

Thank you for your consideration of my testimony.

LATE

FROM Linda Toms Barker
Board Member, Disability Rights Hawaii
1660 Haleloke Street
Hilo, Hawaii 96720
808 934-7574

CCPH Senate Hearing HB2739 HD1 3/16/18 8:30 #229

Madame Chair and members of the health committee,
Assisted suicide—Personal Choice or Public Policy?

Most people I know find the idea of taking a pill to end their life a very comforting and appealing option. At first glance, I too would want to have all options available, were I tired of living. But that doesn't make legalizing assisted suicide good public policy.

As a public minded citizen and a person with chronic pain, I have been studying this issue and am horrified at what I have learned.

- 1) In the Netherlands, euthanasia is sliding down the slippery slope of "termination without specific request".
- 2) The protections in the Oregon law are essentially meaningless if the action was taken with "good intent".
- 3) Some HMO administrators consider assisted suicide a reasonable cost-containment strategy.
- 4) Doctors are often too afraid of liability to offer enough medication to effectively manage pain.
- 5) Many doctors know little about pain management or end of life care.
- 6) Many people don't know that suicidal depression, even that which often accompanies terminal illness, is treatable.
- 7) Many people—including doctors—are ignorant about disability and think that needing to ask for help is worse than death.

I don't trust in our ability to write laws that are precise enough to guard against a poorly informed medical community or general public.

It is time for the medical community to give serious attention to relieving suffering and improving quality of life for both those with long-term disease and those reaching the end of their lives. Give them a simple solution like euthanasia and they will stop struggling to provide better care. Legalization of assisted suicide is not the answer.

I strongly oppose.

Thank you,
Linda Toms Barker

Emma B. Avilla

1728 Dillingham Blvd

Honolulu, Hawaii 96819

LATE

CCPH Senate Hearing HB2739 HD1 3/16/18 8:30 #229

I oppose.

I sincerely hope you haven't already made up your minds about this dangerous bill.

Assisted suicide is ultimately a withdrawal from the harder path of compassion.

Modern medicine is able to relieve pain, treat depression, and provide hospice and palliative care so that your last days can have value. They do have value to us as physicians and fellow human beings. Our pledge is to help make sure life does not lose its dignity, even in the last moments. It is about life and hope.

Thank you for considering my concerns.

ee,

NDY and I are opposed to Assisted Suicide
Michael Tada, Hawaii Advocate

LATE



is a national, grassroots disability rights group that opposes legalization of assisted suicide and euthanasia as deadly forms of discrimination.

Not Dead Yet initially formed in 1996 to help articulate a disability rights critique of proposals to legalize assisted suicide. Some of our initial observations, issues and concerns are as valid today as they were in the early years,^[1] some even more so:

Suicide v. Assisted Suicide

It should be noted that suicide, as a solitary act, is not illegal under any state's statutes. Disability concerns are focused on the systemic implications of adding assisted suicide to the list of "medical treatment options" available to seriously ill and disabled people.

Physicians Are Assisted Suicide Gatekeepers

Anyone could ask for assisted suicide, but physicians decide who gets it. Physicians must predict, however unreliably, whether a person will die within six months. Physicians judge whether or not a particular request for assisted suicide is rational or results from impaired judgment.

Disability is the Issue

Although intractable pain has been emphasized as the primary reason for enacting assisted suicide laws, the top five reasons Oregon doctors actually report for issuing lethal prescriptions are the "loss of autonomy" (91%), "less able to engage in activities" (89%), "loss of dignity" (81%), "loss of control of bodily functions" (50%) and "feelings of being a burden" (40%). (*Death With Dignity Act Annual Reports*) These are disability issues.

We Don't Need To Die to Have Dignity

In a society that prizes physical ability and stigmatizes impairments, it's no surprise that previously able-bodied people may tend to equate disability with loss of dignity. This reflects the prevalent but insulting societal judgment that people who deal with incontinence and other losses in bodily function are lacking dignity. People with disabilities are concerned that these psycho-social disability-related factors have become widely accepted as sufficient justification for assisted suicide.

Physicians Misjudge Quality of Life

In judging that an assisted suicide request is rational, essentially, doctors are concluding that a person's physical disabilities and dependence on others for everyday needs are sufficient grounds to treat them completely differently than they would treat a physically able-bodied suicidal person. There's an established body of research demonstrating that physicians underrate the quality of life of people with disabilities compared with our own assessments. Nevertheless, the physician's ability to render these judgments accurately remains unquestioned. Steps that could address the person's concerns, such as home care services to relieve feelings of burdening family, are not explored. In this flawed world view, suicide prevention is irrelevant.

Broad Agenda, Incremental Strategy, Not Just for the Terminally Ill

The political agenda of many assisted suicide organizations includes expansion of eligibility to people with incurable but not necessarily terminal conditions who feel that their suffering is unbearable, without examining the cause of the suffering or whether it can be alleviated.

Health Care Cuts Severe

For seniors and people with disabilities who depend on publicly funded health care, federal and state budget cuts pose a very large threat. Many people with significant disabilities, including seniors, are being cut from Medicaid programs that provide basic help to get out of bed, use the toilet and bathe.

Involuntary Denial of Care

Most people are shocked to learn that futility policies and statutes allow health care providers to overrule the patient, their chosen surrogate or their advance directive and withhold desired life-sustaining treatment. With the cause of death listed as the individual's medical conditions, these practices are occurring without meaningful data collection, under the public radar.

Window Dressing Safeguards, Immunity Law for Physicians

The Oregon law grants civil and criminal immunity to physicians providing lethal prescriptions based on a stated claim of "good faith" belief that the person was terminal and acting voluntarily. This is the lowest culpability standard possible, even below that of "negligence," which is the minimum standard theoretically governing other physician duties. The Oregon Health Division does not investigate the reports filed by doctors who issue lethal prescriptions.

Disability Discrimination

Legalized assisted suicide sets up a double standard: some people get suicide prevention while others get suicide assistance, and the difference between the two groups is the health status of the individual, leading to a two-tiered system that results in death to the socially devalued group. This is blatant discrimination.

Unacceptable Losses

Disability is at the heart of the assisted suicide debate. Some people fear disability as a fate worse than death. Proponents of legalized assisted suicide are willing to treat lives ended through assisted suicide coercion and abuse as "acceptable losses." We are not.

Assisted suicide advocates paint themselves as "compassionate progressives," fighting for freedom against the religious right. That simplistic script ignores inconvenient truths that are all too familiar to disability advocates, such as:

Predictions that someone will die in six months are often wrong.

People who want to die usually have treatable depression and/or need better palliative care.

Pressures to cut health care costs in the current political climate make this the wrong time to add doctor-prescribed suicide to the "treatment" options.

Abuse of elders and people with disabilities is a growing but often undetected problem, making coercion virtually impossible to identify or prevent.

Despite the frequent claim that Oregon's experience has disproven the concerns of opponents of the Oregon law, the Oregon Reports as well as independent news reports and journal articles show otherwise:

People who are not within six months of dying are getting lethal prescriptions.

Depression is not identified or treated (only 6% have been referred for a psychological consult).

People have been denied prescribed medical treatments by insurers but offered assisted suicide as an alternative.

About half of the assisted suicide deaths in Oregon did not have a health provider present at the time of death, so there is no evidence of self-administration of the lethal dose or consent in those cases.



LATE

Michael Tada, mtada347@gmail.com

Not Dead Yet Disability Activists Oppose Assisted Suicide As A Deadly Form of Discrimination

Lessons From Disability History

Prior to the formation of Not Dead Yet, disability activists opposed a number of so-called "right to die" court cases involving ventilator users who sought freedom from nursing homes, essentially arguing "give me liberty or give me death." Society's response, denying them freedom but granting them death, was a wake up call to the disability rights movement. (Herr, S.S., Bostrom, B.A., & Barton, R.S. (1992). *No place to go: Refusal of life-sustaining treatment by competent persons with physical disabilities. Issues in Law & Medicine*, 8 (1), 3-36.)

Suicide v. Assisted Suicide

It should be noted that suicide, as a solitary act, is not illegal in any state. Disability concerns are focused on the systemic implications of adding assisted suicide to the list of "medical treatment options" available to seriously ill and disabled people.

What's Disability Got To Do With It?

The disability experience is that people who are labeled "terminal," predicted to die within six months, are – or will become – disabled. It is well documented that the six month prediction called for in the Oregon and Washington laws is unreliable. The Oregon Reports demonstrate that some people who received prescriptions were not terminal (i.e. lived longer than six months).

Broad Agenda, Incremental Strategy, Not Just for the Terminally III

The political agenda of many assisted suicide organizations includes expansion of eligibility to people with incurable but not necessarily terminal conditions who feel that their suffering is unbearable (*Barton, C.H. et al. (1996). Statute: A model act to authorize and regulate physician-assisted suicide. Harvard Journal on Legislation, 33 (1), p.11*), without examining the cause of the suffering or whether it can be alleviated.

Physicians Are Assisted Suicide Gatekeepers

Anyone could ask for assisted suicide, but physicians decide who gets it. Physicians must predict, however unreliably, whether a person will die within six months. Physicians judge whether or not a particular request for assisted suicide is rational or results from impaired judgment.

Disability is the Issue

Although intractable pain has been emphasized as the primary reason for enacting assisted suicide laws, the top five reasons Oregon doctors actually report for issuing lethal prescriptions are the "loss of autonomy" (89.9%), "less able to engage in activities" (87.4%), "loss of dignity" (83.8%), "loss of control of bodily functions" (58.7%) and "feelings of being a burden" (38.3%). (*Death With Dignity Act Annual Reports, [PDF download](#)*) These are disability issues.

We Don't Need To Die to Have Dignity

In a society that prizes physical ability and stigmatizes impairments, it's no surprise that previously able-bodied people may tend to equate disability with loss of dignity. This reflects the prevalent but insulting societal judgment that people who deal with incontinence and other losses in bodily function are lacking dignity. People with disabilities are concerned that these psycho-social disability-related factors have become widely accepted as sufficient justification for assisted suicide.

Physicians Misjudge Quality of Life

In judging that an assisted suicide request is rational, essentially, doctors are concluding that a person's physical disabilities and dependence on others for everyday needs are sufficient grounds to treat them completely differently than they would treat a physically able-bodied suicidal person. There's an established body of research demonstrating that physicians underrate the quality of life of people with disabilities compared with our own assessments (*Gerhart, K. A., Kozoil-McLain, J., Lowenstein, S.R., & Whiteneck, G.G. (1994). Quality of life following spinal cord injury: knowledge and attitudes of emergency care providers. Annals of Emergency Medicine, 23, 807-812; Cushman, L.A & Dijkers, M.P. (1990). Depressed mood in spinal cord injured patients: staff perceptions and patient realities, Archives of Physical Medicine and Rehabilitation, 1990, vol. 71, 191-196*). Nevertheless, the physician's ability to render these judgments accurately remains unquestioned. Steps that could address the person's concerns, such as home care services to relieve feelings of burdening family, need not be explored. In this flawed world view, suicide prevention is irrelevant.

Elder Abuse Equals Coercion

The prevalence of elder abuse has been one factor that raises concerns about the risk that older people with health impairments may be coerced into choosing assisted suicide. Disability abuse is similarly prevalent but less well known.

Door Open for Involuntary Euthanasia

Assisted suicide's so-called "safeguards" apply when the lethal prescription is requested, but not when it is administered. Oregon's law contains no requirement that the patient be capable of give consent when the lethal dose is administered. Someone other than the patient is allowed to provide the lethal dose.

Health Care Cuts Severe

For seniors and people with disabilities who depend on publicly funded health care, federal and state budget cuts pose a very large threat. Many people with significant disabilities, including seniors, are being cut from Medicaid programs that provide basic help to get out of bed, use the toilet and bathe.

Involuntary Denial of Care

Most people are shocked to learn that facility policies and statutes allow health care providers to overrule the patient, their chosen surrogate or their advance directive and withhold desired life-sustaining treatment. With the cause of death listed as the individual's medical conditions, these practices are occurring without meaningful data collection, under the public radar.

Window Dressing Safeguards, Immunity Law for Physicians

The Oregon law grants civil and criminal immunity to physicians providing lethal prescriptions based on a stated claim of "good faith" belief that the person was terminal and acting voluntarily. This is the lowest culpability standard possible, even below that of "negligence," which is the minimum standard theoretically governing other physician duties. The Oregon Reports also consistently admit that the state has no way to assess the extent of non-reporting or the extent of non-compliance with the law's criteria.

ADA Discrimination

Legalized assisted suicide sets up a double standard: some people get suicide prevention while others get suicide assistance, and the difference between the two groups is the health status of the individual. This is blatant discrimination and a violation of the Americans with Disabilities Act (ADA).

National Disability Rights Organizations

A number of established national disability organizations have joined Not Dead Yet to adopt positions against assisted suicide, including ADAPT, the National Council on Independent Living, the National Spinal Cord Injury Association, the Disability Rights Education and Defense Fund, the National Council on Disability and others.

Unacceptable Losses

Disability is at the heart of the assisted suicide debate. Some people fear disability as a fate worse than death. Proponents of legalized assisted suicide are willing to treat lives ended through assisted suicide coercion and abuse as "acceptable losses" when balanced against their unwillingness to accept disability or responsibility for their own suicide.



LATE

CCPH Senate Hearing HB2739 HD1 3/16/18 8:30 #229

We stand in opposition to this bill in Hawaii and across the United States

We are writing to express OPPOSITION to this HB2739 HD1 **Obtaining services for our members is hard enough as it is without adding another layer of stress to their lives—wondering if someone will feel they would be better off dead.**

"As an organization dedicated to advancing the rights of people with disabilities to live independent, productive lives, assisted suicide is counter to everything we believe in."

Billy Altom

Executive Director, Association of Programs for Rural Independent Living

Hawaii Contact Information for our organization offering up this testimony:

Eliza and Wilmer Galiza wilmergaliza@gmail.com

Wailuku, Maui, Hawaii 96793

LATE

DREDF: Doing Disability Justice

CCPH Senate Hearing HB2739 HD1 3/16/18 8:30 #229

Please accept this **strenuous opposition** HB2739 HD1
Advocate Chris Niemczyk

The Disability Rights Education & Defense Fund (DREDF) is a leading national law and policy center on disability civil rights. We have worked against assisted suicide laws in Hawaii and across the U.S., since 1999. There are many reasons for our opposition including:

- There's a deadly mix between our broken, profit-driven health care system and legalizing assisted suicide, which will be the cheapest so-called treatment. Direct coercion is not even necessary. If insurers deny, or even merely delay, expensive life-saving treatment, the person will be steered toward assisted suicide. Will insurers do the right thing, or the cheap thing?
- Elder abuse, and abuse of people with disabilities, is a rising problem. Where assisted suicide is legal, an heir (someone who stands to inherit from the patient) or abusive caregiver may steer someone towards assisted suicide, witness the request, pick up the lethal dose, and even give the drug—no witnesses are required at the death, so who would know?
- Assisted suicide bills provide only very weak safeguards.
- Diagnoses of terminal illness are often wrong, leading people to give up on treatment and lose good years of their lives, and endangering people with disabilities, people with chronic illness, and other people misdiagnosed as terminally ill.
- People with depression and other psychiatric disabilities are at significant risk.
- The state oversight & data collection are grossly insufficient.
- Supporters of doctor-prescribed suicide always say this proposal won't affect people with disabilities. But it will, whether or not they realize it.

For any further questions we are at all times available

- Marilyn Golden
- Senior Policy Analyst
- Disability Rights Education & Defense Fund (DREDF)
- mgolden@dredf.org
- Phone (510) 549-9339

- Chris Niemczyk Phone (808) 744-6561 niemczyk@hawaii.edu

WHEREAS, many people with non-terminal disabilities are currently and repeatedly pressured to sign "do-not-resuscitate" orders and other advance directives calling for withholding and withdrawal of medical treatment; and

WHEREAS, there is no empirical data indicating that current laws concerning advance directives are applied on a nondiscriminatory basis; and

WHEREAS, over a decade of experience with these "safeguards" in the Netherlands demonstrates that significant numbers of people with non-terminal illnesses and disabilities have been involuntarily euthanized; and

WHEREAS enforcement of laws and regulations is unlikely in a social context which devalues people with disabilities as a drain on limited health care resources,

THEREFORE BE IT RESOLVED THAT, TASH opposes the legalization of Physician-Assisted Suicide.

info@tash.org



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www.ncil.org

Kelly Buckland
Executive Director

**CCPH Senate Hearing HB2739
HD1 3/16/18 8:30 #229**

Please consider the below on behalf of all our CIL members in Hawaii who are unable to attend the hearing not because they don't want to; they can't get there.

The National Council on Independent Living (NCIL) is the longest-running national cross-disability, grassroots organization run by and for people with disabilities. Founded in 1982, NCIL represents thousands of organizations and individuals including individuals with disabilities, Centers for Independent Living (CILs), Statewide Independent Living Councils (SILCs), and other organizations that advocate for the rights of people with disabilities throughout the U.S.

NCIL has long opposed the legalization of assisted suicide. This is an extremely important issue to the disability community, because disability plays a large role in many end-of-life decisions. Whether individuals are making decisions due to aging, chronic conditions, or terminal illness, disability often accompanies these processes, resulting in functional losses that become pivotal in the decision-making process.

Individuals with disabilities and increased health needs are at a much higher risk for abuse, coercion, and exploitation. These risks are significantly increased by assisted suicide laws. Moreover, assisted suicide laws set up a double standard whereby most suicidal people get suicide prevention while certain others get suicide assistance. For those who are old, ill, or "disabled enough", society will not only agree that suicide is appropriate but will provide the lethal means to complete the act. This is blatant discrimination, and it must not be allowed.

Instead of legislation that makes it easier for people to end their lives, efforts should be taken to increase access to quality supports and services and provide equal suicide prevention. If you would like to discuss our position further, please do not hesitate to call (202) 207-0334 ext. 1104.

Sincerely,

Kelly Buckland, Executive Director
NCIL

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