AAPD
American Association of People with Disabilities

LATE

To Honorable Members of the House Health Committee March 23, 2017 at 8:30. Chair Belatti and Members,

I am writing in opposition to bills including HB201 and SB1129 which, if enacted, would have the effect of legalizing Assisted Suicide and would hold harmless members of the medical community who participate in this process.

I am blind and have lived my life as a person with a disability. While I have been successful in my career, I can truthfully say that society still regards us as less than or second-class citizens. How much easier it would be for doctors and others involved with the care of persons with disabilities to accept that we already have a marginal quality of life.

I recognize that these issues can be very complex and emotional. I don't want it to be easier for people with disabilities to feel that they are a burden and that we should do the noble thing and opt out of life, when our health is failing.

While my political views are generally liberal, I cannot stay silent on this important issue. Ann Lemke Ph.D

Statement on Assisted Suicide

The American Association of People with Disabilities (AAPD) opposes the legalization of assisted suicide. AAPD fully supports the self-determination, competency, and the ability of people with disabilities to make decisions regarding all aspects of their lives. However, mistakes by health care professionals, widespread misinformation, coercion and abuse limit the opportunity for people with disabilities to make informed and independent decisions. In addition, the legalization of assisted suicide devalues the lives of people with disabilities and would create a double standard in our society: it would mean providing suicide assistance to individuals with disabilities and health conditions, as opposed to the suicide prevention services that we provide to others.

The abuse and coercion that has occurred in places where assisted suicide is currently legal provides strong evidence that no safeguards can be effective in ensuring that people with disabilities can make an informed and independent choice. Rather than legalizing assisting people with disabilities and health conditions to end their lives, AAPD believes we should focus our efforts on ensuring that home and community based services and supports and access to quality, comprehensive, affordable health care are available to ensure that people have options that enable them to live independently and with dignity.

For further questions in Hawaii you may contact me:
Ann Lemke, Ph.D., Counselor and Assistant Professor
Work 808-235-7448 Cell 808-232-4040

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

Luz Patricia Medina, M.D., Inc.
Obstetrics/Gynecology and General Practice
99 South Market Street Wailuku, HI 96793
Ph: 808.249-8862
Fax: 808 249 8870

LATE

March 15, 2018

Senator Roz Baker and members of the Commerce, Consumer Protection and Health Committee:

Thank you for allowing me to testify. I am Luz Patricia Medina. I am a practicing physician in Maui since 2006. I am here to strongly oppose HB 2739.

Listen to your heart. Love yourself. Life is precious. You see, you come from an oocyte that is an egg that was one in 7 million. At the time this oocyte, was in the ovary of a 20-week fetus who later became your mother. At the time your mother was inside your grandmother. Thus, you were inside your grandmother as well. You are wonderfully made. You are a great masterpiece. The time will come, when your heart will complete its lifetime here on earth. You will get lonely, fearful, and restless. You will grieve. However, all these emotions will be softened by your loved ones who will be around you: your family and friends. They will care and love you until your last heartbeat.

This is how I envision it. We can all envision it this way. This is the right way.

The wrong way is for you to be handed an overdose of a lethal drug and be left alone to take it and die.

LATE

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

To my colleagues deliberating on the question of doctor-assisted suicide in Hawaii,

I am an internal medicine physician, practicing in Portland Oregon, and I would like to share with you a story about one of my patients.

Recently, I was caring for a 76 year-old man when I made the diagnosis of malignant melanoma, found a metastasis in his shoulder, and referred him to both medical and radiation oncologists for evaluation and therapy. I had known this patient and his wife for over a decade. He was an avid hiker, a popular hobby here in Oregon. As he went through his chemotherapy and radiation therapy, he became less able to do this activity, causing a depression, which was documented by his radiation oncologist.

At his final visit with his medical oncologist, he expressed a wish for doctor-assisted suicide. Rather than taking the time and effort to address his depression, or ask me to respond to his depression as his primary care physician and as someone who knew him, the medical oncologist called me and asked me to be the "second opinion" for his assisted-suicide. The oncologist told me that secobarbital "works very well" for patients like this, and had done this many times.

My reply was that assisted-suicide was not appropriate for this patient, and that I did NOT concur. I was very concerned about my patient's mental state and I told the oncologist that addressing his underlying issues would be better than simply prescribing a lethal medication. Unfortunately, my concerns were ignored and two weeks later my patient was dead from a lethal overdose prescribed by this oncologist. With the permission of his spouse, I obtained a copy of his death certificate. It listed the cause of death as melanoma.

The public record is not accurate. My patient did not die from his cancer, but at the hands of a once-trusted colleague. This experience has affected me, my practice, and my understanding of what it means to be a physician. What happened to this patient, who was weak and vulnerable at the end of his life, raised several important questions that I have had to answer, and that you in Hawaii need to understand as you deliberate this question for your citizens:

1. Who can you trust? If you send a patient to a colleague and expect excellent care, do you have to specifically ask "Will you kill my patient when he becomes depressed at end of life?"
2. What does the request for 'assisted-suicide' mean? Suicidal ideation used to be interpreted as a cry for help, and the only help my patient received was a lethal prescription, intended to kill him.
3. What could I have done to help this patient? I had referred him on to specialty care, a person who I trusted, and the outcome proved to be fatal. My patient's needs were not met. If my colleague had bothered to find out more about him and worked with him to treat his depression, help him find meaningful new ways to function, perhaps things might have turned out differently.

To the physicians and health care workers in Hawaii, is this where you want to go? Is this what you want to become? Please learn the real lesson from the Oregon experience of doctor-assisted suicide. Despite all of the so-called "safeguards" in our assisted suicide law, numerous instances of coercion, inappropriate selection, botched attempts, and active euthanasia have been documented in the public record. This however is not the worst of it. In my opinion, the tragedy of Oregon is that instead of doing the right thing, which is to provide excellent care, patient's lives are being cut short by physicians who are not addressing the issues underlying patient suicidality at the end of life. This change in the direction of our profession, after 2400 years of "Do No Harm", has me concerned. This should concern all Hawaiians as well.

Respectfully submitted,

Charles J. Bentz MD, FACP
Clinical Associate Professor of Medicine, Division of General Medicine and Geriatrics
Oregon Health & Sciences University, Portland Oregon
Department of Medicine Faculty Practice, St. Vincent Hospital and Medical Center
9205 SW Barnes Road, Suite 2800, Portland, OR 97225
phone: (503) 216-7496
email: charles.bentz@providence.org

Mahalo Nui Loa,

Luz Patricia Medina, M.D.
OB/GYN and General Practice

LATE

TESTIMONY IN STRONG **OPPOSITION** TO **HB 2739 HD1**
2018 BILL TO ENACT PHYSICIAN ASSISTED SUICIDE IN HAWAII

For Hearing by Senate Committee(s) on Commerce, consumer Protection & Health

Hearing Date and Time: March 16, 2018; 8:30 o'clock a.m. Room 229

Dear Committee Chair and Members:

I submit this testimony in strong **OPPOSITION** to HB 2739 HD1 and physician assisted suicide (PAS) under any description for the following reasons:

____ Medical care includes only promoting health/treating disease - NOT killing the patient

____ PAS tells troubled teens that suicide is an acceptable way to solve problems

____ Unused lethal medication is not adequately controlled/ causes risk to others

____ In Hawaii, we take care and love our Kupuna, we don't abandon them to suicide

____ It is not good for Hawaii's reputation to join only five states and DC to enact PAS

____ The legislative findings in support of this bill that 20 years is long enough to work on PAS legislation misses the entire point

____ HB 2739 HD1 completely protects from civil or criminal liability conduct that would otherwise be criminal and subject the person who engages in the conduct to civil damage claims

____ Other: _____

I urge you to vote no and do not pass HB 2739 HD1 at the hearing.

Liane Slom
Sign name

Liane Slom
Print name

341 makalii Pl. Kailua Hi. 96734
Print street address with zip code

SENT VIA WEB from http://www.capitol.hawaii.gov/submittestimony.aspx

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I urge you to vote no and do not pass HB 2739 HD1 at the hearing.

Virginia Jeannie Dolan
Signature

Print name

415B N. Kainalu Dr. Kailua, Hi 96734
Print street address with zip code

SENT VIA WEB from http://www.capitol.hawaii.gov/submittestimony.aspx

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Margo-Ann Dolan
Sign name

Margo-Ann Dolan
Print name

415 A U Kainalu Dr
Print street address with zip code

Kailua Hi 96734

SENT VIA WEB from http://www.capitol.hawaii.gov/submittestimony.aspx

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I urge you to vote no and do not pass HB 2739 HD1 at the hearing.

Sign name

Mary A. Chun

Print name

415 A N. Kainalu Dr.

Print street address with zip code

Kailua-Hi. 96734

SENT VIA WEB from http://www.capitol.hawaii.gov/submittestimony.aspx

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____ Other: _____

I urge you to vote no and do not pass HB 2739 HD1 at the hearing.

Niki Miller
Sign name

Niki Miller
Print name

423 Aulima Lp 96734
Print street address with zip code

SENT VIA WEB from http://www.capitol.hawaii.gov/submittestimony.aspx

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____ Other: _____

I urge you to vote no and do not pass HB 2739 HD1 at the hearing.

Sign name

Brillian D. Leonardo
Print name

94-234 Kahuahani St Waipahu, HI 96797
Print street address with zip code

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I urge you to vote no and do not pass HB 2739 HD1 at the hearing.

Sylvia R. Morris
Sign name

Sylvia Morris
Print name

45-638 Halekou Pl 96744
Print street address with zip code

Kaneohe

SENT VIA WEB from http://www.capitol.hawaii.gov/submittestimony.aspx

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L.C. Morris
Sign name

L.C. Morris
Print name

45638 Kaokoa Pl. 96744
Print street address with zip code

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____ Other: _____

I urge you to vote no and do not pass HB 2739 HD1 at the hearing.

Sign name

Brandon Berinobis
Print name

320 B Wilania St. Kailua HI 96734
Print street address with zip code

SENT VIA WEB from http://www.capitol.hawaii.gov/submittestimony.aspx

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✓ HB 2739 HD1 completely protects from civil or criminal liability conduct that would otherwise be criminal and subject the person who engages in the conduct to civil damage claims

✓ Other: Too much risk for things to go awry

I urge you to vote no and do not pass HB 2739 HD1 at the hearing.

Jacqueline Lovin-Yap
Sign name

JACQUELINE LOVIN-YAP
Print name

411 MAHINUI AVE. KAHULUI, HAWAII 96732
Print street address with zip code

SENT VIA WEB from

LATE

have chosen not to execute even the most heinous of criminals, believing, instead in the sanctity of human life.

In *Decisions Near the End of Life* it is proposed that instead of participating in assisted suicide physicians must aggressively respond to the needs of patients at the end of life. Patients cannot be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

Due to multiple community efforts in Hawaii, significant progress is being made in educating physicians, other health care professionals and health care institutions about pain management, palliative care and end of life care, which provide meaningful alternatives to physician assisted suicide and are at risk with this legislative proposal. Simple solutions to complex problems are usually never the right answer; hard cases still make bad law.

Members of the House Committee on Health, please do not impose on our citizens, the well intentioned, but misguided idea of Physician Assisted Suicide.
Thank you, once again for your attention to this very important matter.

John T. McDonnell, M.D.
Past President
Hawaii Medical Association

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

LATE

To the Honorable Members of the State Legislature

My name is Nancy Long. I am a physician, and resident of Maui County. I am opposed to the proposed legislation regarding Physician Assisted Dying in Hawaii. I am a board-certified hospice and palliative medicine physician and family physician. I have been practicing in Maui since January, 2009.

While I have the deepest respect for individuals' choices regarding their health care, their illness and their dying, the complexities of this issue and of the interface of law and medicine around this issue necessitate my voicing my opinion regarding this matter.

1. I am deeply concerned about how the legislation will ensure that all residents of Hawai'i have access to this program if it is legalized. What about our residents who do not have the financial resources to purchase the medication? What about the homeless population, new immigrants, non-English speakers, the uninsured? Would the inevitable outcome be that only wealthy or resourced residents of Hawai'i be able to "die with dignity"?

2. I am deeply concerned about allowing all physicians to write these prescriptions. Most of what I have learned about addressing suffering, depression, and requests to hasten death in the terminally ill I have learned as specialty training following my usual medical school and residency training. These are specialized skills, and patients facing these serious questions and issues deserve to be cared for by trained professionals, not anyone with an MD degree. In addition, many of the physicians staffing our hospital here in Maui are travellers. They are here temporarily. They do not have the time nor the inclination to truly get to know the unique qualities, diversity, and culture of our community.

3. The issue of prognosis troubles me. Recently I helped to care for a 37 yearold female who was released from hospital to home being told she had just a few days to live. This message was given to her strongly by the hospital physicians and team. She lived for three additional months, celebrated her 10th wedding anniversary, and spent many precious hours with her three children. Physicians are wrong sometimes; I am wrong sometimes.

4. I am concerned that Hawaii will become a "destination" for those requesting physician aided dying. Already I get calls nearly weekly from terminally ill people who want to come to Hawaii, want to die in Hawaii...as part of their "bucket list". How will these requests be handled? How will we care for this potential influx of very sick patients when we cannot meet our current needs?

5. In my work as a hospice physician, I witness many situations where the motives of caregivers, and at times family members, are questionable at best. Financial incentives are highly motivating at stressful times, and there is no clear way to know that a patient ingests the prescription himself, or if it is given by a caregiver or family member with a questionable motive.

6. Like every other physician in Hawaii, I have never been trained to write a prescription for a lethal dose of medication. I have never been trained on

what to do if it does not work. I have never been trained on what to do with unused medication, or what to do if a person's depressed teenage grandson ingests the medication that is present in the home and that I prescribed. Suicide is a major and growing problem in Maui County. Unintended uses of these lethal medications are an important consideration.

Thank you for respectfully considering these important points, and working to craft legislation that is safe for everyone in our beautiful state.

Respectfully,
Nancy Long, MD
808-344-5166

Gabriel Ma MD
1280 Lusitana Street Suite 214
Honolulu, Hawaii 96813
808 524-7333

LATE

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

Honorable Committee Members,

Thank you for this opportunity to express serious concern about this proposed legislation. This bill is not only not necessary; the physician community does not want it. I do not want it.

Currently, patients have the choice to refuse prolongation of life by artificial means and to limit treatment. The profession of being a physician, as I was taught in Medical School, is to "cure sometimes, relieve often, and comfort always". These principles still guide our profession today. To this end medications and counseling, especially to relieve pain, are prescribed to provide relief.

Pain is regularly publicized by proponents' and the people with their tragic and sad stories, as the reason it is needed. It turns out that "inadequate pain control or concern about it" is listed as the #6 reason for requesting assisted suicide in Oregon. We have some of the best palliative care physicians and Hospice access in the Nation right here in Hawaii. We struggle with end-of –life issues and have an advocacy group Kokua Mau who also struggles. We don't need an Out of State "Group" to set themselves up as our gurus for end of life care by bringing assisted suicide to the table to "help us" as they said on their television presentation.

You can't protect innocent people from coercion if you make a law saying it is OK for someone to ask them if they want to kill themselves and then easily provide them the means to do it. In their despair, loneliness, or wanting to please others, they may say yes although they would never really want it. We need to focus on life, life lived as best it can be, just as they lived their whole life with its trials and tribulations. And we as a society need to reassure them that we will be with them until the end. Just as physicians often commit to be with their patients to the end as best as that can be.

As I wrote in the Star Advertiser LTE....Please do not pass this bill.

I close with the thought that I have seen many patients live beyond their initial six month diagnosis and I have seen many families at peace with the sharing of the end of life care and experience of their loved one (even at great personal inconvenience and cost). I am also aware that sometimes the family does not have the best interest of the patient at heart. We need to protect our elders from abuse, not give anyone even a doctor, an easy way to make them dead.

Thank you,
Dr. Gabriel Ma

Dr & Mrs. Lloyd and Janet Jones
Anesthesiology
747 Ululani Street
Kailua, Hawaii 96734

LATE

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

Dear Chair Della AuBelatti, Vice Chair Kobayashi, and Members Tupola, Todd, Har, Morikawa, Oshiro:

As a physician, I oppose HB2739 HD1 The definition of compassion is "deep awareness of the suffering of another coupled with the wish to relieve it". As a compassionate physician, my commitment to you the patient includes:
I value you as a person worthy of my efforts.
I will do all I can to find ways to relieve your pain, discomfort, and suffering.
I will be honest with you.
I will never intentionally kill you.

The poor, the physically and mentally handicapped, the homeless, the "non-productive" of society, religious and racial minorities, must know that I as a physician am not about killing my patients. And that I am not a tool for the government, insurance company, nor HMO to reduce costs.

As an anesthesiologist, I can tell you that the level of pain relief and control available now is remarkable compared to just a few years ago. We have implantable morphine infusion pumps, nerve blocks, brain and spinal cord electrical stimulators among other treatments and there are new therapies on the horizon.

Making a law that affects all people based on the few "hard" cases, is very dangerous.

IF you want to see a road map for physician assisted suicide, look to the Netherlands. Euthanasia (physician performed "suicide") was legalized for the competent, terminally ill who asked for it. This was the late 1970's. Next it included competent people with incurable illnesses or disabilities. This progressed to competent people with the "pain" of depression. Next came incompetent depressed people, e.g. Alzheimer's patients. Now, in the Netherlands, "Groningen University Hospital has decided its doctors with euthanize children under the age of 12 years old if the doctors believe their suffering is intolerable or if they have an incurable illness" (The Weekly Standard, 9/13/2004).

People have always had the right to die.
Do not give physicians the right to kill.

H.L. Mencken has said "For every complex problem there is a simple solution. And it is always wrong."
Physician assisted suicide is one such a "simple solution"

Please do not pass this bill out of committee.

Lloyd Jones, M.D.

KEVIN K. KUROHARA, M.D.
FAMILY PRACTICE
75 PU'UHONU PLACE, SUITE 205
HILO, HAWAII 96720
TELEPHONE (808) 969-3814

LATE

POSITION: As a physician, I oppose
From: Kevin K. Kurohara M.D.

Honorable committee,

Physician Assisted Suicide is unnecessary and physicians don't want it. Pain can be managed by modern medicine. This bill will damage the doctor-patient relationship and the trust necessary for good care. We already see that in Oregon where patients have gone to my colleagues' office and inquired..."are you one of those doctors that kill their patients or will you be with me until the end?"

HB2739 HD1 harms medical care. A study in Oregon found that dying patients in Oregon are twice as likely to experience pain during their last week of life then they did prior to the passage of their legislation. Though the majority of people in Oregon do not list pain and suffering as the reason they chose to use the drugs, you are basing your Hawaii vote on this non-issue due to tragic stories proclaimed by some.

Assisted Suicide devalues a patient's dignity. Fear of becoming a burden is the most common reason for assisted suicide in Oregon. Good pain management and comfort care, including new methods of pain control, palliative care, hospice and treatment, if depression is present, are far more likely to lead to dignity than a cheap suicide.

Safeguards in Oregon protect no one. HMO administrators have overruled their physician to authorize it. Doctors have given suicide drugs to depressed patients they met only two weeks earlier. And physicians have already crossed the line and euthanized patients.

B2739 HD1 authorizes 'treatment' that is not treatment and it is dangerous because it is cheaper than good care and eliminates real treatment options for the poorest and most vulnerable.

Many states have, for good reasons, rejected assisted suicide for their citizens, as has Hawaii, for all these years. There is truly no compelling reason or benefit to society to make the change now. Please to not be deceived by those who tell you there haven't been and won't be unintended consequences for public policy and the health care system by this proposal to kill the patient for the good of society. At the very least we can and should do more than this to support our fellow humans.

Thank you for your consideration of my point of view.

Kevin Kurohara, M.D.

LATE

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

Thank you for allowing me to testify on this highly controversial bill. The title you have given it is Medical Aid in Dying. This is somewhat misleading as the subject of the bill is Physician assisted suicide/physician assisted death. The furor over this topic has gone on since pathologist Dr. Jack Krevokian assisted Janet Adkins of Portland Oregon to commit suicide in Michigan. She was suffering from Alzheimer's disease. In those days pain was a serious problem.

There is no reason for anyone to die an agonizing death. The world has changed. We have JACHO approved pain management services, palliative care certified as a medical specialty. Most of the opposition to physician assisted suicide comes from palliative care and hospice physicians and nurse who know what can be done for these patients. Hawaii has Kokua Mau. We don't need a competing Compassion & Choices organization to bring us excellent end of life care. They want to bring death—Kokua Mau wants to focus on life.

This should not be about death—It should be about life.

The power to assist in intentionally taking the life of a patient is counter to and fundamentally incompatible with his role as a healer. It would be difficult or even impossible to control and would pose serious societal risks. It is a power that most health care professional s do not want.

As with many other problems in our society, education is the answer. Both education of our physicians and nurses that deal with dying patients, and education of our patients so that all present legal avenues are utilized to control their own dying process as much as is possible without crossing ethical and moral boundaries.

I encourage all physicians to become more competent in end of life care so you will be comfortable when your favorite patient enters the dying process. After all is said, just remember that we are going to die under the same circumstances that we create for our patients today. That time will come for each of us. It is already possible today, in Hawaii, for all of us.

Thank you for your kind attention.

Leonard R. Howard MD, FACOG, (Ret.)
Past President HMA
Past Director, Educating physicians for end of life care

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

LATE

My name is Don W Hill, M.D., F.A.C.P. email address is dhill@hhsc.org. As Medical Director for the Hematology/Medical Oncology Department for MMMC, I am writing you this letter to express my concern regarding SB1129 and any potential future state bills that may address the issue of physician assisted suicide. As a Medical Oncologist with 29 years of practice experience I believe patient assisted suicide is morally wrong and unnecessary.

At this time, through the advancements made through hospice care we are able to provide comfort, dignity and pain free death for the majority of patients now afflicted with terminal illnesses. I believe patient assisted suicide, by whatever euphemistic title that may be labeled upon such action to be a dangerous and potential "slippery slope" that will devalue human life.

Please recall Nazi Germany in the 1930's started a euthanasia program with the support of National Socialist physicians to eliminate terminally ill, elderly, and mentally challenged individuals. Although initially considered "good intentions" the dehumanization this casued spiraled into a broad policy of genocide.

As a Medical Oncologist practicing in the State of Hawaii, I am vehemently opposed to any legislation that would allow the legalization of any law that would permit overt physician assisted suicide.

Sincerely,
Don W Hill, M.D., F.A.C.P

LATE

Hellreich Philip D MD
Address: 40 Aulike St #311, Kailua, HI 96734
Phone: (808) 261-6133

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

As said so well by Joni Tada – 'It should not be the state's responsibility to help despairing people to kill themselves. Rather, let's channel more effort into improving—management therapies—into the hospice movement. Let's lift people out of depression through compassionate support, family assistance and help... we must do all we can to protect, defend, and preserve every life.'

Personal autonomy should not in all cases trump public policy. This is one of those cases.

Physicians do not want to be involved. The doctor-patient trust relationship is important to protect and there is no need for assisted suicide especially disguised in your own words as medical treatment. Please remove those words from this bill- better yet- stop the bill in committee.

Thank you for the opportunity to express my concerns.

Philip D Hellreich, M.D.

LATE

Jeffrey Michael Drood MD
Clinical cardiac electrophysiology
1962 E Vineyard St, Wailuku, HI 96793
(808) 244 - 3278

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

As a physician, I oppose this measure as do many, many of my colleagues.

Physician Assisted Suicide is an idea that is as old as medicine itself. 2,500 years ago the Hippocratic Oath was conceived to end patient distrust of doctors who had become both healers and killers. The bond of trust between a patient and a physician is the basis of medical practice and central to the art of healing. This bill as drafted would undermine that trust.

In an era when medical care can and has been driven by cost concerns, this proposal is dangerous.

Suicide is not simply one more end of life choice.

It would change the nature of all choices and restrict good medical care.

Suicide may be cheaper than good care, but it is not compassionate and does not reflect the culture and values that we who live here exemplify on a daily basis. No matter how cleverly you think you have crafted this legislation, better minds than ours have seriously studied this and found it wanting. We see abuse in Oregon no matter what the proponents may say. And we see a culture change. The abuses will fall on those least able to resist it-the weakest, sickest, poorest, and most vulnerable.

Please hold this bill in your committee. We don't need or want it.

Thank you for the opportunity to express my viewpoint.

Jeffrey M Drood, MD

LATE

Joseph Tau Tet Hew Jr MD
1852 Loke Street
Wailuku, Hawaii 96793

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

The current nominee for the Supreme Court holds the same opinion I do and he says it well so I will quote him to you. I hope you will take his opinions (and mine) to your hearts.

Legalizing the practice, he said, could be a slippery slope. Doctors, insurance companies and the healthiest in society might wind up looking for ways to shorten the lives of the frail and the elderly to preserve resources for those with more promising futures. Doing so, he said, would have a disproportionate impact on the poor, the powerless and minorities who sometimes do not receive the same quality of medical care and pain-control management when they are ill.

"If a right to consensual homicide is eventually accepted into the law, we might ask what other ripple effects it could have on social and cultural norms. Why not, for example, allow individuals to sell their body parts or their lives?" he asked.

And he suggested that if killing became a professional duty under certain circumstances, medical care professionals may someday face "wrongful life" lawsuits from families upset their relatives suffered needlessly when a doctor or nurse failed to advocate for death.

Still, his book made clear that his views do not interfere with a right of individuals to choose through living wills to reject certain potentially life extending measures, such as the use of a ventilator.

Thank you for allowing me to comment as you consider this very important issue. Doctors do not want anything to do with this and most will not participate. However, you only need two to open up a death center in Hawaii.

LATE

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

FROM: William Fong, M.D., 1319 Punahou Street, Suite 801, Honolulu, HI 96826

I am a physician and a practicing obstetrician-gynecologist and I am testifying against HB2739 HD1

In my 37 years of practice, what I value the most is the trust relationship that I develop with my patients. There are times that in a split second I must make a drastic decision to ensure my patient's safety and well-being. Even under these difficult circumstances she must still trust me completely that I am acting in her best interest.

I do not take this privilege and responsibility lightly. But to be trustworthy, a physician must be consistent and credible. Placing the burden of enabling suicide on the shoulders of physicians will damage all of that, for it will place physicians in a role where the line between protecting a life and terminating a life becomes blurred.

We who have been trained in the healing arts will ironically become the caretaker of the killing arts. This will not benefit anyone's best interest. Patients, especially those who are faced with dysfunctional family situations or financial burdens, should not have to second-guess the motives and intentions of their physicians at a time when they are most vulnerable.

While some may believe that having the option of physician assisted suicide (PAS) at the time of a medical crisis creates a climate of comfort, for many other PAS will instead create a climate of fear and distrust. Why are we considering taking even the slightest risk that if motivation of the wrong kind were to prevail in a case of PAS, the result would be irreversible– the death of an individual will have been caused.

We should not, as a compassionate and caring society, be willing to take that risk. We need to err on the side of protecting and preserving life, not expediting or hastening death.

The advocates of PAS want our community to believe that this represents logical, rational, and conventional medical wisdom. It is not. The majority of physicians will not ever participate in PAS. The official position of the American Medical Association is to oppose PAS. The Hawaii Medical Association does not support it. Advocating suicide in general is a radical departure from the mainstream medical value system and philosophy. It is so radical that the only way that suicide advocates can hope to accomplish their goal is to legitimize it as physician-supported.

Suicide is not a medical treatment and it never should be. It must be made clear that I share the opinion of many of my colleagues who strongly oppose PAS, who believe that it is not good for our society and who urge that HB2739 HD1be defeated.

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

LATE

Benjamin T. Gamboa MD
Kahului Hawaii 96732
808 873-0297

Assisted suicide is an idea as old as medicine itself. 2,500 years ago the Hippocratic Oath was conceived to end patient distrust of doctors who had become both healers and killers. Let us not revert to practice that was common in those ancient times. Hopefully we are more enlightened today.

Please consider those who would ultimately be harmed by this practice, not just those made dead, but the living who bear the burden of that death.

Look over the attached sheet. You will see why safeguards won't work.

LATE

When Death is Sought
Assisted Suicide in the Medical Context

From The New York State Task Force on Life and the Law

The Risks of Legalization

We continue to believe that the profound dangers associated with legalizing Physician-Assisted Suicide (PAS) outweigh any benefits such a change in law might achieve in isolated cases.

- **Undiagnosed or untreated mental illness.** Many individuals who contemplate suicide, including the terminally ill, suffer from treatable mental disorders, most commonly clinical depression. Physicians routinely fail to diagnose and treat these disorders, particularly among patients at the end of life. Many requests are likely to be granted, even though they do not reflect a competent, settled decision to die.
- **Improperly managed physical symptoms.** Requests for assisted suicide are highly correlated with unrelieved pain and other discomfort of physical illness and are often grossly under-treated in current clinical practice. Physicians are likely to grant requests for assisted suicide from patients in pain before all available options to relieve the pain are thoroughly explored.
- **Insufficient attention to the suffering and fears of dying patients.** Suicide may seem the only solution to profound existential suffering, feelings of abandonment, or fears about the process of dying. While psychological, spiritual, and social support – particularly comprehensive hospice services - can often address these concerns, many individuals do not receive these interventions. They are likely to seek assisted suicide because their suffering and fears have not been adequately addressed.
- **Vulnerability of socially marginalized groups.** No matter how carefully any guidelines for PAS are framed, the practice will be implemented through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society. PAS will pose the greatest risk to the poor, elderly, isolated, members of minority groups, or those who lack access to good medical care.
- **Devaluation of the lives of the disabled.** A physician's reaction to a patient's request for suicide assistance is likely to depend heavily on the physician's perception of the patient's quality of life. Physicians, like the rest of society, may devalue the quality of life of individuals with disabilities and be particularly inclined to grant requests for suicide assistance from disabled patients.
- **Sense of obligation.** Legalizing assisted suicide would send a message that suicide is a socially acceptable response to terminal or incurable disease. Some patients are likely to feel pressured to take this option, particularly those who feel obligated to relieve their loved ones of the burden of care. Those patients who do not want to commit suicide may feel obligated to justify their decision to continue living.
- **Patient deference to physician recommendations.** Physicians typically make recommendations about treatment options, and patients generally do what physicians recommend. If implied that PAS is "medically appropriate," some patients will feel they have few alternatives but to accept the recommendation.
- **Increasing financial incentives to limit care.** PAS is far less expensive than palliative care at the end of life. As medical care shifts to capitation systems, financial incentives to limit treatment may influence the way the option of PAS is presented to patients or the range of alternatives they can obtain.
- **Arbitrariness of proposed limits.** Once society authorizes PAS for competent, terminally ill patients experiencing unrelievable suffering, it will be difficult, if not impossible, to contain the option to such a limited group. Individuals not competent, not terminally ill, or who cannot self-administer lethal drugs will also seek the option of PAS, and no principled basis will exist to deny them this right.
- **Impossibility of developing effective regulation.** Clinical safeguards proposed to prevent abuse and errors are unlikely to be realized in everyday medical practice. Moreover, the private nature of these decisions would undermine efforts to monitor physicians' behavior to prevent mistake and abuse.

When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context
(New York: The New York State Task Force on Life and the Law, 1994). http://www.health.state.ny.us/nysdoh/provider/death.htm

LATE

Luz Patricia Medina, M.D., Inc.
Obstetrics/Gynecology and General Practice
99 South Market Street Wailuku, HI 96793
Ph: 808.249-8862
Fax: 808 249 8870

March 15, 2018

Senator Roz Baker and members of the Commerce, Consumer Protection and Health Committee:

Thank you for allowing me to testify. I am Luz Patricia Medina. I am a practicing physician in Maui since 2006. I am here to strongly oppose HB 2739.

Listen to your heart. Love yourself. Life is precious. You see, you come from an oocyte that is an egg that was one in 7 million. At the time this oocyte, was in the ovary of a 20-week fetus who later became your mother. At the time your mother was inside your grandmother. Thus, you were inside your grandmother as well. You are wonderfully made. You are a great masterpiece. The time will come, when your heart will complete its lifetime here on earth. You will get lonely, fearful, and restless. You will grieve. However, all these emotions will be softened by your loved ones who will be around you: your family and friends. They will care and love you until your last heartbeat.

This is how I envision it. We can all envision it this way. This is the right way.

The wrong way is for you to be handed an overdose of a lethal drug and be left alone to take it and die.

HB 2739 is an assisted suicide bill. Strategic lobbyists for this bill come from an organization called Compassion and Choices which comes from an Euthanasia group which was known as the Hemlock society, named after a poisonous plant. This is the dark path to take.

Some of you may remember the fiction thriller movie called Soilent Green. This was in 1973. The movie depicts a dark, hopeless world of overpopulation, depleted resources, and yes EUTHANASIA. There is a scene where one of the main characters seeks assisted suicide at a government clinic.

Senators, you will decide soon on HB 2739. You will know what to do because you will have complete peace in your heart and will know your conscience correctly. You will protect our innocent, vulnerable, disabled, and wounded neighbors from being abused and coerced.

Assisted suicide is not the way to fix our broken U.S. health care system. Focus your efforts instead to educate the community. For example, how to care for our very sick family members. Let us be that one state in our nation that shows the rest of America the true respect we have for life.

As I previously said, you are the chosen one. You came from one in 7 million oocytes. You were inside your mother who was herself inside her mother. Thus, you were inside your grandmother. You are a great masterpiece.

Mahalo Nui Loa,

Luz Patricia Medina, M.D.
OB/GYN and General Practice

LATE

Zora Bulatovic MD
zbulatovic@mauimedical.com

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

Physician participation in assisted suicide or euthanasia may have a profound harmful emotional toll on the involved physicians. Doctors must take responsibility for causing the patient's death. There is a huge burden on conscience, tangled emotions and a large psychological toll on the participating physicians. Many physicians describe feelings of isolation. Published evidence indicates that some patients and others are pressuring and intimidating doctors to assist in suicides. Some doctors feel they have no choice but to be involved in assisted suicides. Oregon physicians are decreasingly present at the time of the assisted suicide. There is also great potential for physicians to be affected by countertransference issues in dealing with end-of-life care, and assisted suicide and euthanasia.

These significant adverse "side effects" on the doctors participating in assisted suicide and euthanasia need to be considered when discussing the pros and cons of legalization.

Please stop this bill in your committee. Physicians don't want this. Thank you for this opportunity to express my opposition

LATE

I Tarita Tehotu a native of Hawai'I Strongly oppose this bill HB2739!

Assisted suicide is now legal in California, but encouraging, (cajoling) marketing, promoting it is still a felony.

Most of the committee said that this was a great bill and the best bill however the truth is that there are still deficiencies and according to the **attorney general of Hawaii CONCERNS** about the wording "GOOD FAITH" the word is still in the bill.

I believe This is why Rep Tupola and Ward asked for a 3 yr review and the house DENIED IT THEY DON'T HAVE ANY CLUE, THIS TELLS ME THAT THEY OVERLOOKED IT.

The way the current bill is currently written now could be an effect because the way the language is written is under the aid and dying law.

Please look over the California testimony regarding the need to clarify the language.

Take note that most laws are applied prospectively which means any of those who are involved in the past debts could be charged for suicide or assisting suicide under the present California law!

This raises the issue of whatever law-enforcement will have access to medical records filed with the department of health.

Also look at the website https://www.compassionandchoices.org/hawaii/

They are a referral service and want to plant their business here in Hawaii to come and find death in Hawaii instead of life and eventually people will come here and they will be providing a service for people to go to their drs that they refer and MAKE MONIES OFF FROM OUR PEOPLE AND TAX PAYERS. How BLIND CAN YOU ALL BE AS LOCALS FROM THIS LAND.

I beg for an amendment in the Senate OR BETTER YET CANCEL THIS BILL. WHST IS THE RUSH. ONE BIG MISTAKE IS CRUCIAL IT WILL BE A MISTAKE YOU WILL REGRET FOR THE REST OF YOUR LIVES IF THIS IS NOT CONSIDERED THOROUGHLY.
ON ANOTHER NOTE, BEFORE GOING TO DO AN OPERATION ON A PERSON USUALLY GOES TO MORE THAT ONE OR 2 OPINIONS. WHY DOESN'T THE COMMITTEE WHO IS IN CHARGE OF THIS MATTER DO THE SAME THING, BEFORE MAKING A BIG MISTAKE.
Even An editor of the newspaper on March 11th recognize the danger of this bill HB 2939.

Look at how the Oregon bill was so cleverly designed to avoid any law-enforcement investigation or civil suit or agency review by the structure of prohibiting any information from being released and the total confidentiality of the parties involved.

Please read what I have below and Please read the attachment of the attorney generals testimony that your HOUSE COMMITTEE HAS IGNORED!
WOW I don't know if I would want that type of people to be making decisions for HAWAI'I especially if its like a SLAP IN THE FACE TO ONE OF THE HIGHEST SPEAKING PERSON IN HAWAI"I

WE ARE WATCHING ALL OF YOU!

Bill Text Bill Text - AB-282 Aiding, advising, or encouraging suicide: exemption from prosecution

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1.*Section 401 of the Penal Code is amended to read:*

401. *(a)* Every person who deliberately aids, ~~or~~ advises, or encourages another to commit ~~suicide,~~ *suicide* is guilty of a felony.

(b) A person whose actions are authorized pursuant to the provisions of the End of Life Option Act (Part 1.85 (commencing with Section 443) of Division 1 of the Health and Safety Code) shall not be prosecuted under this section.

AMENDED IN ASSEMBLY JANUARY 03, 2018

CALIFORNIA LEGISLATURE— 2017–2018 REGULAR SESSION

ASSEMBLY BILL **No. 282**

Introduced by Assembly Members Jones-Sawyer and Bonta

February 02, 2017

~~An act to add Section 13519.45 to the Penal Code, relating to peace officer standards and training.~~ *An act to amend Section 401 of the Penal Code, relating to suicide.*

LEGISLATIVE COUNSEL'S DIGEST

AB 282, as amended, Jones-Sawyer. ~~Commission on Peace Officer Standards and Training: procedural justice training.~~ *Aiding, advising, or encouraging suicide: exemption from prosecution.*

Existing law, the End of Life Option Act, until January 1, 2026, authorizes an adult who meets certain qualifications and who has been determined by his or her attending physician to be suffering from a terminal disease to request a prescription for an aid-in-dying drug. The act, with some exceptions, provides immunity from civil or criminal liability for specified actions taken in compliance with the act. Actions taken in accordance with the act do not, for any purpose, constitute suicide, assisted suicide, homicide, or elder abuse under the law.

Existing law makes a person who deliberately aids, advises, or encourages another to commit suicide guilty of a felony.

This bill would prohibit a person whose actions are authorized pursuant to the End of Life Option Act from being prosecuted for deliberately aiding, advising, or encouraging suicide.

~~Existing law establishes the Commission on Peace Officer Standards and Training and requires it to develop and disseminate guidelines and training for law enforcement officers, as described.~~

~~This bill would require the commission to develop and disseminate training for peace officers on principled policing, which would include the subjects of procedural justice and implicit bias, as defined. The bill would require this training for specified peace officers. The bill would also require the commission to certify and make training available to train peace officers to teach the course of training on principled policing to other officers in their agencies. The bill would require the commission to offer the principled policing course and the training course quarterly commencing in June 2018. The bill would require the commission, no later than June 1, 2019, to evaluate its current course of basic training and promulgate a plan to incorporate the concepts of principled policing into its course of basic training and would require each peace officer to complete a refresher course no less than every 5 years.~~

~~By requiring additional training for peace officers, this bill would impose a state-mandated local program.~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.~~

Digest Key

Vote: MAJORITY Appropriation: NO Fiscal Committee: ~~YES~~*NO* Local Program: ~~YES~~*NO*

Bill Text

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

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ACLU Hawai'i

LATE

Committee:	Senate Committee on Commerce, Consumer Protection, and Health
Hearing Date/Time:	Tuesday, March 16, 2018, 8:30 a.m.
Place:	Conference Room 229
Re:	*Testimony of the ACLU of Hawai'i* ***in Support of*** *H.B. 2739, H.D. 1, Relating to the Health*

Dear Chair Baker, Vice Chair Tokuda, and Committee Members:

The American Civil Liberties Union of Hawaii writes in support H.B. 2739, H.D. 1, which allows competent, terminally ill adults to obtain prescription medication to end their own life. The ACLU of Hawai'i strongly supports the right to bodily autonomy—which includes, among other things, the right to refuse treatment, the right to access necessary medical care, and the right to make personal decisions about how to spend one's final days. Six states — Oregon, Montana, California, Vermont, Washington, and Colorado — and the District of Columbia have legalized physician-assisted death.

While the ACLU of Hawai'i is unaware of any documented widespread abuse, it is important that any physician-assisted death legislation include proper safeguards to prevent abuse and coercion. In order for physician-assisted death to truly be a choice, it cannot be the only option. Patients must have access to information about pain medication, and palliative care must be readily available. Patients should never be pressured or coerced into requesting life-ending medication, whether by a doctor, spouse, or family member. H.B. 2739 provides adequate safeguards to address these concerns.

Thank you for the opportunity to testify.

Sincerely,

Mateo Caballero
Legal Director
ACLU of Hawai'i

The mission of the ACLU of Hawai'i is to protect the fundamental freedoms enshrined in the U.S. and State Constitutions. The ACLU of Hawai'i fulfills this through legislative, litigation, and public education programs statewide. The ACLU of Hawai'i is a non-partisan and private non-profit organization that provides its services at no cost to the public and does not accept government funds. The ACLU of Hawai'i has been serving Hawai'i for 50 years.

American Civil Liberties Union of Hawai'i
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www.acluhawaii.org

March 15, 2018

LATE

Honorable Chair Rosalyn H. Baker, Vice-chair Jill N. Tokuda and Committee Members,

I am submitting my testimony in opposition to HB 2739 HD1. I am Registered Nurse in the state of Hawaii. I would like to give you an idea of my role for these patients who are terminally ill and their families.

HB 2739 HD1 states that if it becomes a law it will allow a "mentally competent adult residents who have a terminal illness to voluntarily request and receive a prescription medication that would allow the person die in a peaceful, humane manner." According to the study conducted by Hui et. Al (2014) published in *The Journal of Pain and Symptom Management*, the following terms "actively dying," "end of life," "terminally ill," "terminal care," and "transition of care" are commonly used but rarely and inconsistently defined. The researchers also added that, "part of the challenge with these prognostic terms is that both our science and language of prognostication are imprecise. Because death is often mediated by catastrophic events such as myocardial infarction and pneumonia, it is difficult to know exactly how long a patient is going to live" (Hui et al., 2014). For the purpose of Medicare coverage for a patient to qualify for Hospice, he or she must have a life expectancy of six month or less. I have taken care of many terminally ill patients who outlived their diagnoses or have lived beyond their "expiration date." A physician, regardless of experience and expertise can only "guesstimate" a patient's last days. My experiences have taught me that no one knows the exact time a human being will die and how will it happen. I am going to also emphasize that a mentally competent individual who has a chronic condition/s who is stable on maintenance medicines or treatment can become terminally ill if they decide to stop treatment. For example, a patient with Diabetes who is dependent on insulin is stable with diet, regular glucose monitoring and insulin regimen can be considered "terminally ill" or will probably die within six months if he or she decides to stop taking insulin and liberalized diet. A person dependent and stable on hemodialysis can die within six months or less if he or she decides to stop hemodialysis treatment. These types of patients have what is stated as "terminal illness" in the bill because Type I Diabetes and Chronic Kidney Failure are both *incurable and irreversible disease that has been medically confirmed and will within reasonable medical judgment, produce death within six months* (Page 8, Lines 9-11). A physician, based on the context stated above, can categorize these patients as terminal ill that are otherwise considered stable.

As the Representative from Kahalu'u have mentioned during the House Chamber Hearing that when someone gets in to an accident though they might be bleeding can refuse medical help. Though, "It is well-accepted that a patient has the right to reject medical treatment even when the patient's treating physician or nurse believes the treatment is in his or her best interest. In such a case, withholding treatment at the patient's request is not considered 'physician-assisted' suicide but rather a gesture of respect towards the dignity and free-will of the patient. However, according to most medical bodies and ethics boards, the duty to provide care to a patient does not encompass a duty to comply with a patient's request to be put to death, no matter how hopeless the patient's condition or how intense the patient's pain" (Dilemma for Nurses: Physician-Assisted Suicide, 2010)

Many of our elderly are subject to the pressures in our society. The advances in science of health promotion and disease prevention gave them the chance to live longer lives. Who is to say that they will not feel like a "burden and useless" to their families? I have come across some elderly patients that their families are not willing to take care of them. They are neither present nor involved in their care. The susceptibility of the elderly to struggle from their own health problems and uncaring family can easily make them choose to take their own life just to "get out of the way." According to The Journal of Advance Practice Nursing (2010), "in order to honor a patient's autonomy, nurses and other medical health professionals must be sure that a patient's choices are informed (i.e., that the patient understands the consequences of his or decision) and not the product of pressure or coercion. Unfortunately, it may not always be clear whether a patient's decision is

actually well-informed and freely made. For example, some patients may request withdrawal of treatment or assisted suicide because they believe themselves to be a financial or emotional burden on their caretakers and thus feel a "duty" to die. Thus, "autonomy" can be compromised by many factors, not all of which can be immediately detected or accurately judged by a treating medical professional." This bill does not protect our kupuna and their self-worth or dignity. HB 2739, HD1 will open the way for the elderly to be exploited instead of provide what it claims as "Death with Dignity." This bill will never protect an elderly from abuse though it claims more protections than legislation offers in some other states

I have the utmost compassion to these individuals who are terminally ill. I have held them in my arms and provided the patient centered care they needed while they are in the hospital. I completely agree in alleviating their suffering but I am not going to consent in assist them in killing themselves just because there is no cure for their disease or they are at the end of their life. As a nurse, I know that the dignity or self-worth of individuals is not dictated by their disease and how much days their doctor told them they are going to live. One's dignity is not decreased by how much pain or discomfort a person is going to endure. I will take care of them with their dignity intact until their heart beat its last. The bill claims that the lethal drug will provide a peaceful and humane death. Swallowing a cocktail of 100 de-capsulated Secobarbital and expecting to die within 3 hours (if all goes right) is nothing humane and peaceful. This bill makes a notion that terminally patients are going to be in great deal of suffering or end up in strange hospital with bright lights surrounded by strangers. This is not all true. If a patient is deemed actively dying or placed in comfort care while in the hospital, the family of that patient is free to stay. The patient will be surrounded with their love ones with whatever amount of light they want. We, the friendliest strangers called doctors, nurses and hospital staff, will provide comfort to the patient, emotional support to the family and explain our care and the dying process. Also, most of our patients are discharged home or go to a facility that will provide hospice care here in the islands. Terminally ill patients are provided and cared for holistically in their own home through hospice care or while in the hospital. There are challenges as the public has huge knowledge deficit about these said services. I firmly believe that this HB 2739, HD1 is not the answer for our terminally ill patients seeking "peaceful death." I ask that the legislature find means to support the current standard evidence-based practice and care to expand these to other islands instead of providing unnecessary "other option." This bill does not provide safeguards for the rest of population but paves the way for more confusion, exclusion and litigation.

Sincerely,
Carm Akim, RN BSN

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The JOURNAL of ADVANCED PRACTICE NURSING®

Dilemma for Nurses: Physician-Assisted Suicide

San Francisco, CA (ASRN.ORG)-- Nurses in today's world face ethical dilemmas that are more challenging, perplexing, and treacherous than ever before. These dilemmas are complicated by advancements in medical technology that serve to prolong life as well as philosophical and legal debates over patient autonomy, quality of life, and the definition of death. No other issue raises more ethical, or practical, questions about the role of the nurse in treating patients than physician-assisted suicide.

"Physician-assisted suicide" is the provision to a patient by a medical health professional of the means of ending his or her own life. The ethical issues raised by the concept of physician- assisted suicide include patient autonomy, quality of life, and what it means to act in the patient's best interests. The health professional's degree of participation in the suicide may vary. The physician may give a patient a prescription for a lethal dose of medication that the patient can take when the patient chooses, or the physician may personally administer the lethal dose at the patient's request. Each of these actions would qualify as "physician-assisted suicide." A nurse may be involved in assisted suicide by providing or administering the means of death in his or her capacity as a health care professional, by assisting a physician in doing so, or by tacitly approving the actions of another health care professional by failing to stop or report a physician-assisted suicide of which he or she is aware. It is also important to define what physician-assisted suicide is not. There is a difference between acting to end life and administering a treatment for another reason—such as to reduce pain—that may have as an unrelated, but foreseeable, consequence the hastening of a terminally ill patient's death.

It is also important to think about what we mean by "patient autonomy" and what limits can and should be placed upon it? Does "patient autonomy" include a "right to die"? It is well-accepted that a patient has the right to reject medical treatment even when the patient's treating physician or nurse believes the treatment is in his or her best interest. In such a case, withholding treatment at the patient's request is not considered "physician-assisted" suicide but rather a gesture of respect towards the dignity and free-will of the patient. However, according to most medical bodies and ethics boards, the duty to provide care to a patient does not encompass a duty to comply with a patient's request to

be put to death, no matter how hopeless the patient's condition or how intense the patient's pain.

In order to honor a patient's autonomy, nurses and other medical health professionals must be sure that a patient's choices are informed (i.e., that the patient understands the consequences of his or decision) and not the product of pressure or coercion. Unfortunately, it may not always be clear whether a patient's decision is actually well-informed and freely made. For example, some patients may request withdrawal of treatment or assisted suicide because they believe themselves to be a financial or emotional burden on their caretakers and thus feel a "duty" to die. In addition, there is the possibility that a patient who is ill or in pain will be depressed or suffer from some other mental disorder. Although the patient is technically competent to make his or her own decisions, it is important to consider to what extent those decisions are affected by treated mood disorders or other mental illnesses. Thus, "autonomy" can be compromised by many factors, not all of which can be immediately detected or accurately judged by a treating medical professional.

Another important consideration is "quality of life." At what point does life cease to have "quality" and who should decide how much "quality" a particular patient's life has? A related and valid question is whether the patient is always capable of judging the "quality" of his or her life, and, if the patient is incapable of doing so, who should make that judgment? Considerations of quality of life are closely linked to a determination of what is in a patient's best interests. The challenge is to define what a patient's best interests are and, again, identify who should be allowed to determine what those best interests are and whether they are met by withdrawing or administering a particular treatment. Some proponents of physician-assisted suicide argue that those who oppose it are placing their own abstract ethical concerns above a practical consideration of the patient's best interests. These proponents argue that it is not in the best interests of a pain-wracked terminally ill patient to suffer needlessly when his or her life is almost over anyway. From this perspective, the failure to end that suffering, even if the only way of doing so is the end the patient's life, is an abdication of the health professional's duty to do what is best for the patient's well-being. For such a patient, death is better than a continued existence of intense, unbearable suffering. However, such an argument presumes that medical professionals, who are trained to discern what is best for a patient's health, will be able to determine what is best for the patient overall. This point of view, though well-intentioned, threatens to verge on paternalism, where the physician believes so much in his knowledge of what is best that he or she ignores the patient's right to self-determination. Thus, there is an inherent tension between respecting a patient's autonomy and acting in his or her best interests.

Additional complications arise when a patient is incapacitated and a surrogate is making decisions on his or her behalf. In that case, deciding what a patient wants or what is in

his or her best interests becomes a matter of guesswork for which a physician or nurse is not trained or qualified.

Throughout the United States, it remains illegal under most circumstances for a medical professional, whether a physician or nurse, to assist in the suicide of a patient, even if that patient has a terminal illness, is suffering pain, and specifically requests the assistance. There are limited exceptions: under Oregon's Death with Dignity Act, a competent adult who is terminally ill with less than six months to live may make a written request to his doctor for a lethal dose of medication. The request must be initiated by the patient, not suggested by a physician, and healthcare providers are not required to comply with the request. As of November 2008, Washington State has a similar law. However, a nurse who participates in an assisted suicide can face severe legal consequences, including prosecution for murder. The debate over assisted suicide has focused so much attention on the decisions healthcare providers make in their treatment of the terminally ill that some courts have found no distinction between palliative care that hastens death and action taken for the purpose of actively ending a patient's life. Thus, nurses and other medical professionals may, in some cases, face adverse legal consequences when they act in accordance with their ethical obligation to ease the suffering of the terminally ill.

The Code of Ethics for Nurses provides some guidance for nurses who are confronted with end-of-life issues and requests for assisted suicide. Nurses, as well as physicians, have a duty to alleviate suffering and to provide "supportive care" to the terminally ill. Nurses treat more than the patient's physical ailments, but also seek to provide psychological comfort and support to the patient and his or her family. Moreover, "a fundamental principle that underlies all nursing practice is respect for the inherent worth, dignity, and human rights of every individual." Thus, nurses have a duty to respect patient autonomy, and to do so with consideration for the patient's "lifestyle, value system and religious beliefs." Nurses should play an active role in helping terminally ill patients prepare for death and to "minimize unwarranted or unwanted treatment and patient suffering" by counseling them with respect to decisions about such as DNR orders, experimental treatments, and pain management. However, it is within a nurse's ethical prerogative to administer palliative care that may incidentally hasten death, he or she is forbidden under the Code of Ethics from "act[ing] with the sole intent of ending a patient's life even though such action may be motivated by compassion, respect for patient autonomy and quality of life considerations"

LATE

HB-2739-HD-1
Submitted on: 3/15/2018 8:50:42 PM
Testimony for CPH on 3/16/2018 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Fenix Grange	Individual	Support	No

Comments:

I strongly support this important measure to allow adults with a terminal illness to have the option to seek medical aid in dying. I am grateful to the Legislature for moving this compassionate legislation forward, providing choice, autonomy and dignity to Hawaii residents facing death from a terminal illness, whether or not they ever choose to take advantage of the rights accorded to them.

HB-2739-HD-1
Submitted on: 3/15/2018 8:38:30 PM
Testimony for CPH on 3/16/2018 8:30:00 AM

LATE

Submitted By	Organization	Testifier Position	Present at Hearing
Jennifer Hsu	Individual	Support	No

Comments:

HB-2739-HD-1
Submitted on: 3/15/2018 8:28:14 PM
Testimony for CPH on 3/16/2018 8:30:00 AM

LATE

Submitted By	Organization	Testifier Position	Present at Hearing
Melvia Leong	Individual	Support	Yes

Comments:

Committee on Commerce, Consumer Protection and Health

Senate Hearing Date: Friday, March 16, 2018

Time: 8:30 am

To: Chair Baker, Vice-Chair Tokuda and Committee Members

From: Melvia Leong

Re: HB 2739 Related to Health, Medical Aid in Dying Act

Position: Strong Support

Currently, I am a full-time student completing my masters of social work degree with a focus on health and bereavement. I have also been employed at a major local medical center and the State of Hawaii, Department of Human Services BESSD division. However, I come before you to express my own viewpoints in strong support of HB 2739.

As an emerging practitioner in the field of social work, I am an advocate for client autonomy when bio-psycho-social, spiritual, ethical, legal and organizational factors are assessed, analyzed and addressed. The rigorous Myron B. Thompson SW program at UH Manoa ensures that I don't cut corners or impose my personal and spiritual beliefs upon my clients.

What I can tell you is that the death experience also affects the living witnesses. Preparation of the client, family and friends increases the perception of "a good death" vs. "a poor death" (LeBaron et al, 2015).

Also, a 2014 study (Lee, 2014) of the Oregon Aid-in-Dying program provided evidence-based research that refuted fears that vulnerable populations would be hurt or that

abuses would occur and represents approximately 0.2% of all deaths in Oregon per year.

In Hawaii, we have our own cultural diversity with attitudes towards honorable death. Although palliative and hospice care exists, they are not adequate to relieve the physical, mental and spiritual suffering of clients.

You know, that 80 year old Aunty with the perfect makeup, red lipstick and flower in her hair, whose dignity is so precious; or Uncle with his bad knees still wanting to help imu the pig. We want our dignity, too. So, please vote for this bill to let us, adults exercise our freedom to choose a peaceful death.

Thank you,

Melvia Leong

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LATE

HB-2739-HD-1
Submitted on: 3/15/2018 6:19:55 PM
Testimony for CPH on 3/16/2018 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Inga Gibson	Individual	Support	No

Comments:

LATE

March 16, 2018

Good Morning Chair Baker, Vice Chair Tokuda & CPH Committee members, and thank you for this opportunity to provide testimony in **STRONG OPPOSITION** to HB2739.

This legislation needs to be scrapped for the following reasons:

Hawaii physicians, who the bill specifically co-opts as the agents to carry out this life-terminating procedure, did not craft this legislation nor did they seek you out to implore its passage because of emergent medical necessity that THEY'VE identified in THEIR duties. ***This legislation is being pushed upon them*** and they're too busy attending to patient and community needs to come before you to testify against this measure.

Any practicing physician who chooses to participate in action that he/she knows will result in suicide is not only **violating the Hippocratic Oath** he/she swore to uphold, but there's no provision in HB2739 for **violating their Duty to Warn** either. In an article entitled,

"*Understanding physicians' duties toward suicidal patients: Physicians must prepare for the ethical and legal ramifications of patient suicide*" found here: http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/centers-disease-control-and-prevention/understanding-physicians-dutie?page=full it states:

"A physician who becomes aware during a treatment visit that a patient is considering suicide would be ill-advised to do nothing with that knowledge. In those circumstances, a physician can face liability for medical malpractice and/or ordinary negligence, as discussed below."

It is clear that whoever crafted this legislation is unfamiliar with the emotional volatility and consequences that often accompany end of life *cases* in Hawaii, and I emphasize PLURAL here because while everyone might have a personal story or two to share, it is doubtful these individuals have to deal with death and dying every day as our Hawaii physicians do.

Even without physician assisted suicide, it is *not unusual* for uninvolved or under-involved grieving adult children to accuse someone of "not doing enough" or accuse a care-giving relative of nefarious intentions, all of which come through attorneys offices with a request for medical records - and that's just for the deceased - the cases where patients have miraculously

recovered (look at Stephen Hawking who was given just 2 years to live at diagnosis) might even be worse: again, *not unusual* for someone knocking on death's door to recover only to learn that a "well-intentioned" someone took certain measures that end up being irrevocable. As it stands there is plenty of finger-pointing to go around but now HB2739 is going to clearly say "the doctor authorized it"? *Where is the iron-clad protections for the doctors*?

Those who want to kill themselves are already free to do so so WHY are doctors being dragged into this?

If you haven't realized this, **Hawaii is in a doctor shortage crisis** - this legislation is not going to keep our doctors here - it's going to be another reason for them to leave Hawaii, quit or retire. (High overhead/high cost of living, low reimbursement for services and the hoops they need to jump through in order to get paid, long workdays with double or triple-booked calendars, too much paperwork, hand-tying regulations, policies and procedures that they have to fight just to get patients the care they need and deserve and then you want to add this to their plate.)

In case you are not familiar with how God operates, guilt by association applies, ie: if I took a pregnant woman to an abortion clinic for an abortion, I'd be guilty for that abortion as well as the parents of the child, the physician, the nurse/s and the scheduler, etc. If you, as a legislator, signed off on permitting abortion in Hawaii then you are guilty not just for overriding God's law but for *every abortion that's resulted since* which is why Jesus Himself warned that "From everyone who has been given much, much will be demanded; and from the one who has been entrusted with much, much more will be asked." Luke 12:48

Signing off in support of this legislation WILL result with "blood on your hands" and whether you believe in God or not, you'll still have to answer for this when your day before Him comes. I can only hope that God will reward you for your choice to stand in opposition. God bless ~

Respectfully,

Dara Carlin, M.A.

LATE

HB-2739-HD-1
Submitted on: 3/15/2018 8:17:09 PM
Testimony for CPH on 3/16/2018 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Ruby Surigao	Individual	Support	No

Comments:

LATE

March 16, 2018

Good Morning Chair Baker, Vice Chair Tokuda and CPH Committee members,

I am an Oahu internist who swore to uphold the Hippocratic Oath 38 years ago, which specifically states,

"Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course."

This oath represents a no-cross line so I ask you, what good is any oath of office if it can be discarded and overridden as HB2739 seeks to do?

As a practicing physician in the community, committed to SAVING LIVES, I am telling you that physician assisted suicide is just wrong. Physicians did not ask for this legislation so why are physicians being roped into this unholy effort to make suicide appear legitimate?

Terminal illness, suffering and end of life issues arise all the time and are expertly taken care of by hospice, palliative care and the current medical system. Physicians don't want this law and don't need HB2739 - just ask the American College of Physicians (148,000) and the American Medical Association (240,000) who stand against physician assisted suicide.

I cannot appear before you today in-person to testify, and I am sure this is also the case with the other physicians, because my office is often triple-booked with patients who are all seeking advice and treatment to extend and improve their health and quality of life, not to end it.

This legislation provides no protections for the doctors and physicians who will be open to liability and litigation in "red herring" cases that are sure to arise and I want no part in it. Where are MY SAFEGUARDS as a physician? What are you doing to protect me and the other medical professionals the community counts on to preserve life?

Hawaii has a doctor shortage as it is, this will only make that worse. This legislation is ill-advised, morally wrong and against medical ethics. I STRONGLY OPPOSE HB2739 and urge you to oppose this as well.

Guy Yatsushiro, M.D.
Board certified Internal Medicine

LATE

HB-2739-HD-1
Submitted on: 3/15/2018 7:43:02 PM
Testimony for CPH on 3/16/2018 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
loretta ching	Individual	Oppose	No

Comments:

HB-2739-HD-1
Submitted on: 3/15/2018 7:07:42 PM
Testimony for CPH on 3/16/2018 8:30:00 AM

LATE

Submitted By	Organization	Testifier Position	Present at Hearing
Susan Oppie	Individual	Support	No

Comments:

March 16, 2018

To: Senate Committee on Commerce, Consumer Protection, and Health

From: Susan Oppie RN BSN

816 Birch St #305

Honolulu, HI 96814

Re: **HB2739- Our Care Our Choice Act**

Written testimony in **support** of this bill

I have been a registered nurse for more than nineteen years. Eight and a half years I served as a hospice nurse and worked several years on various floors in hospitals. During these years of direct patient care I saw death occur dozens of times and I learned what I hold to be true to this day- *there are worse things than death.* I have seen women and men in unbearable pain in their final months, weeks, days and hours. Even with the best hospice and palliative care available nothing could control these individuals' extreme discomfort. I have witnessed the visible panic in the faces of individuals who were not able to breathe due to cancer, Amyotrophic Lateral Sclerosis (ALS, aka Lou Gehrig's disease), Chronic Obstructive Pulmonary Disease (COPD), and other conditions affecting their lungs. I have visited those experiencing frightening hallucinations caused by pain medications. I have attempted (without success) to help

patients who had uncontrollable hiccups, not hiccups that lasted for minutes or hours but those that lasted continuously for days and weeks. This may sound like a minor discomfort to some but please believe me there is nothing minor about constant spasms preventing restful sleep or the ability to eat or drink. I have also dressed countless bed sores that had no real chance of healing due to the ill individual's poor nutrition. I have witnessed agitation in individuals who are unable to let the family or nursing staff know what is causing their unrest. Additionally, I have listened to countless family members of the dying who shared their anguish and feelings of helplessness in making their loved ones more comfortable. These are just some examples of what I consider to be unnecessary suffering.

Four of my eight and a half years in hospice were served in Portland, Oregon and southern Washington. During this time I met several individuals who went through the process of obtaining the medications that could ultimately bring their lives to an end as allowed by the Death with Dignity acts in each of those states. Even though none of these individuals with whom I spoke wanted to get to the point where they felt it was time to use the medications, they expressed great relief that they had the option to do so. I was never in attendance when a life was ended in this manner but heard many reports that it was a very peaceful end. I believe that if there is a means by which people can be in control of how their lives end and not be forced to needlessly suffer it should be made available and protected by law. I wholeheartedly support the passing of HB2739 because I know what having such an option means to those who are dealing with a terminal illness especially one that is known to potentially have a very unpleasant progression to the final moment of life. And I want to live in a state in which this option is available if I am ever diagnosed with a terminal illness. I'd highly encourage you to consider this a human rights issue not a moral or religious one. Our legislature is here to make laws for the living not ones that ostensibly help the souls of the deceased. This is covered in the concept of separation of church and state. For all the reasons I have mentioned here I ask that you vote in favor of HB2739.

Thank you for the opportunity to submit testimony.

LATE

HB-2739-HD-1
Submitted on: 3/15/2018 7:42:01 PM
Testimony for CPH on 3/16/2018 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Susan Jaworowski	Individual	Support	No

Comments:

I support this concept and this bill. Please have compassion for people who really need this bill.

LATE

HB-2739-HD-1
Submitted on: 3/16/2018 6:55:06 AM
Testimony for CPH on 3/16/2018 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Kerrie Villers	Individual	Oppose	Yes

Comments:

I strongly oppose HB 2739 HD 1 and urge this committee to not pass this bill.

LATE

HB-2739-HD-1
Submitted on: 3/16/2018 7:53:49 AM
Testimony for CPH on 3/16/2018 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
pamela j aqui	Individual	Oppose	No

Comments:

While this seems like a benevolent thing to do, it may just come back to bite us. In my experience of working with the eledery, they are very easily manipulated. Soon family will be suggesting to their grandparents or parents something that goes like this: "Grandma/grandpa, you have worked so hard all your life. Thank you. Aren't you ready to just lay it all down? You've suffered enough...."etc. We will feel the pressure to end our life so that our beneficiaries can collect what we've worked for. The doctor component means nothing. Many Physicians will prescribe at the drop of a hat, unfortunately.

LATE

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March 14, 2018

TESTIMONY IN STRONG **OPPOSITION** TO HB 2739 HD1
Hearing: Friday, March 16, 2018; 8:30 a.m. Conference Room 229

SENATE COMMITTEE ON COMMERCE, CONSUMER PROTECTION AND HEALTH
Senator Rosalyn H. Baker , Chair
Senator Jill N. Tokuda , Vice Chair
Stanley Chang
Clarence K. Nishihara
Will Espero
Russell E. Ruderman
Les Ihara Jr.

Dear Chairman, Vice Chairman and Committee Members,

My name is Jim Hochberg and I am a civil rights attorney allied with Alliance Defending Freedom to protect constitutional rights in the federal and state courts in the Hawaii. I have practiced law in Hawaii since 1984 (34 years). I testify in strong opposition to HB 2739 HD1. Due to the unilateral decision to limit the time permitted for oral presentation of our testimony, my oral testimony will only be able to address a small part of the total testimony provided in this written version. Therefore, I hope that you will each fully review my legal analysis of HB 2739 HD1. If the legislature creates a bill, the committees should permit whatever the time is for hearing that it may take the people of Hawaii to address the content of the bill. In this case, a 40 page bill cannot adequately be addressed by the people interested in testifying if only a handful of hours are allocated to hearing the bill. This truth is heightened considerably when the subject of the bill is known to attract tremendous interest in the community - on both sides. Although this testimony does not address all the issues in the 39 page bill, others will address the portions this testimony does not. Some of the specific problems with the bill are addressed below.

A. For some reason, the bill turns its back on the demands for transparency that are currently being required all over the nation in numerous different policies. In section 4, the bill REQUIRES ("shall") the death certificate to list the terminal disease as the immediate cause of death. Why should the death certificate NOT indicate that the cause of death was the intentional taking of the patient's own life? Everyone knows that a prognosis of terminal illness giving six months to live is not a disease driven enforceable deadline on the life of the patient. Often the