DAVID Y. IGE
GOVERNOR OF HAWAII

ELIZABETH A. CHAR, MD
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. Box 3378
Honolulu, HI 96801-3378
doh.testimony@doh.hawaii.gov

Testimony COMMENTING on HB1823
RELATING TO HEALTH.

REPRESENTATIVE RYAN I. YAMANE, CHAIR
HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES, AND HOMELESSNESS

Hearing Date: February 1, 2022 Room Number: Videoconference

Fiscal Implications: N/A.

Department Testimony: The role of the Department of Health (DOH) for chapter 327L, Hawaii Revised Statutes, or the "Our Care, Our Choice Act," is ministerial in function, which is to say that DOH's primary responsibility is the collection and dissemination of forms, data, and reports in aggregate, as required by law. DOH is compelled to collect data only on qualified patients who have followed through on every legally required step. As a result, DOH does not quantify the number of patients who expired prior to executing all the steps, however the anecdotal input from healthcare providers has been very consistent, that: 1) patients in rural communities struggle to find a participating provider (attending, consulting, and mental health), and 2) patients with grave health prognoses expire during the waiting period, often with tremendous suffering.

The department is in the process of evaluating forms for the collection period that ended on December 31, 2021. There are an estimated 70 patients who completed the medical aid in dying request process. In the 2020 annual report, there were 37 patients who qualified of which 32 ingested the medication causing their death. This is a consistent upward trend since enactment in 2019.

Offered Amendments: DOH recommends an amendment to strengthen the non-disclosure protections of this Act due to recent inquiries from law firms requesting information on participants that are not explicitly protected.

SECTION . Section 327L-14, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) The department shall annually collect and review all information submitted pursuant to this chapter. The information collected shall be confidential and shall be collected in such a manner that protects the privacy of all qualified patients, the qualified patients' family, and any attending provider, consulting provider, or counselor involved with a qualified patient pursuant to this chapter. Information collected pursuant to this [~~section~~] <u>chapter</u> by the department <u>or retained as the result of incidental or routine communication with providers and patients</u> shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding."

Testimony of the Board of Nursing

Before the
House Committee on Health, Human Services, & Homelessness
Tuesday, February 1, 2022
10:30 a.m.
Via Videoconference

On the following measure:
H.B. 1823, RELATING TO HEALTH

Chair Yamane and Members of the Committee:

My name is Lee Ann Teshima, and I am the Executive Officer of the Board of Nursing (Board). The Board appreciates the intent and offers comments on this bill only with respect to advanced practice registered nurses (APRNs).

The purposes of this bill are to: (1) authorize advanced practice registered nurses, in addition to physicians, to practice medical aid in dying in accordance with their scope of practice and prescribing authority; (2) authorize psychiatric mental health nurse practitioners and clinical nurse specialists, in addition to psychiatrists, psychologists, and clinical social workers, to provide counseling to a qualified patient; (3) reduce the mandatory waiting period between oral requests from twenty days to fifteen days; and (4) waive the mandatory waiting period for those terminally ill individuals not expected to survive the mandatory waiting period.

The Board appreciates the bill’s intent to authorize APRNs to practice medical aid in dying in accordance with their scope of practice and prescribing authority. APRNs are recognized as primary care providers who may practice independently based on their practice specialty. An APRN’s education and training include, but are not limited to, a graduate-level degree in nursing and national certification that is specific to the APRN’s practice specialty, in accordance with nationally recognized standards of practice.

The Board also appreciates that this bill’s definition of “counseling” includes both a “psychiatric mental health nurse practitioner, or clinical nurse specialist” to consult with a patient to determine whether the patient is capable of making an informed decision regarding ending the patient’s life. There are four categories of APRNs (nurse practitioner, clinical nurse specialist, certified nurse midwife and certified registered nurse anesthetist), and nurse practitioners or clinical nurse specialists whose practice specialty is in psychiatric mental health may provide consultative services in psychiatric mental health.

Thank you for the opportunity to testify on this bill.

HAWAIʻI STATE CENTER FOR NURSING
Connecting Nurses. Transforming Healthcare.

Written Testimony Presented Before the
House Committee on Health, Human Services, & Homelessness
Tuesday, February 1, 2022 at 10:30 A.M.
via Videoconference
by
Laura Reichhardt, MS, AGNP-C, APRN
Director, Hawaiʻi State Center for Nursing
University of Hawaiʻi at Mānoa

Comments on HB 1823

Chair Yamane, Vice Chair Tam, and members of the House Committee on Health, Human Services, & Homelessness, thank you for this opportunity to provide **comments on HB 1823 only as it pertains to Section 2** of this measure which, if enacted, would enable Advanced Practice Registered Nurses (APRNs) to participate as an attending, consulting, and counseling provider in the Our Care, Our Choice Program.

Advanced Practice Registered Nurses have had a 75% increase in the number of in-state APRNs since 2011. Nearly 1,300 licensed APRNs reside in Hawaiʻi. APRNs are noted in national research to be more likely to provide care to underserved people and communities including rural areas, urban areas, to women, and to Medicaid recipients or uninsured people (Buerhaus et al., 2014). Currently, 30% of Hawaiʻi's APRNs reside on a Neighbor Island which also approximates the percent of APRNs working in HSRA designated primary care shortage areas and medically underserved areas (Hawaiʻi State Center for Nursing, 2021).

Hawaiʻi adopted the national best practices for APRN regulation, the APRN Consensus Model (2008), which states that licensure, accreditation, and certification combined provide guidance on an APRN's scope of practice. APRNs include Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists. APRNs are educated from accredited schools of nursing in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related, or psych/mental health. An APRN may apply for licensure only upon achieving national certification in their educated role and population foci. Hawaiʻi law (§457-2.7) defines APRN scope of practice to include advanced assessment and the diagnosis, prescription, selection, and administration of therapeutic measures including over the counter drugs, legend drugs, and controlled substances within the APRN's role and specialty-appropriate education and certification. Hawaiʻi's laws for APRNs ensure public safety during patient care through authorized assessment, diagnosis, and prescriptive authority. APRNs have grown significantly in Hawaiʻi with APRNs providing care in all regions in the state where people live.

Thank you for the opportunity to provide this information as it relates to your decision making on this measure.

The mission of the Hawaiʻi State Center for Nursing is that through collaborative partnerships, the Center provides accurate nursing workforce data for planning; disseminates nursing knowledge to support excellence in practice and leadership development; promotes a diverse workforce; and advocates for sound health policy to serve the changing health care needs of the people of Hawaiʻi.

Written Testimony Presented Before the
House Committee on Health, Human Services, and Homelessness

Hearing: February 1, 2022 @10:30AM
State Capitol, Conference Room 329

By Hawaiʻi – American Nurses Association (Hawaiʻi-ANA)

HB1823 RELATING TO HEALTH

Chair Ryan I. Yamane, Vice Chair Adrian K. Tam and members of the House Committee on Health, Human Services, and Homelessness for this opportunity to provide testimony in strong support for HB 1823 Relating to Health. This bill seeks to explicitly recognize advanced practice registered nurses (APRNs) as attending providers and consulting providers capable of performing all necessary duties under the Our Care, Our Choice Act in accordance with their scope of practice and prescribing authority. This bill also seeks to reduce the mandatory waiting period between oral requests made by a terminally ill individual from twenty to fifteen days, and to allow an attending provider to waive the waiting period for terminally ill individuals not expected to survive the mandatory waiting period.

We are members of the American Nurses Association of Registered Nurses in Hawaiʻi. Over 15,000 Registered Nurses in Hawaiʻi care for patients every day, throughout the lifespan, from birth through dying and death. We have supported the passing of the bill to enact this measure in the past, in our interest to provide choices and options to patients addressing end-of-life issues. We continue to support the Act as an option for both patients and providers, to consider in meeting the personal needs of the individual patient.

We believe the recommendations made by the State of Hawaii Department of Health to the terms of this Act address the very real difficulties individuals in Hawaii are experiencing in meeting the established criteria and safeguards to ensure a secure, compassionate, and patient-centered end-of-life process.

We respectfully request that HB1823 pass out of this committee. Thank you for your continued support for measures that address the healthcare needs of our community.

Contact information for Hawaii – American Nurses Association

President: Katie Kemp, BAN, RN-BC president@hawaii-ana.org
Executive Director: Dr. Linda Beechinor, APRN-Rx, FNP-BC executivedirector@hawaii-ana.org
phone (808) 779-3001
500 Lunalilo Home Road, #27-E
Honolulu Hawaii USA 96825

hawaii family forum

Submitted Online: January 31, 2022

HEARING: Thursday, February 1, 2022

TO: HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND HOMELESSNESS
Rep. Ryan Yamane, Chair
Rep. Adrian Tam, Vice Chair

FROM: Eva Andrade, President

RE: Opposition to HB1823 Relating to Health

Hawaii Family Forum is a non-profit, pro-family education organization committed to preserving and strengthening families in Hawaii. We oppose this bill that chips away at the safeguards that were put in place when the "Our Care, Our Choice" law went into effect.

If this bill is passed, it will (1) allow advanced practice registered nurses to practice medical aid in dying instead of limiting this to physicians who are the only healthcare professionals who are best able to determine a patient's prognoses, (2) allow psychiatric mental health nurse practitioners and clinical nurse specialists to provide counseling to a qualified patient, (3) reduce the mandatory waiting period between oral requests made by a terminally ill individuals and (4) allow the attending provider to waive the waiting period for terminally ill individuals not expected to survive the mandatory waiting period.

We expressed our strong opposition when the Our Care Our Choice Act was passed in 2018 because we were (and still are) very concerned about abuse of the law, primarily against frail elders and other vulnerable patients. At that time, to alleviate our concerns, the introduction to the bill stated that the "rigorous safeguards will be the strongest of any state in the nation and will protect patients and their loved ones from any potential abuse[i]." Therefore, we are disheartened to see that these safeguards are already being removed or modified.

Although there are those in the community that are receptive to the general concept of assisted suicide, we believe that when the public learns about the dangers of assisted suicide, especially for those who are poor, elderly, disabled, or without access to good medical care, their views shift against the practice. Rather than expand the law, we should continue to provide education on available access to palliative care and hospice services.

Please do not sacrifice patient safety during a time of high suicide rates and economic uncertainty. Mahalo for the opportunity to submit testimony.

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[i] https://www.capitol.hawaii.gov/session2018/bills/HB2739_HD1_.HTM

The Hawaiian Islands Association
for Marriage and Family Therapy
(HIAMFT)
We know systems.
We know relationships.
We know FAMILY MATTERS.

COMMITTEE ON HEALTH, HUMAN SERVICES & HOMELESSNESS
Rep. Ryan Yamane, Chair
Rep. Adrian K. Tam, Vice Chair
Tuesday, February 1, 2021 - 10:30am - Conference Room 329 - videoconference

Testimony in Support of HB1823 RELATING TO HEALTH

The Hawaiian Islands Association for Marriage and Family Therapy (HIAMFT) strongly supports HB1823, which would give advanced practice registered nurses and psychiatric mental health nurse practitioners the authority to engage in certain medical aid in dying services. These services have been previously limited to physicians, psychiatrists, psychologists, and social workers.

While HIAMFT strongly supports this bill, we believe **it can be strengthened to further achieve the purpose and intent of Our Care, Our Choice legislation by adding Marriage and Family Therapists (MFTs) to the corps of healthcare professionals allowed to provide "counseling" services** outlined in Hawaii Revised Statutes section 321L-1 to determine if a patient is capable, and has received adequate treatment for depression or other conditions that may impact his or her ability to make informed aid-in-dying decisions.

Marriage and Family Therapists are one of five core mental health professions (along with psychiatrists, psychologists, social workers and advanced practice psychiatric nurses) identified by the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS) of the US Government. Additional information can be obtained in *The Mental Health Workforce: A Primer* (April 20, 2018). They are trained to diagnose and treat mental health issues, such as but not limited to, anxiety, depression, substance abuse, alcoholism, relationship/marital problems, child-parent problems, ADD/ADHD, and schizophrenia.

Perhaps most germane to this measure, MFTs are specifically trained to attend to a patient's primary relationship networks that may become resources for well-being. With a relational and systemic focus, MFTs use a perspective that considers the full context of a patient's situation. This perspective is particularly important when working with critically serious issues like the intentional ending of one's life.

Moreover, MFTs are specifically trained to understand and help patients discuss all aspects of family life and other interpersonal dynamics. In working with a dying patient, that person may be concerned about one or more family members, pets, or others within their personal family "system." Therapy may represent a last opportunity for saying good-bye or the possibility of healing and forgiveness for both the dying patient and various family and/or other community members.

Accordingly, we ask that Marriage and Family Therapists be added to the professionals authorized to provide "counseling" services on page 4, line 14 of this bill as follows:

"Counseling" means one or more consultations, which may be provided through telehealth, as necessary between a psychiatrist licensed under chapter 453, psychologist licensed under chapter 465, [~~or~~] clinical social worker licensed pursuant to chapter 467E, psychiatric mental health nurse practitioner, **marriage and family therapist licensed pursuant to chapter 451J,** or clinical nurse specialist and a patient for the purpose of determining that the patient is capable, and that the patient does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with the patient's ability to make an informed decision pursuant to this chapter."

Thank you for the opportunity to provide strong support and suggested amendment for this important bill.

Sincerely,

John Souza J LMFT, DMFT

Dr. John Souza, Jr., LMFT, DMFT, President
The Hawaiian Islands Association for Marriage and Family Therapy

Hawai'i Association of Professional Nurses (HAPN)

To: The Honorable Representative Ryan Yamane, Chair of the House Committee on Health, Human Services, and Homelessness

From: Hawaii Association of Professional Nurses (HAPN)
Subject: HB1823 – Relating to Health

Hearing: February 1, 2022, 10:30a.m.

Aloha Representative Yamane, Chair; Representative Tam, Vice Chair; and Committee Members

Thank you for the opportunity to submit testimony regarding HB1823. HAPN is in **strong Support** of placing choice in the hands of patients with whom we work every day, which includes patient choice in who their provider is when making a decision of this magnitude. We have reviewed the recommendations made by the Department of Health to include Advanced Practice Registered Nurses (APRN) to practice medical aid in dying in accordance with our scope of practice.

HAPN’s mission, to be the voice of APRNs in Hawaii, has been the guiding force that propelled us to spearhead the advancement of patients’ access to healthcare as well as supporting the recognition of the scope of practice for APRNs in Hawaii. We have worked to improve the physical and mental health of our communities. As our ability to provide close care with our patients progressed, we also opened up our own clinics to provide the care our patients deserve. As a result, the current law requires that a patient remove themselves from the excellent care their APRN has provided them over the years to discuss this end-of-life option with physicians, if they can find one, who may not have the same patient-provider relationship.

APRNs have played an important role in the healthcare of our communities and we will continue to be by our patients’ side as they make many different healthcare decisions throughout their lives. There have been clear indications that patients on our rural islands have been having difficulty finding physicians to support them in their legal right. We support the recommendations to include APRNs in this law, from our partners at the Department of Health in their assessment and evaluation of this issue.

Thank you for the opportunity to share the perspective of HAPN with your committee. Thank you for your enduring support of the nursing profession in the Aloha State.

Respectfully,
Dr. Jeremy Creekmore, APRN
HAPN President

Dr. Bradley Kuo, APRN
HAPN Legislative Committee, Chair
HAPN Past President

NASW. HAWAIʻI CHAPTER
National Association of Social Workers

COMMITTEE ON HEALTH, HUMAN SERVICES & HOMELESSNESS
Rep. Ryan Yamane, Chair
Rep. Adrian K. Tam, Vice Chair
Tuesday, February 1, 2021 - 10:30am - Conference Room 329 - videoconference
Testimony in Support of HB1823 RELATING TO HEALTH

Testimony in Support and Comments on HB1823 HEALTH

The National Association of Social Workers – Hawai'i (NASW- HI) supports HB1823, giving psychiatric mental health nurse practitioners and clinical nurse specialists the authority to engage in certain medical aid in dying services, as well as reduce the waiting time for patients to be eligible for the program.

These services have been previously limited to physicians, psychiatrists, psychologists, and clinical social workers. NASW- HI supports the addition of qualified APRNs to the cadre of medical and mental health professionals to provide these services.

NASW-HI also would also like to see Licensed Marriage and Family Therapists added to the professionals authorized to provide "counseling" services in Hawaii Revised Statutes Section 3217L-1 – as they have specialized training in the relational aspects of a dying patient's family and community.

Accordingly, we ask that Marriage and Family Therapists be added to the professionals authorized to provide "counseling" services on page 4, lines 13-14 of this bill as follows:

"Counseling" means one or more consultations, which may be provided through telehealth, as necessary between a psychiatrist licensed under chapter 453, psychologist licensed under chapter 465, [or] clinical social worker licensed pursuant to chapter 467E, psychiatric mental health nurse practitioner, **marriage and family therapist licensed pursuant to chapter 451J, or a clinical nurse specialist** and a patient for the purpose of determining that the patient is capable, and that the patient does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with the patient's ability to make an informed decision pursuant to this chapter."

There currently is a significant shortage of providers. As the baby boomer generation ages, provider shortages and access to care in this area will only exacerbate.

Thank you for the opportunity to provide this testimony in support.

Sincerely,

Sonja Bigalke-Bannan, MSW, LCSW
Executive Director,
National Association of Social Workers- Hawai'i Chapter

HB-1823
Submitted on: 1/28/2022 6:33:04 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Dr. Maile Harada	Maile Case Management	Oppose	No

Comments:

To Whom It May Concern, as a Registered Nurse and doctor (Ph.D.), who has been practicing in the medical profession for over 24 years, and who has six years of hospice case management experience, I am opposed to this bill. We seem to be on a "slippery slope" as far as our acceptance of death and the hastening of death goes. I'm afraid that when my time comes, you will just line us all up and shoot us! I'm sorry but it is not acceptable to kill people!

As a hospice nurse of six years, I witnessed more amazing stories of healing and restoration than I ever witnessed of suffering! In fact, in the six years that I worked in hospice, everyone except one person, had an amazing end of life experience! The one person who was suffering, was transfered into the hospital for IV pain treatment and ended up passing peacefully.

I did tons of death pronouncements so I have many stories to tell, mostly positive and happy stories. When people are near end of life, they become vulnerable and many times "mend" their wrongs.

By hastening death, we will be eliminating the possibility of family healing, personal healing, and even personal growth. Personal growth can absolutely happen even when a person is at their end of life.

I vote "no" and I pray that you will too. Dear God, please help us to value life!!!

Maile Harada, R.N., Ph.D.

Hawai‘i Psychological Association

For a Healthy Hawai‘i

P.O. Box 833
Honolulu, HI 96808
www.hawaiipsychology.org
Phone: (808) 521 -8995

COMMITTEE ON HEALTH, HUMAN SERVICES & HOMELESSNESS
Rep. Ryan Yamane, Chair
Rep. Adrian K. Tam, Vice Chair
Tuesday, February 1, 2021 - 10:30am - Conference Room 329 - videoconference
Testimony in Support of HB1823 RELATING TO HEALTH

Testimony in Support on HB1873 HEALTH

The Hawai‘i Psychological Association (HPA) supports HB1873, which would give advanced practice registered nurses (APRNs) and psychiatric mental health nurse practitioners the authority to engage in certain medical aid in dying services, as well as reduce the waiting time for patients to be eligible for the program.

These services have been previously limited to physicians, psychiatrists, psychologists, and social workers. HPA takes the position that the counseling called for in this legislation is squarely within the scope of practice of APRNs. They do not need additional training to provide these services. APRNs are experienced counselors and understand medical issues.

Moreover, we also support giving authority to Marriage and Family Therapists to provide similar services under the definition of “counseling” in Hawaii Revised Statutes Section 3217L-1 – as they have specialized training in the relational aspects of a dying patient’s family and community.

Finally, we believe this bill is extremely timely. There currently is a significant shortage of providers. This bill will increase the supply and access to services – particularly as demand increases with the aging baby boomer generation.

Thank you for the opportunity to provide input into this important bill.

Sincerely,

Raymond A Folen, Ph.D., ABPP.
Executive Director

HB-1823

Submitted on: 1/31/2022 10:24:57 AM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Michelle Cantillo	HPH	Support	Yes

Comments:

I, Michelle Cantillo, RN, Advance Care Planning Coordinator for Hawaii Pacific Health (HPH) and representing Hawaii Pacific Health am in support of HB 1823. There is a only a limited amount of physicians who are in support of being a Medical Aid in Dying (MAiD) attending physicians which I myself have witnessed at HPH. There is less than 15 physicians who would participate in writing the MAiD prescription currently at HPH. It is important to pass this bill to include APRNs to have the prescriptive authority and expand the counseling to include them in consultants as well. There is a lack of physicians in HI and also during the pandemic we have seen providers leaving HI and retiring early. In my role as an ACP coordinator, I have to help our patients find a participating physician and it can be very challenging even in a large organization. I am thankful for the few physicians who go above and beyond to see not only their patients but other patients whose physicians will not particpate in the law. At HPH, we also have seen many patients not meet the 20 day, 2nd oral request. HPH is in favor of waiving the mandatory waiting period and reduce the 20 day waiting period to 15 days. The providers are very skilled at assessing this timeline. Today, it is difficult for patients to completed their (4) clinic visits within the 20 day window. Visits to attending physician x 2; consulting physician x 2 and mental health counselor x1. Thank you, Michelle Cantillo, RN.

Testimony of Sam Trad, Hawai'i State Director, Compassion & Choices
Supportive Testimony Regarding HB 1823
House Committee on Health, Human Services and Homelessness

Good morning Chair Ryan Yamane, Vice Chair Adrian Tam and Members of the Committee. My name is Sam Trad and I am the Hawai'i State Director for Compassion & Choices, the nation's oldest and largest nonprofit organization working to improve care, expand options and empower everyone to chart their own end-of-life journey.

Thank you for passing the Our Care, Our Choice Act, which has provided peace of mind to the terminally ill over the last three years it has been in effect; and thank you for your consideration of HB 1823. We are here today and pleased to offer our support for these crucial amendments to the Our Care, Our Choice Act.

This legislation is based on the suggested amendments the Department of Health has made to the legislature. Just one year into implementation of the Hawai'i Our Care, Our Choice Act, the Department of Health conducted an analysis of the implementation of the law by soliciting input from the medical community. A subsequent report to the legislature[1] found that while compassionately implemented, some of the well intentioned regulatory requirements outlined in the Act are creating unintended barriers and unnecessary burdens in care. Coupled with the state's well-known severe physician shortage, which has only worsened with the COVID-19 pandemic[2][3] and is especially dire on neighbor islands,[4][5] these collective barriers have made it very difficult for terminally ill patients seeking to access medical aid in dying. Unfortunately, many individuals died with needless suffering while attempting to navigate the process. In fact, we know from local healthcare systems that at least 21 eligible patients who wanted the option

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[1] Report to the Thirtieth Legislature, Our Care, Our Choice Act Annual Report, Reporting Period 2019, Hawai'i Department of Health. Accessed at: https://health.hawaii.gov/opppd/files/2020/06/2020-Annual-OCCOA-Report-1.pdf

[2] University of Hawai'i System Annual Report on Findings from the Hawai'i Physician Workforce Assessment Project, November 2021. Accessed at: https://www.ahec.hawaii.edu/workforce-page/

[3] Hawai'i doctor shortage worsens during pandemic, June 15, 2021. Accessed at: https://www.kitv.com/video/hawaii-doctor-shortage-worsens-during-pandemic/article_887db62f-c8ee-5f02-95b5-01d7102395b0.html

[4] Hawai'i's doctor shortage has worsened after the COVID-19 pandemic, Jan 7, 2021. Accessed at: https://www.khon2.com/coronavirus/hawaiis-doctor-shortage-has-worsened-after-covid-19-pandemic/

[5] Physician shortage takes a troubling turn for the worse, John A. Burns School of Medicine University of Hawaiʻi at Mānoa, September 10th, 2019. Accessed at: https://jabsom.hawaii.edu/hawaii-doctor-shortage-takes-a-troubling-turn-for-the-worse/

of medical aid in dying died during the mandatory waiting period, unable to have the peaceful end of life experience they wanted.[6]

Holding true to the intent of the Our Care, Our Choice Act - to ensure that all terminally ill individuals have access to the full range of end of-life care options - the bill before you seeks to ensure eligible patients can access medical aid in dying by amending the law to:

- Reduce the current mandatory minimum 20 day waiting period between oral requests to 15 days.
- Allow the attending provider the authority to waive the mandatory minimum waiting period if the eligible patient is unlikely to survive the waiting period (the patient must still go through the qualifying process).
- Allow qualified Advanced Practice Registered Nurses (APRNs) to support patients in the option of medical aid in dying by acting as the attending provider, consulting provider and/or mental health counselor.

All of these amendments will reduce unnecessary burdens terminally ill Hawaiian residents face when trying to access medical aid in dying.

<u>Expediting and/or reducing the mandatory minimum waiting period as they now do in Oregon, California and New Mexico</u>

Hawai'i currently has the longest mandatory waiting period (20 days) between the first and second oral requests for medical aid in dying, of the 11 authorized U.S. jurisdictions. Hawai'i physicians have said that their eligible terminally ill patients are suffering terribly at the end of life and are not surviving the 20-day mandatory waiting period between oral requests.[7] Internal data from Kaiser Hawai'i and Hawai'i Pacific Health show that a significant amount of eligible patients do not survive the long waiting period.

This experience matches what we have seen from data and experience throughout the other authorized jurisdictions which have less restrictive measures in place than currently exist in Hawai'i. In 2019, in response to the evidence compiled over 21 years of practice, the Oregon legislature amended its law in an attempt to find a better balance between safeguards intended to protect patients and access to medical aid in dying. The amended law (SB579) gives doctors the ability to waive the current mandatory minimum 15-day waiting period

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[6] Susan Amina, NP, Kaiser HI, OCOCA panel on 1.13.21; Michelle Cantillo R.N., Advance Care Planning Coordinator, HPH, OCOCA panel on 1.13.21.

[7] 'Like a Christmas Present': Hawaii's Medical Aid in Dying Law Eased Patient's Anxiety, The Civil Beat, Jul 1, 2019. Accessed at: https://www.civilbeat.org/2019/07/a-palpable-sense-of-relief-hawaiis-medical-aid-in-dying-law-eased-patients-anxiety/

between the two required oral requests and to waive the 48-hour waiting period after the required written request before the prescription can be provided, if they determine and attest that the patient is likely to die while waiting.[8] The similar amendment to the OCOCA before you now is a direct result of evidence and data in Hawai'i that clearly demonstrates the need for easier access for eligible terminally ill patients facing imminent death.[9]

Last year, California amended their waiting period from 15 days to 48 hours, because data from healthcare systems in California showed that approximately 30% of eligible patients who want medical aid in dying do not survive the minimum 15 day waiting period.[10] Additionally, New Mexico's medical aid in dying law, which went into effect last year, only requires one written request and one 48 hour waiting period between when receiving and filling the prescription.[11]

<u>Expanding the Definition of Provider to include Advanced Practice Registered Nurses with Prescriptive Authority (APRN Rx)</u>

Hawai'i is one of 25 states that give advanced practice registered nurses (APRNs) authority to independently carry out all medical acts consistent with their education and training, including prescribing all forms of medication, including controlled substances.[12] However, by not including APRNs within the definition of "provider," the Our Care, Our Choice Act unnecessarily prohibits APRNs from providing high quality health care and support to patients who want the option of medical aid in dying. Amending the law to explicitly allow APRNs to participate as providers under the Our Care, Our Choice Act is consistent with their scope of practice and would help address the disparity in access to participating providers, particularly in rural areas and neighboring islands. For example, Ron Meadow, who lived on the Big Island, was terminally ill and eligible for the Our Care, Our Choice Act, spent his final weeks searching for a physician who would support him in the option of medical aid in dying, so he could end his suffering. Sadly, by the time he found a physician it was too late and Ron died in pain in exactly the way he did not want. Allowing APRNs to support patients in medical aid in dying

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[8] Senate Bill 579, 80th Oregon Legislative Assembly--2019 Regular Session. Accessed at: https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB579

[9] Report to the Thirty-First Legislature, Our Care, Our Choice Act Annual Report, Reporting Period 2020, Hawai'i Department of Health. Accessed at: https://health.hawaii.gov/opppd/files/2021/06/2020-Annual-OCOCA-report-6.30.21.pdf

[10] Characterizing Kaiser Permanente Southern California's Experience With the California End of Life Option Act in the First Year of Implementation. JAMA Internal Medicine, H.Q. Nguyen, E.J. Gelman, T.A.Bush, J.S. Lee, M.H.Kanter (2018). Accessed at: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2665731

[11] Elizabeth Whitefield End of Life Options Act, Ch. 24, art. 7C NMSA 1978. Accessed at: https://nmonesource.com/nmos/nmsa/en/item/4384/index.do#!b/a7C

[12] American Association of Nurse Practitioners, 2021 Nurse Practitioner State Practice Environment. Accessed at: https://storage.aanp.org/www/documents/advocacy/State-Practice-Environment.pdf

will provide patients, like Ron, with more options to access this compassionate option. Additionally, other jurisdictions are recognizing that restricting the definition of “provider” to physicians for the purposes of medical aid in dying creates an unnecessary barrier to access. For example, in 2021 New Mexico passed aid in dying legislation authorizing APRNs to serve as either the attending or consulting provider.[13]

Every eligible patient who wants the peace of mind that the Our Care, Our Choice Act provides should be able to benefit from it no matter which island they live on. These smart amendments will remove barriers to patients, especially in rural areas and on neighboring islands, so that they can have the compassionate option of medical aid in dying. Thank you for your time and attention to this matter.

Sincerely,

Sam Trad
Hawai’i State Director
Compassion & Choices

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[13] Elizabeth Whitefield End of Life Options Act, Ch. 24, art. 7C NMSA 1978. Accessed at: https://nmonesource.com/nmos/nmsa/en/item/4384/index.do#!b/a7C

ALOHACARE

To: The Honorable Representative Yamane, Chair
The Honorable Representative Tam, Vice-Chair
Committee on Health, Human Services, & Homelessness

From: Peggy Mierzwa, Government Affairs, AlohaCare

Hearing: Tuesday, February 1, 2022

RE: **HB1823 Relating to Health -Support**

AlohaCare appreciates the opportunity to provide testimony in **support** of **HB1823.** This measure will authorize Advanced Practice Registered Nurses (APRN), in addition to physicians, to practice medical aid in dying in accordance with their scope of practice and prescribing authority as well as authorize psychiatric mental health nurse practitioners and clinical nurse specialists, in addition to psychiatrists, psychologists, and clinical social workers, to provide counseling to a qualified patient. In addition to the changes for APRNs, this measure will also ease the waiting periods to better serve patients who are terminally ill in a timely manner.

Founded in 1994 by the community health centers, AlohaCare is a community-rooted, non-profit health plan serving 80,000 Medicaid and dual-eligible health plan members on all islands. We are the only health plan in Hawaii that exclusively serves Medicaid beneficiaries. Our mission is to serve individuals and communities in the true spirit of aloha by ensuring and advocating for access to quality health care for all. We believe that health is about supporting whole-person care.

Hawaii has struggled with a shortage of physicians for decades. This shortage means that in a variety of medical circumstances, residents, particularly those who reside on neighbor islands, are unable to access timely health care near their home, or even their home island. Addressing this shortage is not a one-solution approach. The Legislature has several measures before them this year ranging from scope of practice to telehealth bills that will help to increase patient's access to care.

This measure will increase patients' access to care by allowing APRNs to practice to the full scope of their licensure. It will give them the authority to prescribe as well as fully practice in alignment with their licensure allowances under the Our Care, Our Choice Act. APRNs can increase access to care. AlohaCare supports increasing equitable access to care through this measure for the residents of Hawaii. Our members and all residents need to have timely access to important health care and procedures.

We will continue to support allowing APRNs and other healthcare professionals to practice to the full scope of their licensure. We believe this approach helps to address gaps in care found throughout the state.

Mahalo for this opportunity to testify in **strong support of HB1823**.

HB-1823
Submitted on: 1/30/2022 6:52:30 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Charles Miller	Hawaii Society of Clinical Oncology	Support	Yes

Comments:

Dear Representative Yamane

I'm a medical oncologist representing the Hawaii Society of Clinical Oncology, the largest organization of cancer specialists in the state and I also serve as Director of Kaiser Hawaii's Medical Aid in Dying (MAID) program. I have the most experience of any physician in the state with patients requesting MAID, and I'm writing to you today to urge you to support HB1823 which makes very necessary improvements to the Our Care, Our Choice Act. In my three years of seeing MAID patients, I have consulted on over 125 patients. For some patients the law works well, but for many eligible terminally ill patients the requirements of the law presents barriers that prevent them accessing the law even though they meet all of the requirements, causing them needless suffering. We have data from the State Department of Health, Kaiser Hawaii and Hawai'i Pacific Health, that over 30% of patients who requested MAID died of their underlying medical conditions before the required 20 day waiting period. I strongly believe that providers should be allowed to waive the waiting period for their patients if the patient meets all other requirements but is unlikely to survive 20 days. This is inexcusable and one of the problems that these amendments will address. Twenty days is the longest waiting period of any jurisdiction which support MAID and it should be shortened to at least no more than 15 days.

The other major obstacle to access to aid in dying is the growing shortage of physicians. This makes it very difficult to find the two doctors required to qualify for medical aid in dying, especially on neighbor islands. This bill has a solution to this problem: Advanced Practice Registered Nurses (APRNs), also known as Nurse Practitioners (NPs), are highly trained professionals helping to fill this gap in virtually all other areas of care. In fact, Hawai'i is one of 22 states that gives APRNs authority to independently carry out all medical acts consistent with their education and training, including prescribing all forms of medication. Yet as the law is written, APRNs are prohibited from helping in this most crucial area. The Our Care, Our Choice Act currently limits their scope of practice, preventing them from supporting their patients who want the option of medical aid in dying.

If even one qualified patient is forced to spend their final weeks in fear and pain, unable to access the law, then that is one patient too many. Please provide the needed relief to terminally ill Hawai'i residents and ensure everyone in the Aloha State is empowered to choose end-of-life care that reflects their values, priorities, and beliefs.

Sincerely,

Charles F. Miller, MD, FACP, FASCO

Hawaii Society of Clinical Oncology

Program Director, Kaiser Hawaii Aid In Dying

TESTIMONY IN OPPOSITION TO HB 1823

My name is Dr Craig Nakatsuka and I am in opposition to HB 1823 relating to the expansion of the Our Care Our Choice Act.

This bill seeks to: expand the scope of practice of nurse practitioners in medical aid in dying, expand the providers to provide counseling to a qualified patient, decrease the mandatory waiting period between oral requests, and waive any waiting period for those terminally ill individuals deemed unlikely to survive the waiting period.

The OCAC act was passed amidst concerns of abuse that could threaten the lives of the vulnerable, including the frail elderly and the disabled. Therefore, safeguards were put in place, including the mandatory waiting period for individuals to have time to receive hospice and palliative care services and receive the comprehensive support they need, including competent management of their pain. Also, the assessment for the critical piece of whether the individual making the decision was doing this not out of despair, depression, or coercion of any sort was to be done by the most qualified of providers: psychiatrists, psychologists, and clinical social workers. This bill seeking to expand the OCAC act raisers considerable concerns.

Firstly, there already has ample evidence that the professional MOST qualified to assess for assessment and treatment of depression is the psychiatrist. It has been shown that the prevalence of reversible depression in those with advanced illnesses and/or at end of life is around 40%. Yet, only 4-6% of those seeking medical aid in dying per the state of Oregon statistics were referred to a psychiatrist. If the current medical providers are so dramatically underdiagnosing treatable depression, this will only worsen if advanced practice nurses are allowed to assess for mental health.

2ndly, within this climate of increased depression and anxiety, there is therefore good reason for the current mandatory waiting period. This time of processing their decision and the support of good hospice care is absolutely valuable in making a final decision regarding their end of life wishes. This waiting period therefore should NOT be shortened.

Finally, waiving the mandatory waiting period for those who would not survive the remaining 2-3 weeks of their life is an oxymoron. As a recently retired hospice physician, I know first-hand that someone in this situation usually has lost a significant amount of their cognitive ability and are often confused and emotionally fragile. Having the cognitive and emotional stability for clear decisionmaking in this context is extremely unlikely and waiving the mandatory waiting period only serves as a gateway for abuse by others who want to prematurely end the person’s life.

We are now in the midst of a prolonged pandemic where we have seen suicide rates, opiate overdoses, and alarming rates of mental health problems among individuals due to feelings of loneliness, isolation, and abandonment. Certainly this is no time to consider removing the safeguards that have been appropriately in place all this time.

Respectfully submitted,

C Nak

Craig Nakatsuka, MD

HB-1823

Submitted on: 1/28/2022 10:17:40 AM

Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Robert Fontana	Individual	Support	No

Comments:

The right to choose how one wishes to die is a part of ones right to life. This bill only deals with terminally ill people and how they choose to die in a situation where death is inevitable. Hawaii has made progress in this area, and HB1823 is an extention of that progress, allowing a broadening of medical personnel who would be allowed to assist with medical aid in dying. I whole heartedly support this effort as it is the right thing for a government to do for its citizenry. To deny this bill would be to deny the soon-to-be-departed their chosen avenue to leave, which would be unforgivable. Grantng this right is an act of mercy, and any opposition to it would be an attempt to dictate ones philosophy or religion onto another. Our democracy is suppose to free us from such oppression. This bill will help to ensure such freedom.

HB-1823
Submitted on: 1/28/2022 10:26:18 AM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Caryn Ireland	Individual	Support	No

Comments:

I strongly support these important changes to the Our Care, Our Choice Act.

HB-1823
Submitted on: 1/28/2022 12:08:05 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Brian Goodyear	Individual	Support	No

Comments:

Aloha Representatives,

I am writing to express my strong support for HB1823 and to urge you to support passage of this bill. I am a clinical psychologist who conducts mental health consultations for terminally ill patients who have requested medical aid in dying.

Since the Our Care, Our Choice Act went into effect I have had the privilege of doing over 80 of these consultations, mostly for Kaiser patients. Based on my experience thus far, I believe that the Act is working as intended for the most part. All of the patients that I have seen have been grateful and relieved to have this option available in case their suffering becomes unbearable at some point. I have also been impressed by how acceptant these patients have been of the fact that they have only a very limited amount of time remaining in their lives.

There are, however, some changes that should be made to the legislation to address certain problems that have arisen for some patients who have requested medical aid in dying and have not been able to take full advantage of the current law. HB1823 directly addresses these problems.

One problem, particularly for patients on the neighbor islands and in rural areas of Oahu, is the shortage of physicians who are able to act as the attending or consulting provider. This mirrors the more general shortage of medical providers in these areas of the state. Allowing APRNs, who are well qualified to do so, to take on these roles would greatly help to alleviate this shortage.

The second problem is that some critically ill patients have been too ill to survive the 20 day waiting period. Two changes are in order to address this problem. The waiting period could safely be reduced to 15 days to bring the law in line with similar pieces of legislation in other jurisdictions. In addition, the attending provider should be allowed to waive the waiting period completely for patients who are not expected to survive the waiting period. Similar changes have already been enacted in Oregon and California, and are also being considered in other jurisdictions.

Mahalo for your support of these proposed changes and for your attention to this issue.

Brian Goodyear, Ph.D.

2924 Alphonse Place

Honolulu, HI 96816

(808) 285-9393

bsgoodyear@aol.com

HB-1823
Submitted on: 1/28/2022 4:19:35 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Mary Uyeda	retired APRN nurse	Support	Yes

Comments:

Mary M. Uyeda, retired APRN

To our House Committee on Health – January 28, 2022

I support HB 1823 for its removal of access and timing barriers to our terminal residents on the neighbor islands, especially the Big Island.

For example, the Big Island has one physician willing to give terminal patients that choice at end of life. It is known that the specific paperwork is cumbersome, let alone the timing issues of using this alternative but we are deeply grateful for having this law in Hawaii! However, we are still far behind the Oregon law which has addressed their barriers over the last 20+ years.

Let us join together and improve our law by removing the access barrier on the outer islands by including APRNs who will put in the time since most terminal patients would rather die at home, surrounded by the people who care for them including the APRN. In addition, shorten the waiting period that a terminal patient has to endure in order to have their choice at end of life.

Help us pass HB 1823.

HB-1823
Submitted on: 1/28/2022 4:31:50 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Gabriela Ortiz-Omphroy	Individual	Oppose	No

Comments:

Aloha. My name is Gabriela Ortiz-Omphroy. I am a family medicine physician who has practiced in Hawaii for the last 20 years. I oppose this bill because as a medical provider I do not believe that waiving the mandatory waiting period is of benefit to our terminally ill patients. This waiting period is a safeguard and allows the time necessary to process this irreversible decision. During this extended pandemic time, the waiting period is even more critical. It allows the patient, family and physician time to process all that this decision means. The time allows for reversible diagnosis to be corrected or treated. There is no need to rush such a final decision. Sincerely,

Gabriela Ortiz-Omphroy, MD

HB-1823
Submitted on: 1/28/2022 5:19:23 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Kerry Ishihara	Individual	Oppose	No

Comments:

I am writing to oppose House bill1823. It is unethical to allow someone who is not capable of making the decision and then allowing someone other than a doctor to administer death creating drugs. In this day of COVID, people are depressed, people arein a state of financial crisis. To allow people to make rash decisions without a mandatory waiting period of sufficient length is not something that legislators should be passing a law on at this time.

HB-1823

Submitted on: 1/28/2022 8:18:41 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Jane Cordray	Individual	Comments	No

Comments:

Thank you for the opportunity to testify. As someone who attempted suicide in 1976, but was revived, I strongly encourage this bill to be voted against. My life would have ended forty-five years ago, here in Hawaii, if my mother had followed the advice given. I would have missed the blessing of teaching many little ones on Oahu as well as living a full life as a wife and mother. I was depressed and in pain but I am so thankful for intervention that was provided for me. Please give others a chance to live. Thank you, sincerely. Jane Cordray

HB-1823
Submitted on: 1/29/2022 7:37:09 AM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Caroline Kunitake	Individual	Support	No

Comments:

Dear Chair Yamane, Vice Chair Tam, and the Committee on Health, Human Services and Homelessness,

I am submitting testimony in support of HB1823.

I firmly believe that medical aid in dying needs to be accessible to more people, especially on the neighbor islands where there is a shortage of primary care physicians. It is not fair that someone who lives in a less populated county or district will be unable to access the current law on medical aid in dying because they are unable to find a physician (not a registered nurse practioner) willing to perform medical aid in dying. Nurse practioners, who take less time to train and have less school loans compared to physicians, will be able to provide medical aid in dying services once the laws are changed to expand their legal scope of practice,

I am originally from Hawaii County and I was so disappointed to learn that the residents of Hawaii County have a greater difficulty using the Our Care, Our Choice Act (OCOCA) law.

I found the following information below from the Kona Community Hospital website which links a news story from the Hawaii Tribune Herald from Feb. 14, 2021. See below:
https://kch.hhsc.org/news/hospitals-resist-our-care-our-choice-act/

The East Hawaii Region of the Hawaii Health Systems Corp., which includes Hilo Medical Center, does not participate in OCOCA-related services on its premises, according to a policy implemented in Feb. 2021. Those services include the duties required by providers under the law, prescribing or delivering aid-in-dying drugs; and prohibiting patients from self-administering the drug while a patient is in an East Hawaii Region facility. The Hilo Medical Center supports the OCOCA law, but lacks the resources to needed to fulfill all of the requirements of the OCOCA law.

In addition, other hospitals including the Queen's North Hawaii Community Hospital in Waimea (which is on the other side of the island from the district of Hilo) does not participate in the OCOCA-related services. Kona Community hospital does not participate in OCOCA by way of allowing the administration of end-of-life medications on the KCH campus.

Instead these hospitals refer patients to physicians who are willing to provide medical aid in dying treatment away from the hospital campus. Unfortunately, there are not enough primary care doctors especially in Hilo. While living in Hilo, I had so much difficulty finding a primary care physician willing to take a new patient. Most of the physician offices that I contacted in Hilo shared that I probably needed to wait over a year for a slot to open up. If you're lucky enough to even have a primary care doctor in Hilo, you need to have your fingers crossed that your physician is willing to provide medical aid in dying.

The University of Hawaii John A. Burns School of Medicine website (https://jabsom.hawaii.edu/report-finds-hawai%CA%BBi-physician-shortage-exacerbated-by-the-pandemic/) shows that the COVID-19 pandemic has increased the physician shortage on all of our counties. The update on January 2, 2021 reports that older physicians are opting for early retirement and COVID-19 has disrupted and shortened clinical operations. The statewide physician shortage remains between a range of 710 and 1,008.

Please exercise greater compassion for all who wish to use the medical aid in dying law. All of us will not escape death and we will end from old age, sickness or death. Empowering terminally ill individuals with more control over their death does not diminish the right of others to live. I believe that HB1823 will provide greater mental ease and comfort to terminally ill individuals and their families. Please support HB 1823.

Mahalo,

Caroline Kunitake

HB-1823
Submitted on: 1/29/2022 9:05:20 AM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Maureen Abe	Individual	Oppose	No

Comments:

I am against this bill because I believe that the 3 week waiting period should remain as is. During the 3 week waiting period, minds of those terminally ill could be changed, thus allowing them to spend more time with friends and/or loved ones.

HB-1823
Submitted on: 1/29/2022 11:06:31 AM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
AUBREY HAWK	Individual	Support	Yes

Comments:

I am a resident of rural Hawaii Island and I strongly support HB1823. In my role as a volunteer patient navigator I try to help terminally ill patients seeking to use the Our Care, Our Choice Act. Too many of them are being denied this legal end-of-life option, either because they cannot find a provider willing to assist them, or because they cannot survive Hawaii’s arbitrarily long mandatory minimum waiting period—the longest in the nation. HB1823 amends the OCOCA with common sense, no-cost solutions that will allow for greater equity in accessing the law. Please vote yes.

February 1, 2022

Representative Ryan I. Yamane, Chair
Representative Adrian K. Tam, Vice Chair
House Committee on Health, Human Services & Homelessness
Hawaii State Capitol
415 South Beretania
Honolulu, HI 96813

RE: <u>In strong support of HB 1823 Relating to Health</u>

Chair Yamane, Vice Chair Tam and Committee Members:

Thank you for considering HB 1823 which offers important amendments to the Our Care Our Choice Act (passed in 2018). These amendments will improve access for all residents of our state and improve the quality of life for many terminally ill patients who choose to access medical aid in dying.

HB 1823 improves the existing legislation by:

- Expanding access to the Our Care Our Choice Act by allowing Advanced Practice Registered Nurses to write prescriptions for medical aid in dying. This will help terminally ill individuals, particularly those who reside on neighbor islands and in rural areas, with access to the law.
- Allowing consultations with psychiatric nurse practitioners which is consistent with their scope of practice.
- Waiving the mandatory waiting period if a patient is unlikely to survive the current wait called for in the statute. Statistics show that too many people die while counting the days to obtain their prescriptions.
- Reducing the barrier for individuals seeking medical aid in dying. Shortening the 20-day waiting period to 15 days between oral requests will alleviate a terminally ill persons' stress. Our current law is the longest waiting period of the ten authorized jurisdictions in the US.

I sincerely hope this committee will recommend passage of HB 1823 which will result in helping more people by providing peace of mind that if needed they will be able to access the law.

Mahalo nui loa,

Mary Steiner
808-225-4563

HB-1823
Submitted on: 1/29/2022 11:42:35 AM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Kathleen Yokouchi	Individual	Support	No

Comments:

In strong support.

HB-1823
Submitted on: 1/29/2022 1:07:59 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Becky McPeek	Individual	Oppose	No

Comments:

My name is Becky McPeek a substitute teacher for the DOE and I am in opposition to HB 1823 as it relates to the expansion of the Our Care Our Choice Act. I am for keeping the law as it now stands and do not want to see any of the safeguards that have been appropriately placed be removed, as they have been working well. As the saying goes, "If it is not broken, there is no need to fix it!"

Sincerely,

Becky McPeek

HB-1823
Submitted on: 1/29/2022 1:39:11 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Wenli Lin	Individual	Oppose	No

Comments:

TESTIMONY IN OPPOSITION TO HB 1823

My name is Wenli Lin. As a private citizen, I am in opposition to HB 1823 relating to the expansion of the Our Care Our Choice Act.

This bill seeks to: expand the scope of practice of nurse practitioners in medical aid in dying, expand the providers to provide counseling to a qualified patient, decrease the mandatory waiting period between oral requests, and waive any waiting period for those terminally ill individuals deemed unlikely to survive the waiting period.

I believe life is granted by God and taken away by God. I believe that human beings do not have the right to end their own lives by suicide. My other reasons are as follows:

Firstly, there already has ample evidence that the professional MOST qualified to assess for assessment and treatment of depression is the psychiatrist. It has been shown that the prevalence of reversible depression in those with advanced illnesses and/or at end of life is around 40%. Yet, only 4-6% of those seeking medical aid in dying per the state of Oregon statistics were referred to a psychiatrist. If the current medical providers are so dramatically underdiagnosing treatable depression, this will only worsen if advanced practice nurses are allowed to assess for mental health.

2ndly, within this climate of increased depression and anxiety, there is therefore good reason for the current mandatory waiting period. This time of processing their decision and the support of good hospice care is absolutely valuable in making a final decision regarding their end of life wishes. This waiting period therefore should NOT be shortened.

Finally, waiving the mandatory waiting period for those who would not survive the remaining 2-3 weeks of their life is an oxymoron. As a recently retired hospice physician, I know first-hand that someone in this situation usually has lost a significant amount of their cognitive ability and are often confused and emotionally fragile. Having the cognitive and emotional stability for clear decisionmaking in this context is extremely unlikely and waiving the mandatory waiting period only serves as a gateway for abuse by others who want to prematurely end the person’s life.

We are now in the midst of a prolonged pandemic where we have seen suicide rates, opiate overdoses, and alarming rates of mental health problems among individuals due to feelings of loneliness, isolation, and abandonment. Certainly this is no time to consider removing the safeguards that have been appropriately in place all this time.

Respectfully submitted,

Wenli Lin

HB-1823
Submitted on: 1/29/2022 4:06:53 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
David Gili	Individual	Support	No

Comments:

Please eliminate or reduce as many obstacles as possible so people can take advantage of this very important end of life measure. Thank you.

HB-1823
Submitted on: 1/29/2022 5:38:13 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Nina Buchanan	Individual	Support	Yes

Comments:

Aloha,

Thank you for accepting this testimony in support of HB1823.

My name is Nina Buchanan, Ph.D. Emerita Professor from the University of Hawaii. I want to tell you my personal experience with the death of my husband, Dr. Robert (Bob) Fox, Emeritus Professor. In July of 2021 Bob was diagnosed with terminal colon cancer. Unfortunately, his cancer was not identified until June 21, 2021 when he had severe stomach pains and was admitted to the Hilo Medical Center Emergency room. After spending time in the hospital in June and again in July, he was finally able to see an oncologist and began a course of chemotherapy. After two weeks it was apparent that he could not continue with the treatment and without successful treatment the doctor estimated he might live from 4 to 6 months.

The first thing he did was make sure his affairs were in order and that I would be financially able to remain in our home. The next thing he did was ask about how he could use Hawaii's death with dignity law that would allow him to die in peace at home before the cancer made it impossible for him to engage with any normal activities of life - things like completing the daily crossword puzzle in ink with no words crossed out or incorrect while sitting outside enjoying the yard he created 6 years earlier in Hilo.

However, there were NO licensed, qualified physicians on the island who were willing to make a professional diagnosis and prognosis regarding Bob's condition even though his primary care physician and oncologist had both diagnosed his cancer and declared that he might live for 4 to 6 months. The only way he could possibly qualified to get the assistance he needed would be to leave the island. But… COVID made travel impossible especially for someone as ill as Bob.

On September 11, 2021 Bob was admitted to Hawaii's Care Choices at home. The title is a misnomer, there was no choice. Their services, limited to pain and comfort management, were extraordinary but…. in the end INHUMANE for both of us.

I was reduced to sitting by his bedside, holding his hand and giving him medication while he slowly became incoherent and starved to death. He gradually lost all ability to communicate and was no longer the brilliant physicist and articulate Hilo community leader that he had been. He died on October 1st and a part of me died with him.

I am an animal lover and surely would have a cat or dog who was suffering put to ‘sleep.’ It is an absolute horror to allow humans to suffer beyond what we would tolerate for a family pet.

I urge you to amend the law to make it possible for those of us in Hawaii to have some real choice and control over our death.

January 30, 2022

Honorable Chair Yamane, Vice Chair Tam, and Esteemed House Committee on Health, Human Services, & Homelessness Members,

I have practiced and taught full-time palliative medicine in Hawaii for over 17 years, and I am writing, as an individual, in **strong opposition to HB1823.**

With barely three years' experience with the Our Care, Our Choice Act (OCOCA), this bill would take Hawaii from what was touted as the safest physician-assisted suicide legislation in the nation to the one most willing to sacrifice safety in the interests of streamlining the process.

- **The bill as written is factually incorrect. Certification of a terminal prognosis is not within the scope of practice for Advanced Practice Registered Nurses (APRN's).** APRN's are an essential component of any high-quality palliative care team. Personally, I am fortunate to work on a daily basis with the most skilled palliative care APRN's in the state. However, <u>Medicare specifically prohibits APRN's from certifying 6-month prognosis for hospice</u> (although they may serve as attending). This certification of six-month prognosis is an <u>essential</u> role of the attending and consulting physicians under the OCOCA. In addition, the Our Care, Our Choice Act, like all other legally accelerated death laws in the US, defines the attending provider as having "responsibility for the care of the patient and treatment of the patient's terminal disease." APRN's do not meet this definition in that they do not have responsibility for the treatment of cancer or the neurodegenerative, pulmonary or cardiac diseases that are the most common terminal illnesses affecting people that pursue legally accelerated death. Why would Hawaii consider it scope of practice for APRNs to certify terminal prognosis when the federal government does not? On what evidence is this based as being safe or appropriate care?

- **Waiving the waiting period for those not expected to survive the waiting period is clinically illogical and an invitation to fraud and abuse.** A physician can only reliably predict that a patient will only survive days and not weeks once the patient has entered the actively dying phase. <u>Patients at this stage nearly always lack the ability to perform the cognitive and physical functions required to self-determine their care under the OCOCA</u>. Passing this provision would open the door to abuse by authorizing patients that are unable to self-determine and self-administer the lethal drugs or abuse by physicians succumbing to pressure to expedite the process. While legally accelerated death is nearly always about controlling life's end, the idea of waiving waiting periods to hasten dying for people who are believed at high risk of dying <u>too soon</u> hardly seems worth any reduction in safety that may come from expediting the process.

I have no objections to the other provisions of HB1823: shortening the waiting period to 15 days, consistent with the practice in other states, and the inclusion of psychiatric APRN's among the behavioral health consultants to confirm capacity.

Thank you for your thoughtful consideration as you weigh this serious matter, attempting to find the best balance between minimizing suffering for the less than 0.5% of people that typically access physician-assisted suicide while promoting safe and compassionate care for the 100% of us that will face the end of life.

Respectfully,

Daniel Fischberg, MD, PhD, FAAHPM
Board-certified in Hospice & Palliative Medicine, Pain Medicine, Addiction Medicine, Internal Medicine
Kailua, HI

HB-1823
Submitted on: 1/30/2022 8:17:54 AM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
sugimoto	Individual	Oppose	No

Comments:

Thank you giving me an opportunity to testify.

I deeply oppose this bill allowing assisted suicide to be legalized. How precious is our kapunas, individuals that have disabilities or ones who cannot speak for themselves. Technology has advanced in the recent years that can all individuals that are suffering can be comforted & still live a decent life. Let them live!

Much Blessings to you all!

cherryl

I write in strong support of HB 1823, to make the Our Care Our Choices actually useable for dying people.

I was very proud of our state when we passed the original Our Care Our Choices bill; but I have since observed first hand how the bill, as written, makes it impossible for patients dying in East Hawaii to use it. I have personally witnessed a friend whose cancer was diagnosed late in the disease's progression, after all treatment options were exhausted, beg to be allowed to end his life. Although he had been told by more than one physician that he had no more than about 4 months to live, and although all treatment options were exhausted, no doctor in the East Hawaii region would provide the medical steps necessary for him to access death with dignity, and by that time, he was far too ill to travel. His only option, and the one he and his family chose, was to accept hospice care (at home) and die of starvation, which took several weeks. I watched as he wasted away, and I watched the toll his passing took on his family.

The original Our Care, Our Choices Act, while well intentioned, has been rendered useless at least on the Big Island. I beg you to extend practice/prescription authorization to additional health professionals and to limit the waiting period for those who will not live long enough to use the Our Care, Our Choices Act.

HB-1823
Submitted on: 1/30/2022 10:18:30 AM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Leon E Hallacher	Individual	Support	No

Comments:

Although Hawaii’s current *Our Care, Our Choice Act* medical aid in dying law is well-intended, it has serious flaws in regard to access and timing that has resulted in many terminally ill individuals having suffered horribly painful and traumatic deaths. The Hawaii Department of Health, in a 2020 report to the legislature, made recommendations to fix the current law’s shortcomings. HB 1823 has been introduced this legislative session to fix problems identified with the current law. HB 1823 should absolutely be passed.

HB 1823 improves access, especially in rural areas and outer islands, by giving Advanced Practice Registered Nurses prescriptive authority and allowing “counseling” to also be done by psychiatric nurse practitioners. It also reduces the current 20-day waiting period between the first and second oral requests for medical aid in dying to 15 days; the length of time used in all other states with medical aid in dying laws.

This bill has my complete support. I urge you to vote in favor of it and thereby improve Hawaii’s currently flawed medical aid in dying law. Thank you for considering my comments.

HB-1823
Submitted on: 1/30/2022 12:16:20 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Kathy Kosec	Individual	Support	Yes

Comments:

I speak as a retired RN with professional and personal experience in Hospice care. I worked as a hospice registered nurse in both Colorado and Texas. I did all I could to assist my youngest sister in her preference for Dignity in Death as she lay dying at home and later at an inpatient hospice of ovarian cancer. She waited too long to deploy the necessary legal pathway for assistance in dying in WA state 2 years ago. She was tormented with pain and fear for the last 3 weeks of her life as we tried everything we could to help her get medication to assist in helping her control her right to choose when the pain and agony of end-stage cancer was hers to end.

I helped families of others cope with the cries of pain and agony in the 1980's and 90's as their hospice RN and did all I could when patients had no choices about dying with dignity. We now have medications that can handle the severe pain for some, but not all patients. We need to give people with end-stage diseases options to have control of the pain. I remember well a young couple where the husband age 32 was dying of a rapidly growing brain tumor whose wife was coping with small children and his screams of pain, especially at night when they were trying to sleep. She asked me how much of his pain medication would be "too dangerous" to give him to "control the pain completely". She worried about legal action if something "bad" happened with giving him adequate pain medication. They were in so much agony--but it was 1982 and they had NO options.

We all need the right to manage our own death with dignity and not have huge roadblocks to slow this process when patients and their families are caught in a nightmare of paperwork that have several waiting periods. Most don't ever use their final option; but knowing it is there is a relief to all. My family was horribly traumatized by what our sister (who was single) went through waiting for a "natural death"! We all vow to get medication as soon as any of us is diagnosed with a terminal illness to avoid having no options as the end nears and the pain multiplies beyond what is tolerable.

Someday this may be the gift you give yourself or a dear family member. This is about compassionate care of the dying--NOT assistd suicide.

HB-1823
Submitted on: 1/30/2022 1:03:18 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Marion Poirier	Individual	Support	No

Comments:

HOUSE CHAIR YAMANE AND MEMBERS OF THE COMMITTEE ON HEALTH, HUMAN SERVICES AND HOUSING:

Testimony in SUPPORT

My name is Marion Poirier and I am a retired nurse administrator in full support of HB1823.

My work experiences have demonstrated the increasing need for these services, namely, the aging population and incidence of chronic illnesses in Hawaii. People need knowledge to control their destiny. This control factor assists them regardless of decisions that they may or may not make. The counseling and education pivots the patients in important ways.

Please know that it is within the scope of practice of APRN's to deliver this service. In fact I believe APRN's education and training uniquely qualify them. I am Secretary of the Hawaii-American Nurses Association Board of Director. In that context I am in continuous contact with their expertise.

I trust you will honor supportive testimony such as mine by passing this measure out of your Committee.

Thank you for this opportunity to testify in full support.

i

HB-1823
Submitted on: 1/30/2022 2:55:49 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Diane Ware	Individual	Support	No

Comments:

Dear Comittee Chair Yamane and members,

I urge you again this year to support and move forward this bill. I am 74 and not getting younger. It is extremely difficult to find doctors to facilitate a terminal patient's request. Thinking about death and possible pain and suffering is very stressful. Passing this measure will relieve anxiety for many of your constituents.

Mahalo nui loa and wishing you well,

Diane Ware

99-7815 Kapoha Pl

Volcano HI 96785

HB-1823
Submitted on: 1/30/2022 3:41:47 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Nikos Leverenz	Individual	Support	No

Comments:

Chair Yamane, Vice Chair Tam, and Members of the Committee:

I am writing in strong support of this bill, which would improve access to medical aid in dying by allowing APRNs to act as providers.

This bill is needed to give terminally ill patients more rapid access to needed care services. Unfortunately far too many doctors in this state's system of care are reluctant to provide them.

This change would most benefit ill persons in rural parts of our state.

Mahalo for your consideration.

Nikos Leverenz

MH
MITCHELL | HAMLINE
School of Law

January 30, 2022

Hawaii Legislature
House Committee on Health, Human Services, and Homelessness

Re: Hearing on H.B. 1823 on February 1, 2022

Dear Committee Members:

I am a law professor who studies medical aid in dying and other laws governing end-of-life medical care. I write in support of H.B. 1823 and its amendments to the *Our Care, Our Choice Act*.

1. Other jurisdictions (like New Mexico and most provinces in Canada) permit MAID to be administered not only by physicians but also by APRNs. This materially improves the accessibility of MAID without compromising patient safety. Other current MAID states (like Washington) also have active bills in 2022 to extend to APRNs.

2. Other jurisdictions have either shortened the mandatory waiting period (like California and New Mexico) or permit the waiting period to be waived (like Oregon) if the patient cannot last that long. This materially improves the accessibility of MAID without compromising patient safety. More than one-third of patients who begin the process lose capacity or die during waiting period. Other current MAID states (like Vermont and Washington also have active bills in 2022 to shorten or permit waiver of the waiting period.

I discuss both these issues in the attached recently published law review article.

Sincerely,

Thaddeus Pope

Thaddeus Mason Pope

Thaddeus Mason Pope, JD, PhD, HEC-C
875 Summit Avenue, Saint Paul, MN 55105-3076
Thaddeus.Pope@mitchellhamline.edu
www.thaddeuspope.com

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Medical Aid in Dying: Key Variations Among U.S. State Laws

Thaddeus Mason Pope

ABSTRACT: Medical aid in dying (MAID) is legal in eleven U.S. jurisdictions representing one-fourth of the U.S. population, but despite its legality, MAID is practically available to only a subset of qualified patients in these states. MAID's eligibility requirements and procedural safeguards may impede a patient's access. In response, state legislatures have begun to craft more flexible rules as they recalibrate the balance between safety and access. There is already significant variability among U.S. MAID statutes in terms of eligibility requirements, procedural conditions, and other mandates. While the Oregon Death with Dignity Act has served as the template for all subsequent MAID statutes, the states have not copied the Oregon law exactly. Furthermore, this nonconformity grows as states continue to engage in an earnest and profound debate about the practicality of MAID.

Thaddeus Mason Pope, *Medical Aid in Dying: Key Variations Among U.S. State Laws*, J. Health and Life Sci. L., Oct. 2020, at 25.

MAID Variations Among U.S. State Laws

ARTICLE CONTENTS

INTRODUCTION

Medical Aid in Dying (MAID) is an end-of-life option that has been spreading across the United States.[1] It provides assurance that a terminally ill patient can die when she wants based on her own criteria and enjoy life for a longer period of time. Twenty years ago, MAID was available in only one state.[2] Ten years ago, it was available in only two states.[3] Today, MAID is available in eleven U.S. jurisdictions that comprise 25% of the U.S. population.[4]

The expansion of MAID is notable not only for its size but also for its pace. States have been legalizing MAID at an increasingly accelerated speed. Five of today's eleven MAID jurisdictions enacted their statutes in the past four years. Six jurisdictions enacted statutes within the past five years. Two states enacted statutes in 2019 alone,[5] and half of the remaining forty states considered MAID legislation in 2020.[6]

Because of growing public and legislative interest in MAID, it is useful to identify and assess lessons that can be drawn from the existing laws. The eleven MAID jurisdictions have taken three different legal paths to legalization: (1) legislative, (2) judicial, and (3) standard of

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[1] MAID is also known as "aid in dying," "physician assisted death" "death with dignity," and "voluntary assisted dying." ALAN MEISEL ET AL., THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING § 12.04 (3rd ed. 2020). MAID is sometimes referred to as "physician assisted suicide," but that term is generally disfavored because of the strong association of suicide with mental illness. In addition, suicide is typically compulsive, not planned, and suicidal individuals are typically not terminally ill. Press Release, Am. Ass'n of Suicidology, Statement of the American Association of Suicidology: "Suicide" Is Not the Same As "Physician Aid in Dying" (Oct. 30, 2017), https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf.

[2] In 1994, Oregon voters approved a ballot initiative enacting the Orgon Death with Dignity Act. *See* Thaddeus Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N.M. L. REV. 267 (2018), https://digitalrepository.unm.edu/nmlr/vol48/iss2/6/; Alan Meisel, *A History of the Law of Assisted Dying in the United States* 73 SMU L. REV. 119 (2020), https://scholar.smu.edu/smulr/vol73/iss1/8/.

[3] In 2008, Washington voters approved a ballot initiative enacting the Washington Death with Dignity Act. *See* Pope, *supra* note 2.

[4] *See infra* notes 9, 42, and 47 (collecting citations for California, Colorado, Hawaii, Maine, Montana, New Jersey, North Carolina, Oregon, Vermont, Washington, and Washington, DC). The population of these eleven states totals 82 million. That is 25% of the U.S. population, 330 million. *QuickFacts: United States,* U.S. CENSUS BUREAU, https://www.census.gov/quickfacts/fact/map/US/PST045219 (last visited Sept. 8, 2020).

[5] Maine Death with Dignity Act, ME. STAT. tit. 22, § 2140 (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. STAT. ANN. §§ 26:16-1 to -20 (2020).

[6] Eighteen state legislatures considered bills to legalize MAID in 2020. Ariz. H.B. 2582 (2020); S.B. 1384, 54th Leg., 2nd Sess. (Ariz. 2020); H.B. 5420, Gen. Assemb., Feb. Sess. (Conn. 2020); H.B. 140, 150th Gen. Assemb. (Del. 2020); S.B. 1800 (Fla. 2020); Ga. S.B. 291 (2020); H.B. 1020, 121st Gen. Assemb., 2nd Reg. Sess. (Ind. 2020); Iowa S.F. 2156 (2020); S.B. 2156, 88th Gen. Assemb. (Iowa 2020); H.B. 224, Reg. Sess. (Ky. 2020); Md. H.B. 643 (2020); Md. S.B. 701 (2020); H.B. 2152, 91st Leg. (Minn. 2020); S.B. 2286, 91st Leg. (Minn. 2020); N.H. H.B. 1659 (2020); A.B. 2694, Reg. Sess. (N.Y. 2019); H.B. 2033, Reg. Sess. (Pa. 2020); H.B. 7369, Gen. Assemb. (R.I. 2020); H.B. 93, Gen. Sess. (Utah 2020); H.B. 1649 (Va. 2020); A.B. 552 (Wis. 2019); S.B. 499 (Wis. 2020). Some of these bills might have been enacted but for the COVID-19 pandemic. *Legislative Sessions and the Coronavirus,* NAT'L CONFERENCE OF STATE LEGISLATURES (Sept. 10, 2020), https://www.ncsl.org/research/about-state-legislatures/legislative-sessions-and-the-coronavirus.aspx. Commentators expect that the next states to enact MAID statutes will be Maryland, Massachusetts, New Mexico, and New York.

care[7]—but most have taken a legislative approach.[8] Nine jurisdictions authorize and regulate MAID through a detailed statute.[9] All nine of these statutes have many common features.

Commentators incessantly emphasize this resemblance. Referencing Oregon, the first state to enact a MAID statute, commentators frequently say that all U.S. MAID laws "have similar provisions based on the Oregon model."[10] Some law professors write that the states have taken a "follow the leader approach."[11] Some write that the states mimic the Oregon "model" or "template."[12] Others write that U.S. MAID laws "closely mirror," "follow" "parrot," or "pattern" the Oregon Act.[13]

However, these commentators overstate the point with this Xerox-like language. While U.S. MAID statutes may copy the Oregon model, they do not copy it exactly. Their approach is better described as "imitation" rather than as "duplication." The nine MAID statutes are not identical. There are material variations among them.[14] This Article identifies and contrasts these differences.

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[7] *See* Pope, *supra* note 2.

[8] *Id.*

[9] End of Life Option Act, Cal. Health & Safety Code §§ 443.1–.22 (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. §§ 25-48-101 to -123 (2020); Death with Dignity Act of 2016, D.C. Code §§ 7-661.01–.16 (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-1 to -25 (2020); Me. Stat. tit. 22, § 2140; N.J. Stat. §§ 26:16-1 to -20; Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800–.897 (2020); Vt. Stat. Ann. tit. 18, §§ 5281–93 (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.010-.220–.904 (2020). One of the best places for tracking the history and status of MAID law is the website of the Death with Dignity National Center and Death with Dignity Political Fund: Death with Dignity, http://www.deathwithdignity.org (last visited Sept. 10, 2020).

[10] Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 35 (2020), https://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2020/5620T490.pdf [hereinafter Rep. No. 34].

[11] Ben White & Lindy Willmott, *Now that VAD Is Legal in Victoria, What Is the Future of Assisted Dying Reform in Australia?*, ABC, June 24, 2019, https://www.abc.net.au/religion/the-future-of-assisted-dying-reform-in-australia/11242116.

[12] *See, e.g., id;* Anita Hannig, *Assisted Dying Is Not the Easy Way Out*, The Conversation, Feb. 18, 2020; Pamela S. Kaufmann, Death with Dignity: A Medical-Legal Perspective, AHLA Long-Term Care and the Law Meeting (Feb. 22, 2017), https://theconversation.com/assisted-dying-is-not-the-easy-way-out-129424.

[13] Cody Bauer, *Dignity in Choice: A Terminally Ill Patient's Right to Choose*, 44 Mitchell Hamline L. Rev. 1024, 1036 (2018), https://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1138&context=mhlr; Edward Davies, *Assisted Dying: What Happens after Vermont?*, 346 Brit. Med. J. f4041 (2013); Arthur Svenson, *Physician-Assisted Dying and the Law in the United States: A Perspective on Three Prospective Futures, in* Euthanasia and Assisted Suicide: Global Views on Choosing to End Life 13 (Michael J. Cholbi ed. 2017), https://publisher.abc-clio.com/9781440836800/14; Taimie Bryant, *Aid-in-Dying Nonprofits*, 57 San Diego L. Rev. 147, 181 n.154 (2020), https://digital.sandiego.edu/cgi/viewcontent.cgi?article=3207&context=sdlr; Mary C. Deneen, *Bioethics—"Who Do They Think They Are?": Protecting Terminally Ill Patients Against Undue Influence by Insurers in States Where Medical Aid in Dying Is Legal*, 42 W. New Eng. L. Rev. 63, 76 (2020), https://digitalcommons.law.wne.edu/cgi/viewcontent.cgi?article=1832&context=lawreview ("All nine jurisdictions with MAiD statutes provide similar provisions . . . ."). *See also* Rep. No. 34, at 35 ("Eight other states followed Oregon with similar laws....").

[14] This exemplifies the role of states as "laboratories" that try novel social experiments. *See* Wash. v. Glucksberg, 521 U.S. 702, 737 (1997) (O'Connor, J., concurring) (citing New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)).

In Section One, the author defines MAID and describes its place in end-of-life health care. Section Two describes non-statutory approaches to legalizing MAID that two states have taken. The remainder of the Article focuses on the nine statutes and describes three types of variations.

Section Three describes two variations in eligibility requirements. These differences concern which patients are qualified to receive MAID. The states vary both in how they assess the patient's state residency and in how they assess the patient's decision-making capacity. Section Four describes three variations in procedural requirements. These differences concern how patients obtain and take MAID prescriptions. The states vary in the permitted routes of drug administration and in the duration of the oral and written request waiting periods. Section Five describes five other variations. The states vary in how they permit clinicians and facilities to opt-out; how they permit telehealth; and how they collect and report data. The states also vary in whether they include a sunset clause.

Finally, in Section Six, the author identifies imminent variations in U.S. MAID laws. During the first two decades of U.S. MAID, policymakers placed heavy emphasis on safety at the expense of access. Today, more states are working to recalibrate the balance between safety and access. Consequently, over the next several years, one can expect additional variations among state MAID laws.

Two innovations are particularly likely. First, all states now require the attending and consulting clinician to be a physician; however, some states will probably extend MAID to advanced practice registered nurses (APRNs). Second, all states now require that the patient be terminally ill with a prognosis of six months or less, but some states will probably extend that to twelve months or longer.

MEDICAL AID IN DYING

Before comparing differences among MAID laws, it is important to first clarify what MAID is. Why would someone hasten their own death? How do they do that with MAID? Who is using this end-of-life option?

Why Hasten One's Death?

There are many circumstances under which a longer life is not a better life. When quality of life diminishes, some individuals would prefer to hasten death (or at least not prolong dying) rather than endure the perils of what, at least to them, is an exceedingly poor quality of life.[15] What exactly comprises a "poor quality of life" covers a broad spectrum that varies significantly from person to person.

For some, loss of independence might diminish quality of life to the point where they would request a hastened death.[16] For others, it may be extreme physical suffering. For these and other reasons, requests to hasten death are common throughout the United States and the world. As Justice Brennan observed, "[f]or many, the thought of an ignoble end, steeped in decay, is abhorrent."[17]

Many seriously ill patients find their lives marked with extreme suffering and both physical and mental deterioration. Unfortunately, many do not have access to a medically supervised, peaceful death. Too many patients commit suicide through violent means such as shooting, hanging, or various other forms of self-deliverance.[18] Moreover, being uncertain about their future options and being worried about future loss of dignity, comfort, and control, many patients hasten their deaths prematurely.[19] Medical aid in dying (MAID) provides an alternative: the assurance that terminally ill patients can die when they want based on their own criteria and can enjoy life for a longer period of time.[20]

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[15] *See* Janet L. Abrahm, *Patient and Family Requests for Hastened Death*, 2008 HEMATOLOGY 475, 475 (2008), https://ashpublications.org/hematology/article/2008/1/475/95873/Patient-and-Family-Requests-for-Hastened-Death ("Patient and family requests for hastened death are not uncommon among patients with advanced malignancies."); Linda Ganzini et al., *Oregonians' Reasons for Requesting Physician Aid in Dying*, 169 ARCHIVES INTERNAL MED. 489, 489 (2009), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/414824 ("One in 10 dying patients will, at some point, wish to hasten death."); Jean-Jacques Georges et al., *Requests to Forgo Potentially Life-Prolonging Treatment and to Hasten Death in Terminally Ill Cancer Patients: A Prospective Study*, 31 J. PAIN & SYMPTOM MGMT. 100, 104 (2006), https://www.jpsmjournal.com/action/showPdf?pii=S0885-3924%2805%2900631-7; Joan McCarthy et al., *Irish Views on Death and Dying: A National Survey*, 36 J. MED. ETHICS 454, 456 fig. 2 (2010) (finding that a majority of individuals strongly agreed with the statement, "If I were severely ill with no hope of recovery, the quality of my life would be more important than how long it lasted."); Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193, 1195 (1998), https://www.nejm.org/doi/pdf/10.1056/NEJM199804233381706?articleTools=true.

[16] For years, the three most frequently reported end-of-life concerns of patients using MAID have been (1) decreasing ability to participate in activities that made life enjoyable, (2) loss of autonomy, and (3) loss of dignity. OREGON HEALTH AUTH., PUBLIC HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2019 DATA SUMMARY 6 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf.

[17] Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 310 (1990) (Brennan, J., dissenting).

[18] Peter M. Marzuk, *Suicide and Terminal Illness*, 18 DEATH STUD. 497, 500 (1994); Matthew Miller et al., *Cancer and the Risk of Suicide in Older Americans*, 26 J. CLINICAL ONCOLOGY 4720, 4722 (2008), https://ascopubs.org/doi/pdf/10.1200/JCO.2007.14.3990.

[19] Ladislav Volicer et al., *Assistance with Eating and Drinking Only When Requested Can Prevent Living with Advanced Dementia*, 20 J. AM. MED. DIRECTORS ASS'N 1353 (2019).

[20] *See* Benzi M. Kluger, *Medical Aid in Living*, JAMA NEUROLOGY (Aug. 24, 2020); STANLEY A. TERMAN, THE BEST WAY TO SAY GOODBYE: A LEGAL PEACEFUL CHOICE AT THE END OF LIFE 326 (Ronald B. Miller & Michael S. Evans eds., 2007).

Certainly, life is valuable, and societal values reinforce attempting to extend life indefinitely. However, death is unavoidable. People suffering from the diseases that cause the most deaths in this country will often experience significant suffering and/or loss of independence.[21] In this situation, the preference, for some, may be to hasten death so that death can be on the individual's own terms and with some predictability, rather than risk the unknown and potential loss of comfort and dignity.[22] Advocates often remark that MAID does not result in more people dying, just in fewer people suffering.

What Is MAID?

MAID is one key last resort "exit option."[23] With MAID, a physician writes a prescription for life-ending medication for an adult patient who is terminally ill and mentally capacitated.[24] The practice has long-standing and well-defined conditions regarding patient eligibility, the role of physicians, and the role of the patient.

Indeed, since the practice is so tightly regulated, the standard of care maps onto the statutory requirements. All nine U.S. MAID statutes have nearly identical conditions and safeguards.[25] Regarding eligibility, the patient must: (1) be over 18 years of age, (2) have decision making capacity, (3) be able to take the medication, and (4) be terminally ill, meaning that they have a prognosis of six months or less.[26]

Regarding physician practice, both the treating physician and a consulting physician must: (1) confirm that the patient satisfies all the eligibility conditions; (2) inform the patient about risks, benefits, and alternatives; and (3) confirm the patient's request for the medication is a settled and voluntary decision. If either the treating or consulting physician suspects that

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[21] Judith K. Schwarz, *Stopping Eating and Drinking*, 109 Am. J. Nursing 52, 53–54 (2009).

[22] Hastening Death by Voluntarily Stopping Eating and Drinking: Clinical, Ethical, and Legal Dimensions (Timothy Quill et al. eds., Oxford Univ. Press, forthcoming 2021); Thaddeus Mason Pope & Lindsey E. Anderson, *Voluntarily Stopping Eating and Drinking: A Legal Treatment Option at the End of Life*, 17 Widener L. Rev. 363 (2011). Most suffering can be alleviated through palliative care. Therefore, MAID is really for the subset of cases where palliative care is insufficient. As palliative care's toolbox expands, the demand for MAID may diminish. *Cf.* Kathryn L. Tucker, *Oregon's Pioneering Effort to Enact State Law to Allow Access to Psilocybin, a New Palliative Care Tool*, Willamette L. Rev. (forthcoming 2020).

[23] *See* Timothy E. Quill et al., *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, *in* Giving Death a Helping Hand: Physician-Assisted Suicide and Public Policy: An International Perspective 49 (Dieter Birnbacher & Edgar Dahl eds., 2008).

[24] David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. Palliative Med. 259, 259 (2016).

[25] Thaddeus Mason Pope, *Medical Aid in Dying: When Legal Safeguards Become Burdensome Obstacles*, ASCO Post (Dec. 25, 2017); Thaddeus M. Pope, *Current Landscape: Implementation and Practice*, Nat'l Acads. of Scis., Eng'g, & Med. Health & Med. Div. (Feb. 12, 2018), https://www.youtube.com/watch?v=yI58KsPl-HM. While Montana and North Carolina have no MAID statute. But the conditions and safeguards are similar. *See infra* notes 65 to 71.

[26] Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.04[C] (3rd ed. 2020).

the patient's judgment is impaired, then they must refer the patient for a mental health assessment by a third clinician.[27]

Once the physician writes the prescription, the patient may obtain the medication. Traditionally, the medication has been secobarbital or pentobarbital, a barbiturate originally developed as a sleeping pill.[28] However, price increases and supply problems have led physicians to prescribe other drugs.[29] These include compounded ones like D-DMA or DDMP2.[30] Importantly, the patient must ingest the drugs herself.[31] The patient alone takes the final overt act that causes her death.[32]

Who Uses MAID?

The United States has over sixty years of experience with MAID, when one sums the experience of each state where MAID has been available.[33] Data on most of that experience has been systematically collected and reported by both state departments of health and by academic researchers.[34] They show that physicians wrote prescriptions for over 5,000 individuals. Many

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[27] *Id. But see infra* notes 75 to 78 (explaining how Hawaii requires an automatic mental health assessment for everyone).

[28] April Dembosky, *Drug Company Jacks Up Cost of Aid-In-Dying Medication*, NPR (Mar. 23, 2016, 3:24 PM), https://www.npr.org/sections/health-shots/2016/03/23/471595323/drug-company-jacks-up-cost-of-aid-in-dying-medication.

[29] Catherine Offord, *Accessing Drugs for Medical Aid-in-Dying*, SCIENTIST (Aug. 16, 2017), https://www.the-scientist.com/?articles.view/articleNo/49879/title/Accessing-Drugs-for-Medical-Aid-in-Dying/.

[30] D-DMA entails Digitalis 30 minutes before Diazepam, Morphine, and Amitriptyline. DDMP2 uses Propranolol but results in a longer average time to death. *See, e.g.,* Anita Hannig, *The Complicated Science of a Medically Assisted Death*, QUILLETTE (Mar. 18, 2020), https://quillette.com/2020/03/18/the-complicated-science-of-a-medically-assisted-death/; CHRISTOPHER HARTY ET AL., CANADIAN ASS'N OF MAID ASSESSORS & PROVIDERS, THE ORAL MAID OPTION IN CANADA: PART 1: MEDICATION PROTOCOLS: REVIEW AND RECOMMENDATIONS (2018), https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Med.pdf.

[31] Amanda M. Thyden, *Death with Dignity and Assistance: A Critique of the Self-Administration Requirement in California's End of Life Option Act*, 20 CHAPMAN L. REV. 421, 421 (2017).

[32] *See infra* notes 97 to 101.

[33] California (2015); Colorado (2016); DC (2017); Hawaii (2018); Maine (2019); Montana (2009); North Carolina (2019); New Jersey (2019); Oregon (1997); Vermont (2017); Washington (2008). There is a longer history of "underground" physician-assisted death. *See generally* Diane E. Meier et al., *A National Survey of Physician-assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED 1193 (1998); Ezekiel J. Emanuel et al., *Attitudes and Practices of U.S. Oncologists Regarding Euthanasia and Physician-Assisted Suicide*, 133 ANNALS INTERNAL MED. 527 (2000); Damien Pearse, *Michael Caine: I Asked Doctor to Help My Father Die,* GUARDIAN (Oct. 8, 2010, 7:56 PM), https://www.theguardian.com/film/2010/oct/09/michael-caine-father-assisted-suicide#:~:text=Sir%20Michael%20Caine%20has%20revealed,he%20agrees%20with%20voluntary%20euthanasia. Because this practice is not transparent, it is not properly described as "MAID."

[34] *See infra* notes 168 to 173. *See also* Luai Al Rabadi et al*., Trends in Medical Aid in Dying in Oregon and Washington*, 2 JAMA NETWORK OPEN 1/7 (2019), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2747692; Charles Blanke et al., *Characterizing 18 Years of the Death with Dignity Act in Oregon*, 3 JAMA ONCOLOGY 1403 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5824315/; Huong Q. Nguyen et al., *Characterizing Kaiser Permanente Southern California's Experience with the California End of Life Option Act in the First Year of Implementation*, 178 JAMA INTERNAL MED. 417 (2018).

patients get MAID prescriptions for their peace of mind, to have as "insurance" just in case their condition becomes intolerable. Since that intolerability often does not happen, only 70% of patients take their prescription.[35]

Nearly 90% of these 5,000 terminally ill patients had cancer or amyotrophic lateral sclerosis (ALS).[36] Other terminally ill patients with cardiovascular, respiratory, or other illnesses have rarely used MAID. The average age has been 74, and over 90% were on hospice.[37] Most were college educated.[38] Patients receiving MAID prescriptions have been almost evenly split male and female, but they have been overwhelmingly white even in racially diverse states like California.[39]

NON–STATUTORY APPROACHES

Most states have legalized MAID through a statute enacted either through the legislature or through a ballot initiative.[40] Those nine statutes are the primary focus of this Article. For the sake of completeness, however, the reader should recognize that two other states took a non-statutory approach. Montana legalized MAID through a court decision, and North Carolina took a "standard of care" approach.[41]

Montana

Montana law has long permitted one individual to help another person hasten death with consent, so long as that assistance is not against public policy.[42] In 2009, the Montana Supreme Court held that this exception in the homicide law applies to MAID. Therefore, a physician will not be subject to prosecution for prescribing medication to bring about the peaceful death of a competent terminally ill patient.[43] Relying upon this decision, patients and physicians participate in MAID in Montana.[44]

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[35] Compassion & Choices, Medical Aid in Dying: A Policy to Improve Care and Expand Options at Life's End (2020), https://compassionandchoices.org/wp-content/uploads/Medical-Aid-in-Dying-report-FINAL-2-20-19.pdf.

[36] *Id.*

[37] *Id.*

[38] *Id.*

[39] *Id.*

[40] *See supra* notes 9, 42, and 47; Pope, *supra* note 2.

[41] The Montana court only removed the criminal prohibition. It did not supply any standards or rules. Therefore, the practice in Montana is properly described as a standard of care approach. *Cf.* Kathryn L. Tucker, *Aid in Dying in Montana: Ten Years after State v. Baxter,* 81 Mont. L. Rev. 207 (2020); Kathryn L. Tucker, *Give Me Liberty at My Death: Expanding End-of-Life Choice in Massachusetts*, 58 N.Y. L. Sch. L. Rev. 259 (2013/14). North Carolina is different because there is no statute, regulation, or court decision authorizing MAID. North Carolina might be described as taking a "pure" standard of care approach.

[42] Mont. Code. Ann. § 45-2-211 (2020).

[43] Baxter v. State, 224 P.3d 1211 (Mont. 2009).

[44] *Hearing on H.B. 284 Before the H. Judicial Comm.* (Mont. 2019); Eric Kress, *Thoughts from A Physician Who Prescribes Aid in Dying*, Missoulian (Apr. 7, 2013), https://missoulian.com/news/opinion/columnists/thoughts-from-a-physician-who-prescribes-aid-in-dying/article_07680d28-9e0b-11e2-84f1-001a4bcf887a.html; Kathryn L. Tucker, *Aid in Dying in Montana: Ten Years after State v. Baxter,* 81 Mont. L. Rev. 117 (2020).

The Montana Supreme Court declared the permissibility of MAID for capacitated, terminally ill adult individuals, but it otherwise provided no rules or standards. In the following eleven years, neither the legislature nor the health care licensing boards filled this gap and provided rules and standards. The notable consequence is that Montana does not formally require the procedural requirements that are present in the nine statutory states.[45] Still, since MAID, like any medical practice, is governed by the standard of care, Montana guidelines are probably similar to the rules in the statutory states.[46]

North Carolina

Montana is not the only state to take a non-statutory approach to legalizing MAID. Some commentators argue that MAID is legal in North Carolina for the same reason that it is legal in Montana.[47] While there is no state supreme court decision addressing the question in North Carolina, there is arguably no need for such a decision. In North Carolina, as in Montana, MAID is not prohibited under current law. Therefore, like most areas of medical practice, it is permitted so long as it complies with the standard of care.[48]

Given the well-known legal risk averseness of clinicians, a standard of care approach might seem quixotic. Will physicians really write lethal prescriptions without the bright line clarity and permission of black letter law? In fact, the answer may be "yes." In closely analogous areas of end-of-life medicine such as Physician's Orders for Life-Sustaining Treatment (POLST), legal experts also recommend a non-statutory, standard of care approach.[49] Such an approach has been working in states like Minnesota where clinicians both write and follow these transportable do-not-resuscitate orders.[50]

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[45] *See infra* §§ III to V.

[46] David Orentlicher et al., *Clinical Criteria for Physician Aid-in-Dying*, 19 J. Palliative Med. 259 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4779271/pdf/jpm.2015.0092.pdf.

[47] *See, e.g.,* John Carbone et al., *Aid in Dying in North Carolina,* 80 N.C. Med. J. 128 (2019), https://www.ncmedicaljournal.com/content/ncm/80/2/128.full.pdf; Kathryn L. Tucker, *Aid in Dying in North Carolina*, 97 N.C. L. Rev. Addendum 1 (2019); Jeffrey Segal, *Can NC Physicians Legally Prescribe Meds to Suffering Terminally Ill Patients to Precipitate a Peaceful Death?*, Med. Just. (Jan. 12, 2019), https://medicaljustice.com/can-nc-physicians-legally-prescribe-meds-to-suffering-terminally-ill-patients-to-precipitate-a-peaceful-death/. *But see* Bryant A. Murphy et al., *No Consensus on AID, But We Can Agree on Palliative Care*, 81 N.C. Med. J. 213 (2020), https://www.ncmedicaljournal.com/content/81/3/213.

[48] Kathryn L. Tucker, *Vermont Patient Choice at End of Life Act: A Historic Next Generation Law Governing Aid in Dying*, 38 Vt. L. Rev. 687 (2014); Daniel Schweppenstedde et al., RAND Europe, Regulating Quality and Safety of Health and Social Care International Experiences 13 (2014), https://www.rand.org/pubs/research_reports/RR561.html. Of course, North Carolina physicians must also comply with many other rules like those from the state Board of Medicine.

[49] Charles P. Sabatino & Naomi Karp, AARP Pub. Policy Inst., Improving Advanced Illness Care: The Evolution of State POLST Laws 17, 45 (2011), https://polst.org/wp-content/uploads/2016/06/POLST-Report-04-11.pdf; National POLST Paradigm, POLST Legislative Guide 24 (2014).

[50] Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 7.10A (3rd ed. 2020) [hereinafter The Right to Die].

Other Non-Statutory Approaches

While Montana and North Carolina are the only current MAID states that have taken a non-statutory approach, other states previously attempted to follow this pathway.[51] For example, before enacting a statute in 2018, Hawaii attempted to follow a standard of care approach like North Carolina.[52] Vermont nearly took the opposite approach of following a standard of care approach ***after*** enacting a statute. The Vermont Patient Choice at End of Life Act originally included a sunset clause for the procedural requirements. Had that clause not been later repealed, Vermont MAID would have been governed by the standard of care.[53] Finally more than a dozen other states tried (albeit unsuccessfully) to legalize MAID through a court decision like Montana.[54]

VARIATIONS IN ELIGIBILITY REQUIREMENTS

Montana and North Carolina are the exceptions. Nine of eleven U.S. MAID jurisdictions authorize MAID with a statute. Because all nine of these statutes are based on the Oregon "model," they are quite similar, but these nine MAID statutes are not 100% identical. They vary along three dimensions in terms of (1) eligibility requirements, (2) procedural requirements, and (3) other dimensions. Eligibility requirements are addressed in this section, and other variations are addressed in the next two sections.

To qualify for MAID a patient must satisfy several eligibility requirements. She must be (1) an adult, (2) who is terminally ill, (3) a state resident, (4) with decision-making capacity. Every MAID statute includes these four requirements, but they differ in how they measure the last two and in how they mandate assessment of the patient's residency and capacity.

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[51] Kathryn L. Tucker & Christine Salmi, *Aid in Dying: Law, Geography and Standard of Care in Idaho*, Advocate, at 1-8 (2010); S.B. 1070, 61st Leg., 1st Reg. Sess. (Idaho 2011), https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2011/legislation/S1070E1.pdf.

[52] Kathryn L. Tucker, *Aid in Dying: An End of Life-Option Governed by Best Practices,* 8 J. Health & Biomed. L. 9 (2012), https://cpb-us-e1.wpmucdn.com/sites.suffolk.edu/dist/e/1232/files/2016/12/Aid-in-Dying-An-End-of-Life-Option-Governed-by-Best-Practices.pdf. *See also* Morris v. Brandenburg, 356 P.3d 564, 570 (N.M. 2015); Kevin B. O'Reilly, *5 Hawaii Doctors Offer Assisted Suicide to Terminally Ill Patients*, Am. Med. News (Apr. 17, 2012), https://amednews.com/article/20120417/profession/304179996/8/. *But cf.* Jim Mendoza, *AG Denounces Aid in Dying Ad*, Haw. News Now (Sept. 24, 2013), https://www.hawaiinewsnow.com/story/23521488/ag-denounces-aid-in-dying-ad/.

[53] The Right to Die, § 12.02.

[54] *See* Pope, *supra* note 2. One such lawsuit is currently on appeal. Kligler v. Healey, No. 2016-03254-F (Mass. Super. Ct. Dec. 31, 2019), https://compassionandchoices.org/wp-content/uploads/Kliger-Memorandum-of-Decision-and-Order-wm.pdf.

State Residency: How to Prove It?

Every MAID statute requires that the terminally ill, adult patient be a resident of that state.[55] For example, the California End of Life Options Act (EOLOA) provides that only "qualified individuals" can access MAID and that only residents of California are qualified individuals.[56]

While every state requires residency, they vary in terms of what evidence is enough to prove it. Most states permit the following four documents to prove state residency:

1. Possession of a driver license or other state-issued identification
2. Registration to vote
3. Evidence that the person owns or leases property in the state
4. Filing of a state return for the most recent tax year[57]

Some statutes specify fewer types of evidence as sufficient to establish residency. For example, Washington permits only the first three.[58] Other states specify more than these four types of evidence, such as Maine, which permits five additional types of evidence.[59] Washington, D.C. lists twelve additional types of evidence, and requires that the patient submit at least two of them.[60]

The ease with which a patient can prove state residency is important. Because only nine jurisdictions have MAID statutes, patients regularly move from non-MAID jurisdictions to MAID jurisdictions.[61] For example, Brittany Maynard, one of the most famous people to use

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[55] End of Life Option Act, Cal. Health & Safety Code §§ 443.1(o), 443.2(a)(3) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-102(13) (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.01(13) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. § 327L-1 (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(2)(K), (15) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. § 26:16-3 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800(11), .805 (2020); Vt. Stat. Ann. tit. 18, § 5281(8) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.010(11), .020(1) (2020).

[56] Cal. Health & Safety Code §§ 443.1(o), 443.2(a)(3).

[57] *Id.* § 443.2(a)(3); Colo. Rev. Stat. § 25-48-102(14); Haw. Rev. Stat. § 327L-13; N.J. Stat. § 26:16-11; Or. Rev. Stat. § 127.860. The Vermont statute does not specify what makes someone a Vermont resident, but the state Department of Health specifies these same four factors. Vt. Dep't of Health, Act 39 Frequently Asked Questions https://www.healthvermont.gov/sites/default/files/documents/pdf/Act39_faq.pdf.

[58] Wash. Rev. Code § 70.245.130. While Washington lists only three documents, it also permits other "[f]actors demonstrating Washington state residency". *Id.*

[59] Me. Rev. Stat. Ann. tit. 22, § 2140(15) (also including: the location of a dwelling currently occupied by the person; place where a motor vehicle is registered; address where mail is received, address shown on a hunting or fishing license, receipt of public benefits conditioned upon residency, and any other objective facts tending to indicate a person's place of residence).

[60] D.C. Health, Death with Dignity: Patient Education Module (Apr. 26, 2018), https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Death%20with%20Dignity%20-%20Education%20Modules.Patient.DC%20HEALTH%20Version.04.26.18.pdf (including: utility bill, telephone bill, mail from a government agency, or student loan statement).

[61] *See, e.g.,* Kevin Roster, Opinion, *I'm Dying from Cancer. I Have to Move Across the Country to Die on My Own Terms*, USA Today, June 7, 2019, https://www.usatoday.com/story/opinion/2019/06/07/medical-aid-dying-face-death-own-terms-column/1365567001/.

MAID, moved to Oregon specifically for the purpose of establishing residency and thus eligibility for MAID.[62] This is a form of medical tourism.[63] Because these patients are terminally ill, they must quickly acquire the necessary documents to prove state residency.

Capacity Assessments: Two or Three?

Every MAID statute requires not only that the patient be a terminally ill adult state resident but also that the patient have decision-making capacity. This means two things: first, it means that the patient can understand the significant benefits, risks, and alternatives to MAID, and second, it means that the patient can make and communicate an informed health care decision.[64]

To confirm the patient's capacity, every statute requires at least two assessments by two different physicians.[65] Both an attending physician and a consulting physician must "[d]etermine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision."[66]

If both the attending and consulting physicians are sure that the patient has capacity, then she is qualified. If either the attending or consulting physician is sure that the patient lacks capacity, then she is not qualified. However, if either the attending or consulting physician is unsure or has concerns about the patient's capacity, then they must refer the patient for a third capacity assessment.[67]

For example, the California End of Life Options Act states: "If there are indications of a mental disorder, refer the individual for a mental health specialist assessment."[68] The District of Columbia statute mandates referral when the attending or consulting physician suspects a "psychiatric or psychological disorder or depression causing impaired judgment."[69]

The clinician who performs this third capacity assessment is a mental health specialist, usually a psychiatrist, psychologist, or clinical social worker. They must determine whether

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[62] Nicole Weisensee Egan*, Terminally Ill Woman Brittany Maynard Has Ended Her Own Life*, People, May 9, 2017, https://people.com/celebrity/terminally-ill-woman-brittany-maynard-has-ended-her-own-life/.

[63] *See* I. Glenn Cohen, Patients with Passports: Medical Tourism, Law, and Ethics ch.8 (2014).

[64] End of Life Option Act, Cal. Health & Safety Code § 443.1(c) (2020).

[65] Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-4, -5 (2020).

[66] Cal. Health & Safety Code §§ 443.6(c), .8(c)-(d). Some states use the terms "competent" or "capable."

[67] Cal. Health & Safety Code §§ 443.5(a)(1), .6(d); Colorado End-of-life Options Act, Colo. Rev. Stat. §§ 25-48-106, -107 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.03–.04 (2020); Haw. Rev. Stat. § 327L-1; Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(6)–(7) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-6, -8 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.815, .820, .825 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(8) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.040, .060 (2020).

[68] Cal. Health & Safety Code §§ 443.5(a)(1)(A)(ii), .6(d).

[69] D.C. Code § 7-661.03–.04.

the patient "is mentally capable and making an informed decision."[70] They do this by determining whether the patient is suffering from impaired judgment due to a mental disorder.[71]

However, decades of government-collected and reported data show that physicians rarely refer patients for this third capacity assessment. Attending and consulting physicians refer only 4% of patients who receive a MAID prescription.[72] Consequently, few MAID patients receive a mental health specialist capacity assessment.[73] Some commentators suggest that this rate may be too low.[74]

But not in Hawaii, where capacity assessment works differently. In Hawaii, every MAID patient gets a third capacity assessment.[75] It is not contingent or conditional on the judgment of the attending or consulting physician. It is automatically and always required.[76] Recognizing that making a terminally ill patient obtain a third clinical assessment could be burdensome, Hawaii

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[70] Colo. Rev. Stat. § 25-48-108.

[71] Cal. Health & Safety Code § 443.7; Colo. Rev. Stat. § 25-48-108; D.C. Code § 7-661.01(4); Haw. Rev. Stat. § 327L-6; Me. Rev. Stat. Ann. tit. 22, § 2140(8); N.J. Stat. Ann. § 26:16-8; Or. Rev. Stat. § 127.825; Vt. Stat. Ann. tit. 18, § 5283(8); Wash. Rev. Code § 70.245.060.

[72] Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 11 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf; Wash. State Dep't of Health, Disease Control & Health Statistics, Ctr. for Health Statistics, DOH 422-109, 2018 Death with Dignity Act Report (2019), https://www.doh.wa.gov/YouandYourFamily/ IllnessandDisease/DeathwithDignityAct/DeathwithDignityData. Notably, Canada has a similarly low referral rate. James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7043822/pdf/192e173.pdf. Not every state reports data on the rate of mental health referrals. *See infra* note 170.

[73] *See generally* Lois A. Weithorn, *Psychological Distress, Mental Disorder, and Assessment of Decisionmaking Capacity Under U.S. Medical Aid in Dying Statutes*, 71 Hastings L.J. 637 (2020), http://www.hastingslawjournal.org/wp-content/uploads/Weithorn_Psychological-Distress-Mental-Disorder-and-Assessment-of-Decisionmaking-Capacity-Under-U.S.-Medical-Aid-in-Dying-Statutes.pdf; Brian D. Carpenter & C. Caroline Merz, *Assessment of Capacity in Medical Aid in Dying, in* Assessing Capacities of Older Adults: A Casebook to Guide Difficult Decisions 243 (Jennifer Moye ed., 2020).

[74] *See, e.g.,* Linda Ganzini, *Legalised Physician-Assisted Death in Oregon*, 16 QUT L. Rev. 76 (2016), https://www.deathwithdignity.org/wp-content/uploads/2015/11/623-2243-1-PB-1.pdf; Linda Ganzini & Anthony L. Back, *The Challenge of New Legislation on Physician-Assisted Death*, 176 JAMA Intern Med. 427 (2016); Council on Psychiatry and Law, APA Resource Document on Physician Assisted Death 11-12, 16 (2017).

[75] While not legally required in any state except Hawaii, some institutions in other states automatically require a third capacity assessment in their own policies. For example, while California law does not automatically require a third capacity assessment, individual facilities like UCSF do. *See, e.g.,* Barbara Koenig, *Reflections on Preparing for And Responding to Legalization in California, in* Physician-Assisted Death: Scanning the Landscape: Proceedings of a Workshop 89–98 (2018); James A. Bourgeois et al., *Physician-Assisted Death Psychiatric Assessment: A Standardized Protocol to Conform to the California End of Life Option Act*, 59 Psychosomatics 441 (2018), https://escholarship.org/uc/item/7xj942bb.

[76] Haw. Rev. Stat. §§ 327L-4(a)(5), -4, -6.

permits it to be performed not only by a physician but also by a psychologist or clinical social worker.[77] Hawaii also permits this third capacity assessment to be performed through telehealth.[78]

VARIATIONS IN PROCEDURAL REQUIREMENTS

MAID statutes vary not only in their eligibility requirements (like residency and capacity) but also in their procedural requirements that dictate how qualified patients may access MAID. Every state requires that the patient: (1) make two oral requests, (2) make one written request, and (3) take the prescription drug themselves. However, the states differ on the details. They vary on the duration of mandated waiting periods between oral requests, the duration of mandated waiting period after the written request, and on the routes by which the drug may be administered.

Oral Request Waiting Period: 0, 15, or 20 Days?

Every MAID statute requires that the patient make two oral requests for MAID. Every statute further requires that those two requests be separated by at least fifteen days.[79] For example, California mandates that "[a]n individual seeking to obtain a prescription for an aid-in-dying drug . . . shall submit two oral requests, a minimum of 15 days apart. . . ."[80] This is designed to assure that the request reflects a considered and voluntary choice by the patient.[81]

While 15 days is the most common duration, some states have longer waiting periods, and some have potentially shorter waiting periods. For example, the Hawaii Our Care, Our Choice

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[77] *Id.* § 327L-1. Some propose extending this to also include psychiatric mental health nurse practitioners. *Testimony Before the S. Comm. on Commerce, Consumer Protection, and Health* (Haw. 2020), https://www.capitol.hawaii.gov/Session2020/Testimony/SB2582_TESTIMONY_CPH_02-04-20_.PDF.

[78] HAW. REV. STAT. § 327L-1.

[79] End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443.3(a) (2020); Colorado End-of-life Options Act, COLO. REV. STAT. § 25-48-104(1) (2020); Death with Dignity Act of 2016, D.C. CODE § 7-661.02(a)(1) (2020); Maine Death with Dignity Act, ME. REV. STAT. ANN. tit. 22, § 2140(11)–(13) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. STAT. ANN. §§ 26:16-10 (2020); Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.840, .850 (2020); VT. STAT. ANN. tit. 18, § 5283(a)(2) (2020); Washington Death with Dignity Act, WASH. REV. CODE §§ 70.245.090, .110(1) (2020).

[80] CAL. HEALTH & SAFETY CODE § 443.3(a). Some clinicians have taken the patient's request on the fifteenth day after the first request, but the plain language of every statute requires that the patient make the second request on the sixteenth day or later. COLO. REV. STAT. § 25-48-104(1) ("separated by at least fifteen days"); D.C. CODE § 7-661.02(a)(1) ("separated by at least 15 days"); N.J. STAT. ANN. §§ 26:16-10 ("at least 15 days shall elapse"); OR. REV. STAT. §§ 127.840, .850 ("no less than 15 days after"); VT. STAT. ANN. tit. 18, § 5283(a)(2) ("[n]o fewer than 15 days"); WASH. REV. CODE §§ 70.245.090, .110(1) ("at least fifteen days after").

[81] State laws often require waiting periods for major life-impacting decisions like abortion, sterilization, marriage, divorce, and adoption. *See* Paul Stam, *Woman's Right to Know Act: A Legislative History*, 28 ISSUES L. & MED. 3, 66 (2012).

Act requires that the patient's oral requests be separated by at least twenty days, instead of just fifteen days.[82] Hawaii has the longest required waiting period in the United States.[83]

Oregon took the opposite approach, shortening rather than lengthening its waiting period. Between 1994 and 2019, the Oregon Death with Dignity Act required a 15-day waiting period, and this was the model followed by every other state except Hawaii. Effective January 1, 2020, however, Oregon amended its statute to permit waiver of the entire 15 days when the patient will not survive that long.[84]

> [I]f the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die within 15 days after making the initial oral request under this section, the qualified patient may reiterate the oral request to his or her attending physician ***at any time*** after making the initial oral request.[85]

Consequently, an imminently dying patient in Oregon could make both her first and second oral requests on the same day (with no waiting period).

Other states are looking to follow Oregon's lead.[86] They are apparently motivated by significant evidence demonstrating that the 15-day waiting period impedes patient access to

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[82] Haw. Rev. Stat. §§ 327L-2, -9 & -11.

[83] Mara Buchbinder & Thaddeus M. Pope, *Medical Aid in Dying in Hawaii: Appropriate Safeguards or Unmanageable Obstacles?*, Health Aff. Blog (Aug. 13, 2018) [hereinafter Buchbinder & Pope]. In fact, it often takes Hawaii patients 34 days to navigate the process. *See, e.g., Testimony in SUPPORT of HB 2451 RELATING TO HEALTH* Before the H. Comm. on Health (Haw. 2020) (statement of the State of Hawaii Department of Health), https://www.capitol.hawaii.gov/session2020/testimony/HB2451_TESTIMONY_HLT_01-31-20_.PDF [hereinafter *Testimony in SUPPORT of HB 2451 RELATING TO HEALTH*]; *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH Before the S. Comm. on Commerce, Consumer Protection, & Health* (Haw. 2020) (statement of the State of Hawaii Department of Health), https://www.capitol.hawaii.gov/session2020/testimony/SB2582_TESTIMONY_CPH_02-04-20_.PDF [hereinafter *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH*]. A significant number of patients die before the end of the 20-day waiting period. *Id.* (statement of Charles F Miller, Director, Kaiser Hawaii Medical Aid in Dying Program).

[84] S.B. 579, 80th Leg. Assemb., Reg. Sess., 2019 Laws Ch. 624, https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB579/Enrolled.

[85] Or. Rev. Stat. § 127.840(2) (emphasis added); see also *id.* § 127.850(2).

[86] *See, e.g.,* H.B. 2739 (Haw. 2020), https://www.capitol.hawaii.gov/session2018/bills/HB2739_HD1_.pdf; Dep't of Health Office of Planning, Policy, & Program Dev., Report to the Thirtieth Legislature State of Hawaii 2020: Pursuant to Act 2 Session Laws of Hawaii 2019 (HB2739 H.D. 1) (2019), https://health.hawaii.gov/opppd/files/2020/01/OPPPD-Our-Care-Our-Choice-Act-Annual-Report-2019-3.pdf; H.B. 2419, 66th Leg., Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200913182845; H.B. 171, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/house/HB0171.pdf; S.B. 252, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252.pdf, https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252.pdf. *See also* Voluntary Assisted Dying Act 2019 § 48(2)(b) (W. Austl. 2019), https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_42491.pdf/$FILE/Voluntary%20Assisted%20Dying%20Act%202019%20-%20%5B00-00-00%5D.pdf?OpenElement.

MAID.[87] Many terminally ill patients do not begin exploring the option until late in their illness trajectory. By that point, they have little remaining time and cannot survive 15 days.[88] For example, one California study shows that one-fourth of patients died or lost capacity during the waiting period.[89] Similarly, in Canada, which has only a 10-day waiting period, more than one-fourth of patients cannot wait even that long.[90]

Written Request Waiting Period: 0 or 48 Hours?

Every MAID statute requires not only that the patient make two oral requests but also that they make a written request.[91] Patients must make this written request on a specified form.[92] Furthermore, just as there is a waiting period between the two oral requests, some states require a 48-hour waiting period between the written request and the writing of the prescription.[93] For example, the New Jersey statute provides: "[A]t least 48 hours shall elapse between the attending physician's receipt of the patient's written request and the writing of a prescription . . . ."[94]

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[87] *See, e.g., Testimony in SUPPORT of HB 2451 RELATING TO HEALTH*; *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH*.

[88] Buchbinder & Pope, *supra* note 83.

[89] Huong Q. Nguyen et al., *Characterizing Kaiser Permanente Southern California's Experience with the California End of Life Option Act in the First Year of Implementation*, 178 JAMA Internal Med. 417 (2018).

[90] James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020). *See also* Debbie Selby et al., *Medical Assistance in Dying (MAiD): A Descriptive Study from a Canadian Tertiary Care Hospital*, 37 Am. J. Hospice & Palliative Med. 58 (2020) (10 days reduced 39% of the time). Lori Seller et al., *Situating Requests for Medical Aid in Dying Within the Broader Context of End-of-Life Care: Ethical Considerations*, 45 J. Med. Ethics 106 (2019); Health Canada, First Annual Report on Medical Assistance in Dying in Canada: 2019, at 6 (2020), https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf (26.5% did not result in a MAID death, because the patients died before receiving MAID). Canadian law permits a waiver of the waiting period if the patient will die or lose capacity before that. S.C. 2016, C-14 (Can.), https://laws-lois.justice.gc.ca/PDF/2016_3.pdf.

[91] End of Life Option Act, Cal. Health & Safety Code § 443.3(b) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-104 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.02 (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-2, -9 (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(4)–(5), (24) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-4 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.810 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(4) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.030, .090 (2020).

[92] Cal. Health & Safety Code § 443.11; Colo. Rev. Stat. § 25-48-112; D.C. Code § 7-661.02(b)–(c); Haw. Rev. Stat. §§ 327L-2, -23; Me. Rev. Stat. Ann. tit. 22, § 2140; N.J. Stat. Ann. §§ 26:16-5, -20; Or. Rev. Stat. §§ 127.810, .897; Wash. Rev. Code § 70.245.220. The Vermont statute does not specify a form, but the state Department of Health has designed forms. https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life. There is variability regarding who may serve as a witness.

[93] D.C. Code § 7-661.02(a)(2); Haw. Rev. Stat. § 327L-11; Me. Rev. Stat. Ann. tit. 22, § 2140(13); N.J. Stat. Ann. § 26:16-10; Or. Rev. Stat. § 127.850(1); Wash. Rev. Code § 70.245.110(2). California and Colorado do not require a 48-hour waiting period after the written request. Oregon's waiver of the oral request waiting period also permits waiver of the written request waiting period. Or. Rev. Stat. §§ 127.840(2), .850(2).

[94] N.J. Stat. Ann. §§ 26:16-10(a)(6).

Unlike the oral request waiting period, this 48-hour requirement typically does not delay patient access, because this waiting period can run concurrent to the oral request waiting period. For example, the patient could make both her first oral request and her written request on January 1.[95] She could make her second oral request on January 16 and receive a prescription that same day. In this example, the patient satisfies ***both*** the oral and written request waiting period requirements in just 15 days.

However, this is not possible in Vermont. There, the written request waiting period runs consecutively to, not concurrently with, the oral request waiting period. The Vermont Patient Choice at End of Life Act requires that the physician not write the prescription until at least 48 hours "after the last to occur" whether that is the patient's written request or the patient's second oral request.[96] Therefore, the minimum total waiting period in Vermont is 17 days. This is the second longest mandatory waiting period after Hawaii's 20 days.

Route of Drug Administration: GI or IV?

MAID statutes vary not only on the duration of oral and written request waiting periods but also in exactly how the patient can take the prescription drug. Every MAID statute requires that the patient herself take the lethal medication. The patient must take the final overt act causing her death. Accordingly, the California End of Life Options Act requires that the patient "has the physical and mental ability to self-administer the aid-in-dying drug."[97] After all, nobody else may administer it to her or for her.[98]

If the physician or another individual administered the lethal medication to the patient, that would be euthanasia.[99] That is not permitted in any U.S. jurisdiction. Legalizing euthanasia has not even been proposed in any U.S. jurisdiction for over thirty years.[100] Self-administration is a consistent centerpiece of U.S. MAID laws.[101]

But while the MAID statutes uniformly require patient self-administration, they use different verbs to describe how the patient may take the drug. Five statutes use the word

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[95] There is some variability regarding when the patient may make her written request. Most states permit it after both physicians have confirmed eligibility. New Jersey permits it at the time of the first oral request. *Id.* §§ 26:16-10(a)(3). The District of Columbia permits it between the first and second oral requests. D.C. Code § 7-661.02(a)(2).

[96] Vt. Stat. Ann. tit. 18, § 5283(a)(12).

[97] Cal. Health & Safety Code § 443.2(a)(5).

[98] Confusingly, the term "MAID" in Canada refers to both patient self-administration and to clinician administration (euthanasia). *See* S.C. 2016, C-14 (Can.), https://laws-lois.justice.gc.ca/PDF/2016_3.pdf.

[99] Compassion in Dying v. Wash., 79 F.3d 790, 840 (9th Cir. 1996) (Beezer, J., dissenting) ("Euthanasia occurs when the physician actually administers the agent which causes death.").

[100] Pope, *supra* note 2.

[101] In contrast, Belgium, Canada, and the Netherlands also permit clinician administration. Australian jurisdictions permit clinician administration only when self-administration is not possible. *See Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016)*, Can. Dep't of Justice, https://www.justice.gc.ca/eng/rp-pr/other-autre/adra-amsr/toc-tdm.html (last modified Jan. 23, 2017).

"ingest."[102] California, for example, requires that the individual "self-administer" the drug which means the "individual's affirmative, conscious, and physical act of administering and ***ingesting*** the aid-in-dying drug to bring about his or her own death."[103] Indeed, the California's End of Life Option Act (EOLOA) uses the term "ingest" fifteen times to refer to the manner by which the patient must take the drug.[104]

This language is legally and practically significant. The term "ingest" indicates that the route of administration is gastrointestinal.[105] This usually means the patient will drink the medication from a cup or straw.[106] But some patients cannot consume the medication orally. Fortunately, for them, there are two other ways to "ingest" drugs. Patients dependent upon clinically assisted nutrition and hydration can press a plunger on a feeding tube.[107] Other patients can press the plunger on a rectal tube.[108]

With any of these three modes of ingestion, clinicians or family members can assist the patient (for example, by opening the medication, by mixing it in a cup, or by inserting a tube), but the patient herself must make the drug enter her body. The California End of Life Options Act emphasizes the distinction between preparing the drug and ingesting the drug. "A person who is present may, without civil or criminal liability, ***assist*** the qualified individual by ***preparing*** the aid-in-dying drug so long as the person does not assist the qualified person in ingesting the aid-in-dying drug."[109] Without this language, preparing the drugs would probably constitute felony assisted suicide.[110]

The remaining four states do not use the word "ingest." Instead, they use broader language like "take"[111] "administer"[112] or "self-administer."[113] Again, this language is legally and practically

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[102] End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443.1(p); Death with Dignity Act of 2016, D.C. CODE §§ 7-661.05(f) & (h)–(i), .09(b), .12, .13(b) (2020); Oregon Death with Dignity Act, OR. REV. STAT. § 127.875 (2020); Maine Death with Dignity Act, ME. REV. STAT. ANN. tit. 22, § 2140(2)(L) (2020); Washington Death with Dignity Act, WASH. REV. CODE § 70.245.010(12) (2020).

[103] CAL. HEALTH & SAFETY CODE § 443.1(p) (emphasis added).

[104] *Id. passim.*

[105] United States v. Ten Cartons, 888 F. Supp. 381, 393–94 (E.D.N.Y. 1995), *aff'd*, 72 F.3d 285 (2d Cir. 1995).

[106] This is usually a powder mixed with liquid. David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. PALLIATIVE MED. 259 (2016); McGehee v. Hutchinson, No. 4:17-cv-00179, ¶ 310 (E.D. Ark. May 31, 2020).

[107] *Id.* ¶ 309.

[108] Email from Kimberly Kirchmeyer, Executive Director of the Medical Board of California, to Gary Johanson, MD (Sept. 6, 2016); Thalia DeWolf, *Rectal Administration of Aid-in-Dying Medications*, AM. CLINICIANS ACAD. ON MED. AID IN DYING, https://www.acamaid.org/rectal-administration-of-aid-in-dying-medications/ (last visited Sept. 14, 2020).

[109] CAL. HEALTH & SAFETY CODE § 443.14(a) (emphasis added).

[110] *See* CAL. PENAL CODE § 401 (2020) ("Any person who deliberately aids . . . another to commit suicide is guilty of a felony.").

[111] Our Care, Our Choice Act, HAW. REV. STAT. § 327L-1 (2020) (defining "self-administer" to means an "individual performing an affirmative, conscious, voluntary act to ***take into the individual's body*** prescription medication to end the individual's life") (emphasis added).

[112] Medical Aid in Dying for the Terminally Ill Act, N.J. STAT. ANN. §§ 26:16-3 (2020).

[113] Colorado End-of-life Options Act, COLO. REV. STAT. § 25-48-102(7), (15) (2020); VT. STAT. ANN. tit. 18, § 5284 (2020).

significant. These verbs permit routes of administration other than gastrointestinal.[114] Most notably, these other statutes permit intravenous administration. So, rather than having to administer the medication through the gut, the patient can inject it with a needle into a vein.[115]

This is important for two reasons. First, some patients cannot effectively take the drugs through a gastrointestinal route.[116] They may have a bowel obstruction, poor absorption, or uncontrolled vomiting. While ingestion may be possible it is not as effective as intravenous administration, especially for these patients.[117] Second, intravenous administration is safer and faster. The rate of complications (like regurgitation) from ingestion is significant in "ingest only" states like Oregon.[118] These complications could be substantially reduced with intravenous administration.[119]

Furthermore, IV administration is workable. Patients self-administer antibiotics and other medications through IV at home.[120] Evidence on this practice shows that home IV therapy is

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[114] *See, e.g.,* Texas Controlled Substances Act, TEX. HEALTH & SAFETY CODE § 481.002 (2020) (defining 'administer" to include "injection, inhalation, ingestion, or other means").

[115] BETTIE LILLEY NOSEK & DEBORAH TRENDEL-LEADER, IV THERAPY FOR DUMMIES (2012). Note that intravenously administered medication would not be the same medication as that which patients orally ingest. Indeed, U.S. clinicians have not yet worked out protocols and procedures for IV self-administration.

[116] *Hearing on H.B. 2217 Before the S. Comm. on Judiciary* (Ore. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/198434 (statement of Charles Blanke); Jody B. Gabel, *Release from Terminal Suffering? The Impact of AIDS on Medically Assisted Suicide Legislation*, 22 FLA. ST. U. L. REV. 369, 426 (1994).

[117] H.B. 2217, 80th Leg. Assemb., Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB2217/A-Engrossed (hearing on May 19, 2019). *See also* QUEENSLAND PARLIAMENT, HEALTH, CMTYS., DISABILITY SERVS. & DOMESTIC & FAMILY VIOLENCE PREVENTION COMM., REP. NO. 34, 56TH PARLIAMENT, VOLUNTARY ASSISTED DYING 43 (2020) (noting that 9 of 52 people to receive MAID in Victoria needed clinician administration because self-administration was not possible).

[118] OREGON HEALTH AUTH., PUBLIC HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2019 DATA SUMMARY 11 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf; WASHINGTON STATE DEPARTMENT OF HEALTH, 2018 DEATH WITH DIGNITY ACT REPORT 13 (July 2019), https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf. These problems were anticipated from the beginning. *See, e.g.,* Timothy Egan*, Suicide Law Placing Oregon on Several Uncharted Paths*, N.Y. TIMES (Nov. 25, 1994), at A1. They even threatened to cause the repeal of the Oregon Death with Dignity Act in 1997. *See, e.g.,* H.B. 2954 (Or. 1997); *Basics on Ballot Measure 51*, OR. LEGIS. POL'Y & RES. OFF. (1997), https://digital.osl.state.or.us/islandora/object/osl%3A4732/datastream/OBJ/view.

[119] Notably, in jurisdictions where both MAID and euthanasia are available, almost no patients use MAID. HEALTH CAN., FOURTH INTERIM REPORT ON MEDICAL ASSISTANCE IN DYING IN CANADA (2019), https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019/medical-assistance-dying-interim-report-april-2019-eng.pdf. In those rare cases when ingestion is used, Canadian clinicians are prepared to offer "IV rescue" as a backup in case oral self-administration is unsuccessful. CHRISTOPHER HARTY ET AL., CANADIAN ASS'N OF MAID ASSESSORS & PROVIDERS, THE ORAL MAID OPTION IN CANADA: PART 1: MEDICATION PROTOCOLS: REVIEW AND RECOMMENDATIONS (2018).

[120] *See generally* Antonella Tonna et al., *Home Self-Administration of Intravenous Antibiotics As Part of an Outpatient Parenteral Antibiotic Therapy Service: A Qualitative Study of the Perspectives of Patients Who Do Not Self-Administer*, 9 BMJ OPEN 1 (2019), https://bmjopen.bmj.com/content/bmjopen/9/1/e027475.full.pdf; Deepak Agrawal et al., *Patients Welcome IV Self-Care; Physicians Hesitate*, NEJM CATALYST (Dec. 6, 2017); Elizabeth D. Mitchell et al., *Clinical and Cost-Effectiveness, Safety and Acceptability of Community Intravenous Antibiotic Service Models: CIVAS Systematic Review*, 7 BMJ OPEN 1 (2017), https://bmjopen.bmj.com/content/bmjopen/7/4/e013560.full.pdf.

safe and cost-effective. Consequently, hospitals are increasingly discharging patients with prescriptions for home IV medications.[121] Still, many physicians are uncomfortable with allowing patients to self-administer IV medications. So, the practice is not yet widespread.[122]

Even with MAID specifically there are precedents for patient intravenous self-administration. Physician advocates Jack Kevorkian and Phillip Nitschke created mechanical devices and used them with patients.[123] Note that while Kevorkian set up the IV line for his first patient, "Mrs. Adkins was the one who pushed the button, which began the flow of pain killer and potassium chloride into her system."[124]

Some object that intravenous administration is prohibited even in states that use broad language to define the permissible routes of drug administration.[125] They point to the following language in every MAID statute: "Nothing in this part may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia."[126]

However, this prohibition does not apply on its face. It does not prohibit lethal injection ***by the patient***.[127] The prohibitory language proscribes only lethal injection by "a physician or any

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[121] *Discharge Instructions: Administering IV Antibiotics,* Fairview, https://www.fairview.org/patient-education/86488 (last visited Sept. 15, 2020).

[122] Kavita P. Bhavan et al., *Achieving the Triple Aim Through Disruptive Innovations in Self-Care* 316 JAMA 2081 (2016).

[123] Nicole Goodkind, *Meet the Elon Musk of Assisted Suicide, Whose Machine Lets You Kill Yourself Anywhere*, Newsweek (Dec. 1, 2017 8:00 AM), https://www.newsweek.com/elon-musk-assisted-suicide-machine-727874; George J. Annas, *Physician Assisted Suicide: Michigan's Temporary Solution*, 328 New Eng. J. Med. 1573 (1993). Gary Schnabel, a pharmacist with the Oregon Board of Pharmacy, also developed a device. Mark O'Keefe & Tom Bates, *Hearings Reveal Confusion about Committing Suicide*, Oregonian (Mar. 15, 1997).

[124] Jennifer Zima, *Assisted Suicide: Society's Response to a Plea for Relief or a Simple Solution to the Cries of the Needs*, 23 Rutgers L.J. 387, 387 n.4 (1992). *See also* Susan Clevenger, Dying to Die - The Janet Adkins Story: A True Story of Dying with the Assistance of Doctor Jack Kevorkian (2019).

[125] Personal communications to author after NCCMAID. Lethal injection was proposed and rejected in early MAID bills and ballot initiatives. Pope, *supra* note 2. However, that was lethal injection by the clinician, not by the patient. *See, e.g.,* Washington Physician-Assisted Death, Initiative 119 (1991).

[126] End of Life Option Act, Cal. Health & Safety Code § 443.18 (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-121 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.15(a) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-18(a) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(20); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-15(a) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.880 (2020); Vt. Stat. Ann. tit. 18, § 5292 (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.180(1) (2020).

[127] Pamela S. Kaufmann, Death with Dignity: A Medical-Legal Perspective, AHLA Long-Term Care and the Law Meeting (Feb. 22, 2017); Council on Psychiatry and Law, APA Resource Document on Physician Assisted Death 8 (2017) (interpreting the "other" as a third person). The language of the prohibition may also not extend to intravenous "infusion" into the blood which is distinct from "injection" which may be intermuscular or subcutaneous.

other person." It references "the individual" as the subject of the injection but not as the agent of the injection.[128] Therefore, this prohibitory language is irrelevant to self-administered MAID.

Legislative history confirms this reading. This "lethal injection" language originated with the 1994 Oregon Death with Dignity Act. The voter pamphlet for the ballot initiative included this language indented under a bold heading that stated: "Under Measure 16, only the dying person may self-administer the medication."[129] This clarifies that "lethal injection" was focused on the agent of administration and not the manner of administration.

An even broader look at the legislative history confirms this. Before 1994, bills and ballot initiatives aimed to legalize both MAID and euthanasia.[130] Those efforts failed because having the physician be the final agent was comparatively more controversial. Therefore, reform efforts since 1994 have focused only on MAID.[131] In short, the point of the prohibition was to authorize MAID yet prohibit euthanasia.[132]

Self-administered IV MAID is consistent with this requirement. It changes only the route of administration, not the agent of administration. The patient ***herself*** pushes the lethal medication. The patient herself causes the "lethal injection." With self-administered IV MAID, the physician only establishes the intravenous line. This is analogous to a third person preparing the medication that the patient then drinks herself.[133] As a recent government report describes it, "the person who provides the assistance, such as a relative or doctor, does not perform the final act that causes the death. The death is caused by the person themselves."[134]

This has already been judicially tested. In December 1990, a Michigan court dismissed criminal charges against Jack Kevorkian for assisting in the death of Janet Adkins. While

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[128] Contrast a new law in Victoria, Australia that permits physician administration when the patient cannot self-administer. That changes not only the *route* of administration but also *who* administers the lethal medication. Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020), http://www.unswlawjournal.unsw.edu.au/wp-content/uploads/2020/06/02-WHITE-ET-AL.pdf.

[129] State of Or. Sec'y of State, Voter's Pamphlet 127 (1994) (although the booklet also says the Measure does not allow "suicide machines").

[130] *See, e.g.,* Initiative 119 (Wash. 1991); S.B. 1141 (Or. 1991); Proposition 161 (Cal. 1992); Allan Parachini, *Bringing Euthanasia Issue to the Ballot Box: Group Sponsors State Initiative to Legalize 'Physician-Assisted Suicide'* , L.A. Times (Apr. 10, 1987), https://www.latimes.com/archives/la-xpm-1987-04-10-vw-165-story.html.

[131] Timothy E. Quill et al., *Sounding Board: Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician Assisted Suicide*, 327 New Eng. J. Med. 1380 (1992).

[132] Several authors of the Oregon Death with Dignity Act opined that it did not prohibit self-administered IV MAID. *See, e.g.,* Mark O'Keefe & Tom Bates, *Hearings Reveal Confusion about Committing Suicide*, Oregonian (Mar. 15, 1997) ("Peter Goodwin . . . a co-author of Measure 16, said, 'My own belief is that medication would cover intravenous medication.'"'); Mark O'Keefe, *House Takes Up Assisted Suicide*, Oregonian (May 13, 1997) ("Cheryl Smith, who helped write Measure 16 . . . said, `I believe that Measure 16 allows a machine like Kevorkian's.'"). There were later extensive hearings about routes of administration. H.B. 2954 (Or. 1997).

[133] *Cf.* Baxter v. State, 224 P.3d 1211, 1217 (Mont. 2009) ("[A] physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act. He or she only provides a means by which a terminally ill patient *himself* can give effect to his life-ending decision").

[134] Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 12 (2020).

Michigan has not affirmatively authorized MAID, it had not yet prohibited it. The court explained that "Mrs. Adkins was the proximate cause of her own death."[135] For the same reason, other Michigan courts dismissed charges against Kevorkian in the deaths of Shery Miller and Marjorie Wantz.[136]

The prohibition on lethal injection is written to require self-administration and thereby prohibit euthanasia. It does not address the route of administration.[137] MAID statutes are silent as to the specific means of self-administration. Consequently, commentators have concluded that despite the prohibition on "lethal injection," "self-administered lethal intravenous infusion . . . may not be prohibited."[138] It is permissible if the patient "pushes a switch to trigger a fatal injection after the doctor has inserted an IV needle."[139]

Furthermore, we can look to Swiss law for guidance. Like U.S. MAID laws, Swiss law requires self-administration. "The final action in the process leading to death must always be performed by the patient."[140] Swiss providers have reconciled this self-administration requirement with IV administration. They openly and regularly have patients administer MAID through IV drips.[141] Some have even developed an "easy to handle remote control" that the patient can "activate through a small movement (e.g. a finger, toe, or jaw) to start the

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[135] George J. Annas, *Physician Assisted Suicide -- Michigan's Temporary Solution*, 20 Ohio N.U. L. Rev. 561 (1993-1994); People v. Kevorkian, No. CR-92-115190 (Mich. Cir. Ct. Oakland Cnty. July 21, 1992).

[136] *Michigan v. Kevorkian*, 9 Issues L. & Med. 189, 200 (1993) ("Ms. Miller pulled the screwdriver which caused the flow of carbon monoxide to commence . . . Ms. Miller took her own life."). *Cf.* Sanders v. State, 112 S.W. 68, 70 (Tex. Crim. App. 1908) (distinguishing furnishing poison from "placing it in the mouth or other portions of the body"), *overruled on other grounds,* 277 S.W. 1080 (Tex. Crim. App. 1925).

[137] *But see Hearing on H.B. 2217 Before the S. Judiciary Comm.*, Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/198274 (statement of Geoff Sugerman, Death with Dignity National Center).

[138] Raphael Cohen-Almagor & Monica G. Hartman, *The Oregon Death with Dignity Act: Review and Proposals for Improvement*, 27 J. Legis. 269, 287 (2001), http://www.ethesis.net/cohen/Oregon.pdf.

[139] Lynn D. Wardle, *A Death in the Family: How Assisted Suicide Harms Families and Society*, 15 Ave Maria L. Rev. 43, 47 n.11 (2016-2017).

[140] Swiss Acad. of Med. Scis., *Medical-Ethical Guidelines: Management of Dying and Death*, 148 Swiss Med. Weekly w14664 § 6.2.1 (2018), https://smw.ch/article/doi/smw.2018.14664.

[141] *See, e.g., Swiss Law & Requirements*, Pegasos Swiss Ass'n, https://pegasos-association.com/requirements/ ("Pegasos offers VAD using intravenous transfusion, and even though it is a doctor who will insert the cannula into the person's arm, it is the person, themselves, who must activate the drip delivering the drug."); Dignitas, Dignitas Brochure 7 (15th ed. 2019), http://www.dignitas.ch/images/stories/pdf/informations-broschuere-dignitas-e.pdf ("In every case, for legal reasons, the patient must be able to undertake the last act . . . to open the valve of the intravenous access tube") [hereinafter Dignitas]. *See also* Luke Harding, *A Little Sightseeing, a Glass of Schnapps, then a Peaceful Death in a Suburban Flat*, Guardian (Dec. 4, 2004), https://www.theguardian.com/society/2004/dec/04/health.medicineandhealth1 (interview with Ludwig Minelli, founder of Dignitas Clinic); Susan Stefan, Rational Suicide, Irrational Laws: Examining Current Approaches to Suicide in Policy and Law (American Psychology-Law Society Series 190 (1st ed. 2016); Daniel Sperling, Suicide Tourism: Understanding the Legal, Philosophical, and Socio-political Dimensions 33 (2019); Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 34 & n.182 (2020).

attached pump."[142] They even videotape the procedure to document that the patient opened the valve all by herself.[143] There is no legal obstacle to administering MAID the same way in Colorado, Hawaii, New Jersey, and Vermont.

OTHER VARIATIONS AMONG U.S. MAID STATUTES

We have examined five ways in which U.S. MAID statutes vary. Two concern patient eligibility requirements: (1) how to assess the patient's state residency, and (2) how to assess the patient's decision-making capacity. Three differences concern the manner of accessing MAID: (3) the duration of the oral request waiting period, (4) the duration of the written request waiting period, and (5) the permitted route of drug administration.

But the nine MAID statutes vary not only in terms of eligibility and procedural requirements but also along five other dimensions.[144] These include: (a) how clinicians can assert conscience-based objections, (b) how facilities can assert conscience-based objections, (c) whether assessment and counseling can be done through telehealth, (d) how death certificates are completed, (e) how states collect and report data, and (f) whether the statute includes a sunset clause.

Conscience-Based Objections by Clinicians

Every MAID statute makes participation voluntary not only by patients but also by clinicians and facilities.[145] Individual clinicians may assert a conscience-based or personal objection and they cannot be punished for refusing to participate.[146] This means that clinicians can refuse to discuss or educate the patient on eligibility or process. They can refuse to conduct eligibility

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[142] Dignitas, How Dignitas Works 16 (May 2014), http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf.

[143] George Mills, *What You Need to Know About Assisted Suicide in Switzerland*, Local (May 10, 2018), https://www.thelocal.ch/20180503/what-you-need-to-know-about-assisted-death-in-switzerland.

[144] There are also other variations. For example, will state Medicaid (or other insurance) pay for MAID consultations and prescriptions? Must facilities post their policies on MAID? How should patients and families dispose of unused drugs? Yet, many of these rights and obligations come from other sources of law, not from the MAID statutes themselves. *See, e.g.,* H.B. 2326, 66th Leg., Reg. Sess. (Wash. 2019), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Bills/2326-S.pdf?q=20200915125826. *But cf.* S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf.

[145] End of Life Option Act, Cal. Health & Safety Code § 443.14(e) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-117 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.10(a) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-19(a)(2) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(21) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.885(2), (4) (2020); Vt. Stat. Ann. tit. 18, § 5285 (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.190(1)(b), (d) (2020).

[146] While physicians play a central role, MAID also involves pharmacists, non-physician mental health specialists like social workers and psychologists. Cal. Health & Safety Code § 443.1(l); Colo. Rev. Stat. § 25-48-102(6); Me. Rev. Stat. Ann. tit. 22, § 2140(2)(E) (also including clinical social workers and clinical professional counselors); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-3 (2020) (including clinical social worker).

assessments, write prescriptions, or fill prescriptions for MAID. They can even refuse to make or assist referrals to participating providers.

But the right to refuse is not unlimited. When the patient finds a new physician who is willing to participate, the original objecting physician must transfer the patient's medical records and must do that even if they think it makes them complicit in what they judge to be an immoral act.[147]

The scope of permitted refusal is narrower in Vermont. Most MAID statutes permit objecting physicians not to inform a patient regarding his or her rights and not to refer the patient to a physician who participates.[148] But Vermont has a separate end-of-life informed consent rights statute.[149] A federal court interpreted this statute to require that objecting physicians must either inform patients about their MAID rights or refer them somewhere they can learn their options.[150]

Conscience-Based Objections by Facilities

Not only individual clinicians but also health care entities assert conscience-based objections—many facilities have opted-out. For example, few religiously affiliated institutions participate with MAID.[151] But what about non-objecting individual clinicians that work for such entities (as either employees or independent contractors)? May they participate when their hospital or health care system has opted out?

MAID statutes in every state permit health care facilities to prohibit their employees and staff from participating with MAID while on the premises or while acting within the purview of the entity.[152] The general understanding has been that such clinicians may participate in MAID on their own time. In Colorado, however, a large Catholic system is litigating a claim

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[147] Cal. Health & Safety Code § 443.14(e)(3); Colo. Rev. Stat. §§ 25-48-113(2), -117; D.C. Code § 7-661.10(b); Haw. Rev. Stat. § 327L-19(a)(4); Me. Rev. Stat. Ann. tit. 22, § 2140(21); N.J. Stat. Ann. § 26:16-17(c); Or. Rev. Stat. § 127.885(4); Wash. Rev. Code § 70.245.190(1)(d).

[148] *See, e.g.,* Cal. Health & Safety Code § 443.14(e)(2).

[149] Vt. Stat. Ann. tit. 18, § 5282.

[150] Vt. All. for Ethical Health Care v. Hoser, 274 F. Supp. 3d 227 (D. Vt. Apr. 5, 2017) (citing Vt. Stat. Ann. tit. 18, § 1871 and Vt. Stat. Ann. tit. 12, § 1909(d)). *Cf.* Mara Buchbinder, *Aid in Dying Laws and the Physician's Duty to Inform,* 43 J. Med. Ethics 666 (2017).

[151] Cindy L. Cain et al., *Hospital Responses to the End of Life Option Act: Implementation of Aid in Dying in California*, 179 JAMA Internal Med. 985 (2019). With mergers and consolidation, fewer health systems may participate in the future. *See* Ian D. Wolfe & Thaddeus M. Pope, *Hospital Mergers and Conscience-Based Objections — Growing Threats to Access and Quality of Care,* 382 New Eng. J. Med. 1388 (2020); Harris Meyer, *Proposed Virginia Mason-CHI Franciscan Merger Increases Worry about Catholic Limits on Health Care in Washington State*, Seattle Times (Aug. 3, 2020, 8:24 AM), https://www.seattletimes.com/seattle-news/health/proposed-virginia-mason-chi-franciscan-merger-increases-worry-about-catholic-limits-on-health-care-in-washington-state/.

[152] Cal. Health & Safety Code §§ 443.15–.16; Colo. Rev. Stat. § 25-48-118; D.C. Code § 7-661.10(c)-(e); Haw. Rev. Stat. § 327L-19(b)–(e); Me. Rev. Stat. Ann. tit. 22, § 2140(22); Or. Rev. Stat. § 127.885(5); Vt. Stat. Ann. tit. 18, § 5286; Wash. Rev. Code § 70.245.190(2). The New Jersey statute does not contain this language.

that it can prohibit its physicians from participating in MAID even when they act outside the purview of their employment.[153]

Telehealth Assessment and Counseling

Particularly since the COVID-19 pandemic, there has been an increased interest in and use of telehealth.[154] This includes MAID.[155] Indeed, a new professional society, the American Clinicians Academy on Medical Aid in Dying (ACAMAID) released guidance on how to provide MAID through telehealth.[156]

The Hawaii MAID statute addresses telehealth explicitly in the context of the mental health counseling. This is the third clinical assessment for determining that the patient is capable and does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with her ability to make an informed decision.[157] The Hawaii law states that these mental health consultations with a psychiatrist, psychologist, or clinical social worker "may be provided through telehealth."

But what about the attending and consulting physician who assess terminal illness and capacity?[158] No U.S. MAID statute specifically says that may be done by telehealth, and none specifically prohibits it. Consequently, one might conclude that clinicians may provide MAID through telehealth to the same extent as they can provide other health care services through telehealth.

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[153] Morris v. Centura Health Corp., No. 2019-CV-31980 (Arapahoe Cnty. Dist. Ct., Colo., Dec. 20, 2019). Relatedly, the U.S. Supreme Court is hearing a case that questions the thirty-year old rule that government can enforce laws that burden religious beliefs or practices as long as the laws are "neutral" or "generally applicable." Fulton v. City of Phila., Pa., No. 19-123 (U.S. Nov. 4, 2020) (oral argument). Federal regulations may permit an even broader scope of conscience-based refusal. Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2019) (to be codified at 45 C.F.R. pt. 88). These regulations have been enjoined and those injunctions are on appeal. New York v. U.S. Dept. Health & Human Servs., No. 19-4254 (2d Cir. 2020); City and County of San Francisco v. Azar, No. 20-35044 (9th Cir. 2020).

[154] Cathleen Calhoun, *Strategic Perspectives: Telehealth Has Taken a Giant Step Forward, But Will the Momentum Continue?*, Wolters Kluwer Health L. Daily (May 20, 2020).

[155] *See* Konstantin Tretyakov, *Medical Aid in Dying by Telehealth*, 30 Health Matrix 325 (2020), https://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?article=1650&context=healthmatrix.

[156] Comm. to Evaluate Telemedicine for Aid-in-Dying Requests in the Context of the Coronavirus Epidemic, *Telemedicine Policy Recommendations*, Am. Clinicians Acad. on Med. Aid in Dying (Mar. 25, 2020), https://cpsns.ns.ca/wp-content/uploads/2020/09/Medical-Assistance-in-Dying-Standard-Temporary-Amendment-Mar-27-2020-Sept-18-2020.pdf. Medical licensing boards in other jurisdictions have also issued telehealth guidance during the COVID-19 pandemic. *See, e.g.,* Coll. of Physicians & Surgeons of N.S., Temporary Amendments to the College's MAiD Standard (2020), https://cpsns.ns.ca/wp-content/uploads/2020/09/Medical-Assistance-in-Dying-Standard-Temporary-Amendment-Mar-27-2020-Sept-18-2020.pdf; College of Physicians and Surgeons of British Columbia, *Practice Standard: Medical Assistance in Dying* (Mar. 26, 2020).

[157] Haw. Rev. Stat. § 327L-1.

[158] *Cf.* S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf (allowing telehealth for all clinicians when the patient is unable to leave her residence).

On this analysis, telehealth for MAID is not equally available in every state. For example, in Vermont, telehealth can only be provided in the context of a "[b]ona fide physician-patient relationship."[159] That requires not only assessment of the patient's medical history and current medical condition but also a "personal physical examination."[160] So, both the attending and consulting physician must have visited with the patient in person before or concurrent with providing MAID.

Other constraints may also be manageable. For example, California requires that the physician "[c]onfirm that the qualified individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, ***outside of the presence*** of any other persons."[161] While it may be more difficult to know that the patient is alone when meeting through a phone or computer camera, the physician can confirm this by asking the patient to move the camera around the room.[162]

Death Certificate Completion

While most provisions in MAID statutes focus on how patients may obtain MAID, some provisions address what happens ***after*** MAID. One perennially controversial issue concerns whether the patient's death certificate identifies MAID as the cause of death. Here, the states take three different approaches.[163]

Four MAID statutes prohibit MAID from being listed as the cause of death on the patient's death certificate. Instead, the death certificate must list the underlying terminal illness.[164] In four other states the statute is silent, but state agency guidance directs listing the underlying terminal illness.[165] For example, the California Department of Public Health states:

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[159] Vt. Stat. Ann. tit. 18, § 5281(1) (2020).

[160] *Id.*

[161] End of Life Option Act, Cal. Health & Safety Code § 443.5(a)(4) (2020).

[162] Konstantin Tretyakov, *Medical Aid in Dying by Telehealth*, 30 Health Matrix 325, 343 (2020).

[163] Canadian provinces also vary in whether they require or prohibit MAID from being listed as the cause of death. Janine Brown et al., *Completion of Medical Certificates of Death After an Assisted Death: An Environmental Scan of Practice*s, 14 Healthcare Pol'y 59 (2018).

[164] Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-109(2) (2020); D.C. Code § 7-661.05(h); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-4(b) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.040(2) (2020). Many bills in prospective MAID states also require listing the terminal illness. *See, e.g.,* A.B. 2694 § 2899-p, Reg. Sess. (N.Y. 2019), https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A02694&term=2019&Summary=Y&Text=Y.

[165] New Jersey Medical Aid in Dying for the Terminally Ill Act Frequently Asked Questions 3–4 (July 31, 2019), https://www.state.nj.us/health/advancedirective/documents/maid/MAID_FAQ.pdf ("NJDOH Office of Vital Statistics and Registry recommends that providers record the underlying terminal disease as the cause of death and mark the manner of death as 'natural'."); Or. Health Auth., *Frequently Asked Questions: Oregon's Death with Dignity Act (DWDA),* Oregon.gov, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/faqs.aspx#deathcert (last visited Sept. 14, 2020) (same); Vt. Dep't of Health, Report to the Vermont Legislature: Report Concerning Patient Choice at the End of Life 4 (2018), https://legislature.vermont.gov/assets/Legislative-Reports/2018-Patient-Choice-Legislative-Report-12-14-17.pdf ("100% of the death certificates listed the appropriate cause (the underlying disease) and manner of death (natural), per Act 39 requirements.").

"Certifiers . . . report the underlying terminal disease as the cause of death on the death certificates. This approach complies with applicable law . . . and effectuates the California Legislature's intent to maintain the confidentiality of individuals' participation in the Act."[166] Only Maine offers no guidance on whether to list MAID on the patient's death certificate.[167]

Data Collection and Reporting

Conscience-based objection and telehealth affect how patients access MAID, but the states also vary in how they collect and report data. Every MAID statute requires that state agencies publish annual reports on usage.[168] The data reports from the first two states (Oregon and Washington) demonstrate a strong safety record that paved the way for enactment of legislation in the subsequent seven states.[169]

But the states vary in terms of what information they collect and report.[170] Oregon and Washington collect and report the broadest range of data. California does less.[171] Colorado, Vermont, and Washington, DC collect and report the least.[172] This variability is unfortunate, because reform is more difficult when one knows less about how the law is working.[173]

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[166] Cal. Dep't of Public Health, California End of Life Option Act 2019 Data Report 5 (2020), https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPHEndofLifeOptionActReport2019%20_Final%20ADA.pdf. *But see Document #3459: The California End of Life Option Act* ¶ 26, CMA Legal Counsel (2016), https://www.uclahealth.org/workfiles/eol/cma-guidance-end-of-life-option-act-on-call.pdf (directing physicians to list the cause "they feel is the most accurate").

[167] Maine legislation originally followed the approach taken in Colorado, DC, Hawaii, and Washington, but as in California and Vermont, that was amended in later versions of the bill.

[168] End of Life Option Act, Cal. Health & Safety Code §§ 443.9, .19 (2020); Colo. Rev. Stat. § 25-48-111(2); D.C. Code § 7-661.07; Haw. Rev. Stat. §§ 327L-14, -25; Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(17) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. § 26:16-13 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.865 (2020); Wash. Rev. Code § 70.245.150.

[169] N.J. Stat. Ann. § 26:16-2(b). Oregon and Washington data were also important to reform in jurisdictions around the world. *See, e.g.,* Carter v. Canada (Attorney General), 2013 BCCA 435, https://www.canlii.org/en/bc/bcca/doc/2013/2013bcca435/2013bcca435.html.

[170] Jean T. Abbott et al., *Accepting Professional Accountability: A Call for Uniform National Data Collection on Medical Aid-In-Dying*, Health Aff. Blog (Nov. 20, 2017), https://www.healthaffairs.org/do/10.1377/hblog20171109.33370/full/ [hereinafter Abbott et al.]. This study was published before Maine and new Jersey enacted their statutes, but that would not change the analysis, although the state agencies could promulgate regulations that promote the collection ad reporting of broader data. *See* Me. Rev. Stat. Ann. tit. 22, § 2140(17); N.J. Stat. Ann. § 26:16-13.

[171] But in addition to the annual DOH reports, the California Assembly holds periodic hearings on the implementation of the EOLOA. *See, e.g.,* Cal. State Assembly, Assembly Select Committee on End of Life Health Care, Tuesday, February 25th, 2020, https://www.assembly.ca.gov/media/assembly-select-committee-end-life-health-care-20200225/video.

[172] Abbott et al.

[173] *See* Thaddeus M. Pope, *Extrajudicial Resolution of Medical Futility Disputes: Key Factors in Establishing and Dismantling the Texas Advance Directives Act*, *in* International Perspectives on End of Life Reform: Politics, Persuasion, and Persistence (Ben White & Lindy Wilmott eds., forthcoming 2021); Health Canada, First Annual Report on Medical Assistance in Dying in Canada, 2019 9 (2020), https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf ("Nearly all countries that permit some form of medically assisted dying consider public reporting to be a critical component to support transparency and foster public trust in the application of the law.").

Sunset Clauses

The future of most MAID statutes has been threatened by litigation or legislation.[174] But as enacted, those laws were intended to be permanent options. None was enacted on a trial or pilot basis.[175]

In contrast, when California enacted its End of Life Option Act during an extraordinary legislative session in October 2015, it included a sunset clause.[176] "This part shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date."[177] Unlike other MAID statutes, the EOLOA expires.[178] Therefore, unless reauthorized, MAID will cease to be a legal practice in California.[179]

FORTHCOMING VARIATIONS

The previous sections described current differences among U.S. MAID laws, but the variability will likely continue to grow as states continue studying "barriers to access."[180] Many are already seeking to recalibrate the balance between safety and access.[181]

Two aspects of MAID laws are especially primed for change: scope of practice and terminal illness. The states are currently uniform in permitting only physicians to provide

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[174] *See, e.g.,* Ahn v. Hestrin, No. RIC-1607135 (Riverside Cnty. Sup. Ct., Cal.), https://compassionandchoices.org/legal-advocacy/recent-cases/ahn-v-hestrin/; Glassman v. Grewal, No. MER-C-53-19 (Mercer Cnty. Sup. Ct., NJ), https://compassionandchoices.org/legal-advocacy/recent-cases/glassman-v-grewal/.

[175] While the Vermont statute's legalization of MAID was permanent, the procedural safeguards were initially designed to sunset. *See* Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.05 (3rd ed. 2020).

[176] A.B. 15 (Cal. 2015), codified at End of Life Option Act, Cal. Health & Safety Code §§ 443 to 443.22 (2020). The law went into effect on June 9, 2016.

[177] Cal. Health & Safety Code § 443.215.

[178] *Id.*

[179] Without the EOLOA, MAID would be a felony in California. Cal. Penal Code § 401(a) (2020) (Any person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony.").

[180] H.B. 2419, Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200915155130 (passed both chambers but vetoed on April 3, 2020 because of COVID-19); Cal. State Assembly, Assembly Select Committee on End of Life Health Care, Tuesday, February 25th, 2020, https://www.assembly.ca.gov/media/assembly-select-committee-end-life-health-care-20200225/video. *See also* Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417, 442–43 (2020) (noting that many patients "find the process overwhelming and too difficult to navigate" and that "few medical practitioners will agree to be involved"); Rosalind McDougall & Bridget Pratt, *Too Much Safety? Safeguards and Equal Access in the Context of Voluntary Assisted Dying Legislation*, 21 BMC Med. Ethics 1 (2020), https://bmcmedethics.biomedcentral.com/track/pdf/10.1186/s12910-020-00483-5 (arguing that aiming to maximize safety has negative implications for access).

[181] Not every new bill seeks to expand access. For example, one of the newer MAID statutes, in Hawaii, added or increased several procedural requirements. Buchbinder & Pope, *supra* note 83. More recently, a Maryland bill would have significantly constrained access. Md. S.B. 311 / H.B. 399 (2019). On the other hand, states can also expand access through non-legal means like public education and provider outreach.

MAID. However, some states are likely to allow APRNs to provide MAID. The states are also currently uniform in how they define terminal illness, but some states are likely to define terminal illness more broadly than a six-month prognosis. The states may also diverge along several other dimensions.

Scope of Practice: MD or APRN?

Every U.S. MAID statute now requires that both the attending and the consulting clinician (who assesses eligibility, provides counseling, and writes the prescription) be a physician. While most statutes are more flexible about who can perform the mental health assessment (*e.g.* clinical social worker or psychologist), none permit a non-physician to otherwise determine eligibility or write the prescription.

But limiting MAID to physicians constrains access to MAID, especially in rural areas where there is a shortage of physicians. In response, some states have proposed legislation that would allow APRNs to perform these tasks.[182] Already, 6% of MAID in Canada is performed by APRNs,[183] and this makes sense. Across the United States, many states have already expanded scope of practice to permit APRNs to assess capacity and write POLST orders regarding life-sustaining treatment.[184]

Terminal Illness: Six Months or Longer

Every U.S. statute now requires that the patient have a terminal illness. This is typically defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”[185] Both the attending and consulting physician must certify a prognosis that the patient has a terminal disease that will cause her death within six months.

At first glance, the six-month prognosis seems reasonable. It aligns with the eligibility for hospice under Medicare.[186] Hospice, a program of care and support for people who are

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[182] S.B. 2582, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB2582_SD1_.pdf; S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf; H.B. 171, Reg. Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/house/HB0171.pdf (also extending to physician assistants); S.B. 252, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252JUS.pdf (same); A.B. 10059 (N.Y. 2016), https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A10059&term=2015&Summary=Y&Text=Y. MN. *See also* Western Australia Voluntary Assisted Dying Act of 2019 § 54(1)(a), http://www.austlii.edu.au/cgi-bin/viewdb/au/legis/wa/consol_act/vada2019302/. *See also Testimony in SUPPORT of HB 2451 RELATING TO HEALTH* Before the H. Comm. on Health (Haw. 2020); *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH Before the S. Comm. on Commerce, Consumer Protection, & Health* (Haw. 2020).

[183] James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass’n J. E173 (2020).

[184] Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 7.10A (3rd ed. 2020).

[185] Our Care, Our Choice Act, Haw. Rev. Stat. § 327L-1 (2020).

[186] 42 C.F.R. §§ 418.3, .20 (2020).

terminally ill, focuses on comfort (palliative care) rather than curing illness. Because there are over 4000 hospices used by more one million patients each year, this six-month terminal illness requirement is familiar and salient.[187]

But the six-month requirement has been a big limit on MAID access.[188] Among other things, it wrongly assumes that life expectancy can always be accurately predicted.[189] The arbitrary time scale has meant that patients with cancer are the primary users of MAID. While cancer deaths comprise just 20% of total deaths, cancer accounts for 80% of MAID. Canadian studies have found that an even more flexible standard substantially limits access.[190]

In response, current MAID states have sought to amend their statutes to relax the temporal limit.[191] For example, Oregon has considered bills to extend the terminal illness requirement from six months to ***twelve months***.[192] Bills in other states go even further, eliminating the temporal requirement altogether. For example, a New Mexico bill defines terminal illness as a "disease or condition that . . . will result in death ***within a reasonable time***."[193] Such a standard has proven workable in Canada for years.[194]

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[187] *National Center for Health Statistics*: *Hospice Care,* CDC, https://www.cdc.gov/nchs/fastats/hospice-care.htm (last visited Sept. 15, 2020).

[188] Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 120 (2020); Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020).

[189] *See* All-Party Parliamentary Grp. for Terminal Illness, Six Months to Live?: Report of the All-Party Parliamentary Group for Terminal Illness Inquiry into the Legal Definition of Terminal Illness (2019), https://www.mariecurie.org.uk/globalassets/media/documents/policy/appg/all-party-parliamentary-group-for-terminal-illness-report-2019.pdf.

[190] Truchon v. Procureur Général du Canada, 2019 QCCS 3792, https://www.canlii.org/fr/qc/qccs/doc/2019/2019qccs3792/2019qccs3792.html [hereinafter Truchon].

[191] H.B. 2419, Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200915162544 (commissioning a study on barriers to access).

[192] H.B. 2232, 80th Leg. Assemb., Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB2232/Introduced [hereinafter Or. H.B. 2232].

[193] H.B. 171 § 2(F), 53rd Leg., 1st Sess. (N.M. 2017) (emphasis added).

[194] *Truchon*, *supra* note 190. Even though this is a comparatively flexible standard compared to the U.S. terminal illness requirement, the Quebec court held it unconstitutional, since it is more restrictive than the Supreme Court of Canada judgment that declared a right to MAID.

Other Future Variations

Variability along other dimensions is not as likely as variability in terms of scope of practice and terminal illness. However, there are ongoing academic and policy debates concerning whether MAID should be available: (1) to mature minors,[195] (2) through advance requests,[196] and (3) through third party administration.[197]

CONCLUSION

Medical aid in dying is a legal end-of-life option for one in four Americans. It is, however, one of the most heavily regulated health care services. The scope and manner of that regulation already varies materially across the eleven U.S. MAID jurisdictions. As more states enact MAID statutes and as current states amend their existing statutes, variability is likely to increase. Innovation and non-conformity are positive developments. States considering reform are now less likely to blindly copy and paste older statutes and more likely to engage in "critical review."[198]

In 1997, the U.S. Supreme Court observed: "Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[199] More than two decades later, the debate is continuing. Innovation is continuing in the "laboratory of the states."[200] Over the next five years, we will see more states legalize MAID.[201] We will also see more differences among MAID states as some move to recalibrate the balance between access and safety.

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[195] Council of Canadian Acads., The State of Knowledge on Medical Assistance in Dying for Mature Minors: The Expert Panel Working Group on MAID for Mature Minors (2018), https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-for-Mature-Minors.pdf.

[196] S.B. 893, 79th Leg. Assemb., Reg. Sess. (Or. 2017), https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/SB893/Introduced [hereinafter Or. S.B. 893]; S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf. *See also* Council of Canadian Acads., The State of Knowledge on Advance Requests for Medical Assistance in Dying: The Expert Panel Working Group on Advance Requests for MAID (2018), https://cca-reports.ca/wp-content/uploads/2019/02/The-State-of-Knowledge-on-Advance-Requests-for-Medical-Assistance-in-Dying.pdf. *Cf.* Nicholas Goldberg, *California's Aid in Dying Law is Working: Let's Expand It to Alzheimer's Patients*, LA Times (July 15, 2020); Elie Isenberg-Grzeda et al., *Legal Assistance in Dying for People with Brain Tumors,* Annals Palliative Med. 1, 4 (2020), http://apm.amegroups.com/article/view/48382/pdf ("Patients with neurologic disease . . . sought MAID earlier in their illness trajectory than if the law allowed for an advanced directive to choose MAID.").

[197] *See, e.g.,* Or. S.B. 893 (2017) (allowing request by agent); Or. H.B. 2232 (2019) (changing definition of "self-administration").

[198] Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020); Taimie Bryant, *Aid-in-Dying Nonprofits*, 57 San Diego L. Rev. 147, 185, 217 (2020). *Cf.* Ed Longlois, *Efforts to Expand Assisted Suicide Underway,* Catholic Sentinel (Oct. 9, 2020).

[199] Wash. v. Glucksberg, 521 U.S. 702, 735 (1997).

[200] *Id.* at 737 (O'Connor, J., concurring).

[201] These states will probably include Maryland, Massachusetts, New Mexico, and New York.

SUMMARY OF VARIATIONS AMONG MAID LAWS

	CA	CO	DC	HI	ME	NJ	OR	VT	WA
Indicia of residency	4	4	16	4	9	4	4	4	3
Minimum capacity assessments	2	2	2	3	2	2	2	2	2
Minimum total waiting period (days)	15	15	15	20	15	15	0	17	15
Route of administration	GI	Any	GI	GI	Any	Any	GI	Any	GI
Conscience based objection by clinicians	B	B	B	B	B	B	B	N	B
Conscience based objection by institutions	B	XB	B	B	B	B	B	B	B
Death certificate	TI	TI	TI	TI	MAID	TI	TI	TI	TI
Data collection & reporting	B	N	N	M	TBD	TBD	B	N	B
Sunset clause	Yes	No	No	No	No	No	No	No	No

B (broad), GI (gastrointestinal), M (medium), N (narrow), X (extra)

Author Profile

THADDEUS MASON POPE is a foremost expert on medical law and clinical ethics. He maintains a special focus on patient rights and health care decision-making.

Thaddeus is the Director of and Professor at the Health Law Institute at Mitchell Hamline School of Law in Saint Paul, Minnesota. While he serves in a range of consulting capacities, he has been particularly influential through his extensive high-impact scholarship. Ranked among the Top 20 most cited health law scholars in the United States, Thaddeus has over 225 publications in leading medical journals, bioethics journals, and law reviews. He coauthors the definitive treatise The Right to Die: The Law of End-of-Life Decisionmaking, and he runs the Medical Futility Blog (with over four million page-views). Prior to joining academia, Thaddeus practiced at Arnold & Porter and clerked on the U.S. Court of Appeals for the Seventh Circuit. He earned a JD and PhD from Georgetown University. Contact him via email at thaddeus.pope@mitchellhamline.edu.

This Article is adapted from a February 14, 2020 presentation at the National Clinicians Conference on Medical Aid in Dying in Berkeley, California (http://www.nccmaid.org). This conference was the launch of a new professional health care association, the American Clinicians Academy on Medical Aid in Dying (https://www.acamaid.org/). For comments on earlier drafts, thanks to physicians Lonny Shavelson and Charles Blanke; attorneys Robert Rivas, Kathryn Tucker, Kevin Diaz, and Eliana Close; advocates Barbara Coombs Lee, Kim Callinan, and Betsy Walkerman; and the American Health Law Association editorial advisory board.

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HEALTH LAW
ASSOCIATION

1099 14th Street, NW, Suite 925 • Washington, DC 20005
(202) 833-1100 • Fax (202) 833-1105 • www.americanhealthlaw.org

HB-1823
Submitted on: 1/30/2022 6:45:58 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Roxanne Haverkort-Yeh	Individual	Support	No

Comments:

I am writing to express **support** of HB 1823.

HB-1823
Submitted on: 1/30/2022 6:52:52 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Matt Bishop	Individual	Support	No

Comments:

I support this measure as it is presented. One of the most important steps that Hawaii needs to take to solve our healthcare crisis is to allow all advanced practice registered nurses to function to the full extent of their license and training! This measure is one more way that the people of Hawaii can have access to safe, competent care when they need it most!

HB-1823
Submitted on: 1/30/2022 7:11:49 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
stephanie marshall	Individual	Support	No

Comments:

Dear Representative Yamane,

I am a retired oncology nurse and also a retired faculty from UH Manoa school of nursing. I have supported this bill from the beginning. In over forty years of nursing I have seen many patients suffer needlessly from not being able to make a choice of how they die. I followed this law and saw it implemented , also saw the data that validates that these amendments need to be passed.
As a nursing faculty, I now attest to the fact that APRNS are fully competent to perform the role of attending or consulting provider. The percentage of patients that can not meet the 21 day mandate is not acceptable I ask you to move this bill forward for the benefit of those patients who access this law please provide this relief to those who are in their final days

Sincerely,

Stephanie Marshall, RN, FAAN

Re: HB 8123

To Chair Ryan Yamane, Vice Chair Adrian Tam and Members of the Committee,

My name is Susan Amina and I am a Advance Practice Registered Nurse. Since the Our Care, Our Choice Act took effect on January 1, 2019 I, along with another coordinator, have helped navigate over 130 people interested in the medical aid in dying option. Unfortunately, many were not able to obtain the medication as they died before the mandatory 20 day waiting period. In 2021, based on our experience, 13 of the 30 people who died a natural death did so before the second oral request. Those individuals met all the eligibility requirements; however, due to the 20-day roadblock in the law, they could not access the compassionate option of medical aid in dying. It was devastating to family members knowing that their loved ones qualified for and wanted this option; however, could not access it due to their imminent death. Hawai'i currently has the longest waiting period between the first and second oral request for medical aid in dying of the 11 authorized U.S. jurisdictions, the majority have 15 days. In California and New Mexico, the waiting period in 48 hours.

I ask on behalf of patients and families to amend the law to:

- Reduce the current mandatory 20 day waiting period between oral requests to 15 days to improve access for the terminally ill seeking this option.
- Allow the attending provider the authority to waive the mandatory minimum 20-day waiting period if the eligible patient is unlikely to survive the waiting period (the patient must still be evaluated by the three providers: attending, consultant and mental health).

I am employed on O'ahu and work with an excellent team of providers who evaluate the patients in a timely manner. My colleagues on the neighbor islands are less fortunate as it is a struggle for them to find providers. The disparity in access to the Our Care, Our Choice act between O'ahu and the neighbor islands is inequitable and unfair. The compassionate medical aid in dying option is for all Hawai'i residents despite where they live in.

Advance Practice Registered Nurses have an advanced education, broad scope of practice and prescriptive authority which allows them to evaluate, diagnose, and treat a wide range of conditions. We can project the outcome of diseases based on our training and clinical experience. If there is a question regarding prognosis, we would consult with a specialist as my physician partner did recently. As a Nurse Practitioner, I approach patient care with the perspective of, “if this was my mother …” and provide compassionate and high-quality care. On the neighbor island there is a good chance “my mother” would die before starting or completing the process.

I ask you on behalf of patients and families who live on all the Hawaiian Islands to amend the law to:

- Allow qualified Advance Practice Registered Nurses support patients with the option of medical aid in dying by acting as the attending, consulting, or mental health provider.

Thank you for your time and attention to this matter.

Sincerely,

Susan Amina, MSN, RNC, FNP

HB-1823
Submitted on: 1/30/2022 9:15:09 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Bob Grossmann	Individual	Support	No

Comments:

All the proposed amendments will strengthen this important bill.

HB-1823

Submitted on: 1/30/2022 9:24:48 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
hitomi nakaoka	Individual	Oppose	No

Comments:

I am opposed to this bill. I believe in the sanctity of life and believe it should be protected at every stage.

My name is Dr. Charlotte Charfen, and I am a board-certified emergency physician that practices emergency medicine on the Big Island in North Kohala and Kona. I am providing written testimony in **support** of HB 1823 which makes very necessary improvements to the Our Care, Our Choice Act.

Because of my ER work over 20 years across our nation, I have come to realize the severe lack of communication and discussion when it comes to end-of-life issues. I see how that often translates into fear and suffering for the patient, families and medical providers. This led me to create a nonprofit called Life & Death Wellness to educate and support about all life matters, especially the end-of-life.

In doing this work, I have now helped several patients that have attempted to access the Our Care Our Choice Act. Some were successful. Many were not. I have seen first-hand the many flaws in this law although I am still very grateful for its existence. I developed cancer last year and had to step back from helping patients. I saw just how fragile the outer islands really are. I was one of three physicians willing to help dying patients with this option. Without me in the workforce, the entire island only had two physicians willing to participate that were completely overwhelmed with requests and their own private patient loads. That is a sad testament to how this law needs change.

I am in full support of amending the law so that more of our residents, especially on outer islands, can have access. To date, I am one of only one three physicians that has prescribed on the Big Island. That is multifactorial I am sure. But I do work with advance nurse practitioners that would be willing to help make this choice more accessible if not enough physicians are prepared. And right now, that appears to be the case at least on my island. I have now helped twelve patients get access. All of them found me because their own physicians would not or were not allowed to help them due to the hospital system they belonged. Some have gone so far as to be blatantly condescending and cruel when they were approached by the patients that trusted them.

And as a physician I believe it would be helpful and humane to limit the waiting period from 20 to 15 days and allow providers the flexibility of waiving the waiting period if our sound judgment determines the patient will most likely not survive but would qualify. One of my six patients died the very day I was legally able to write his prescription. My clinical judgement would have waived his case had I been given that chance under the law and saved his wife the pain and suffering she endured knowing his wishes were not met because of the current barriers our law affords.

I have heard some report that we have the safest MAID law in the country. I beg to differ. We have the most prohibitive. Barriers do not ensure safety, but they do ensure more pain and suffering in patients and their families that are already struggling with the complexities that come with ones ending.

Thank you for accepting my testimony. I am always willing to speak to this matter if I can help in any way.

Mahalo,

Dr. Charlotte Charfen

HB-1823
Submitted on: 1/30/2022 10:18:26 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Neal T Shimoda	Individual	Oppose	No

Comments:

Dear Members of the Committee on Health, Human Services and Homelessness

In opposition to HB 1823

My name is Dr. Neal Shimoda. I am an internist. In my various physician roles, I bear witness to the very disturbing contemporary trends of:

1. rising suicide rates in all age bands, especially the 20-39 age group even prior to the Covid 19 pandemic. During the pandemic, suicide rates have tripled.
2. The rise in opiate overdoses and deaths, not just a mild rise, but an alarming accelerated rise that has become a true public health crisis

These two trends reflect the distress and despair of individual struggling to cope with life. The actions of succumbing to ever increasing doses of opiates or the act of taking one’s life is a cry for help.

In similar fashion, the mental and physical agony of facing a terminal illness often leads to distress and despair. Certainly there are individuals who, after experiencing the holistic support of hospice services and given much thoughtful consideration of their situation, calmly decide to end their lives with the ingestion of lethal medication. But it is BECAUSE the current law has built in the 3 week period of consideration that many have either changed their minds or have only obtained the medications “just in case”, and have never used it. Also, the mandate for psychiatrists and psychologists to perform a comprehensive assessment to ascertain for depression that can be alleviated by medications assures appropriateness for an action that, if executed upon, is the final one of his/her life. Indeed, the seriousness of the need to assure appropriateness for this final, irreversible act of one’s life is such that excluding primary care physicians and ancillary health providers with only general training in mental health assessments is correct. Similarly, advanced practice nurses who are not specially trained specifically in mental health assessments nor any other practitioners should be excluded as well.

Finally, waiving the waiting period for those who have <2-3 weeks to live defies logic: the very definition of eligibility of someone with just 2-3 weeks to live is one who is bedridden, with severe generalized weakness, swallowing issues, and especially, a waxing and waning mental status. Clearly that person does not have decision-making capacity and will be too impaired to appropriately ingest the lethal medication. Any rush to obtain medications for such an individual only makes the situation ripe for abuse.

HB-1823
Submitted on: 1/30/2022 11:05:48 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Kathy Cypriano	Individual	Oppose	No

Comments:

The concern is that this people do not respect life, that they will take lives prematurely. You make the decision based on who is not mentally "normal", such as the demented or those who are severely depressed, or those with birth defects or the frail elderly. You want to put them out of their misery! You're treating them like they're lives have no worth based on someone's determination. No one has that right! I believe God gives and God takes. There is no one above this. No one! We need safeguards for our PAS system which is already in place and do not agree with extensions that this bill promotes!!

AMENDING THE OUR CARE, OUR CHOICE ACT
HB 1823

It is critical that the 20-day mandatory waiting period under the Our Care, Our Choice Act be revised to allow attending providers a much shorter and more flexible timeframe.

For some who are terminally ill, the pathway is clear, for others it is a conflicted journey. At times, in the fog of pain and the loss of quality of life, steadfast decisions may change. Unfortunately, these decisions usually come too late in the journey with many people not being able to meet the 20-day mandatory requirement in the Our Care, Our Choice Act. There is also the added stress of not having doctors that understand or even agree with this Act.

My brother George Coleman was diagnosed in 2019 with a malignant appendiceal neoplasm. He waged a fierce battle against this disease. Chemotherapy would see George become skeletal with swallowing food a major effort.

We all believed that after a clear PET scan in November 2019, our brother would get strong and have a life again. George moved house and enjoyed a bit of peace on the golf course. This was not to last.

George began to have pain in his stomach in early 2021 and eventually had this investigated. He received the devastating news that the cancer had come back and this time it was far more aggressive. Within a matter of months, our brother went from the golf course to finding it too painful to stand up to brush his teeth.

George was in enormous pain so his choice was an easy one. In Hawaii, the Our Care, Our Choice Act is still in its infancy but there are more and more people out there shining a light on this path. When our brother left us, it was on his terms, in his own way. George left us as he was looking out over the ocean where he had watched many sunsets with family and friends. He was surrounded by love and respect for the light he would continue to shine long after he was gone. There was chatter and stories being told as our brother peacefully slipped away. George is no longer in terrible pain and every day is a ‘good day’.

Initially my brother and my family struggled. His choice was crystal clear but the processes and the red tape were not. It was like swimming through murky water. One of the problems we found on Maui was that many of the doctors either chose not to participate for private reasons or to not participate because the process was unclear. It was a stressful and fearful time as the clock kept ticking. The 20-day mandatory wait time was fraught with fear and pain for both my brother and for my family as we sat and waited and prayed hoping nothing would go wrong.

My brother was one of the ‘lucky ones’, he lasted the 20-day requirement. He had his wish, which was to die with dignity and with love around him. Most importantly, he eventually had the assistance of a great team on Maui and an amazing Doctor from Oahu. Without their assistance, my brother and our family would have had great difficulty navigating through the red tape. It was a very tumultuous time and we are forever grateful that they walked every step of the way beside us.

We all have much to learn and to share in assisting terminally ill patients and their families. It is a journey of enlightenment not always shared by others. My brother George asked us to “pass it on” and for the rest of our lives we will try to do this.

Because of my brother George’s experience and our experience as a family, I cannot stress how critical it is that the Our Care, Our Choice Act be amended to allow attending providers to have flexibility to either lower or to waive the current 20-day mandatory waiting period of an eligible patient. This process also needs to be streamlined with minimum stress to the terminally ill patient and their family. There should be no disparity in access and care to neighbor islands particularly regarding access to pharmacies that can fill medical aid in dying (MAID) prescriptions.

The journey forward continues …

Julie Coleman-Crawford *(rmcjcc@bigpond.net.au)*
0416 081 214

HB-1823
Submitted on: 1/31/2022 3:19:13 AM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Leilani Kupahu-Marino Kahoano	Individual	Support	Yes

Comments:

Aloha e ke Akua, na Oiwi kupuna, House of Representative members, guests,

First, mahalo nui to all who remained dedicated to bring Hawai'i to becoming the 8th of the 50 states to pass Our Care, Our Choice. This was monumental and gives the patient a chance to make their own end-of-life choice after being made to live responsibly to all prior life decisions. Please accept the following information to SUPPORT HB 1823 and amending the current language as requested.

POINT #1: AMEND THE CURRENT LANGUAGE TO ALLOW QUALIFIED APRNs TO PROVIDE MEDICAL AID IN DYING (MAiD)

As Belgium, Canada and Oregon have been leaders when it comes to nurses involved in MAiD, evidence shows:

- Most important factor in the outcome of MAiD is the nurse.
- Canada has had the 'hardest' approach to assisted death, however, became the first country to allow nurse practitioners to act as MAiD assessors and providers.
- A Nurse's role is more significant than evidence is able to show and where studies have been done, a larger group of nurses support MAiD.
- Nurses are often the first to discern a request, and the medication that causes death may actually be delivered, instructed and spiritually, psychologically, supported by nurses.
- APRNs with prescriptive authority are permitted to prescribe medications in Schedules II - IV, which include the medications in DDMP2 (common prescription in MAiD).
- APRNs and MDs are the only acceptable professional signatures on a POLST form.

The APRN is already an expert clinical "assessor and provider" in his/her current role as noted by these few examples. **The time to formalize the APRN role in MAiD is in 2022.** The nursing field has been impacted since Covid 2020 and patients, too. Amending the MAiD language to include APRNs will allow the duality role of nurse with physician privileges in one clinician. Also, bring more clarity to this role and greater support to the physician, clinical team, families and most important, the patient and last days.

POINT #2: SHORTEN THE WAITING PERIOD FROM 20 DAYS AND ALLOWING A PROVIDER TO WAIVE IT IF A PERSON WILL NOT SURVIVE IT

Oregon's "reflection period" is a 10 day window. Even this window is too long for more than 35% of their patients as evidenced in a 2019 report. By the time a patient has made this decision, they know the inevitable is near. For example, A patient with metastatic cancer that has spread to other areas of his/her body should be allowed the choice to move up their EOL date. Why create agony by disputing days of another's life? They were given the choice to make the MAiD decision and now we take a part of this responsibility away by not allowing a waiver?

As a Hospice, Palliative Care and Bereavement Nurse for NICU babies, pediatric patients and adults, as well as, a caregiver for over 40 years, we are in monumental times making historical decisions. Having held the hand of one in his last breath or comforting the patient who's pain is unbearable or remaining in silence near parents who've had to make the difficult decision to remove life support for their baby and watch their baby transition, when making these critical choices, we need to truly put ourselves into those we are trying to help with this important HB1823.

In closing, let us help patients truly live their best last moments by giving them the full choice to their end. Also, by bringing greater clarity to the APRNs role in the last days by amending HB1823. Covid has continued to bring much anxiety to many, why would we want to add another element of anxiety by adhering to a 20-day window - let us also amend this language to 10 days with a waiver. Death is imminent no matter how many days, however, we can lessen the patient's anxiety by knowing they still have a choice about their last days of living, if desired.

Mahalo nui for considering this testimony for the benefit of others who will need this closure for their own lives one day. Mahalo for being legislative members for choosing to use compassion and hope, along with other considerations, when making this decision.

Resources:

1. Article: The rocks and hard places of MAiD: A qualitative study of nursing practice in the context of legislative assisted death https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7025406/#:~:text=Not%20only%20has%20Canada%20taken,as%20MAiD%20assessors%20and%20providers

2. Article: Ethical, Policy and Practice Implications of Nurses Experiences with Assisted Death https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6686960https://www.canada.ca/en/health-canada/services/medical-assistance-dying-annual-report-2019.html#a8.1

https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/specialty%20group/arc/ama-chart-np-prescriptive-authority.pdf

https://polst.org/wp-content/uploads/2021/07/2021.07.12-Signature-Requirements-by-State.pdf

https://journals.sagepub.com/doi/full/10.1177/1049909119859844

HB-1823
Submitted on: 1/31/2022 9:21:34 AM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Robert Juettner	Individual	Support	No

Comments:

My name is Robert Juettner of Hakalau, HI. I am writing in support of HB1823.When my mother was diagonosed with terminal uterine cancer in another state, the medical profession was quick to offer pallative chemo therapy in the hospital for whatever reason. After taking an evening to consider the options, both mom and I came to the conclusion that we would reject the offer of treatment to extend her life. She had no other alternative but to come home and die, which was her choice. Knowing that death was inevitable and with the care of Hospice we waited. She slipped into a coma after several days without taking nourishment or water.

I don't know whether she would have chosen the options offered by HB1823 but I know that I would. Therefore, I support HB1823.

Thank you for the opportunity to speak in behalf of this important legislation.

HB-1823
Submitted on: 1/31/2022 10:03:08 AM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Sandra Toles	Individual	Support	No

Comments:

Good morning,

I am a nurse of 37 years and have participated in the realm of hospice on and off for the last 20 years. I love hospice work and consider that my expertise in nursing. I have participated in medical aid in dying once in my career path.

I have practiced nursing in NJ, HI, and OR, and medical aid in dying is legal in all three states. I participated with one patient in OR with this practice. In my career, I was never supportive of this practice, as I was not well informed of the practice fully, and considered it "checking out," when the normal path should have been taken.. This particular patient had planned to use medical aid in dying, and I had the priviledge to get to know her during her stay with hospice, and her reasons why she was electing to do this. She had lung cancer and she stated that she knew where her disease was taking her, and she didn't want to put her family through this. She requested that I be present for her when she was doing this. As her nurse, and as a practice, I supported her decision, so I was present during this procedure. We had several times while she was on hospice to discuss with her the personal reasons for her deciding to use medical aid in dying.

She had her daughter apply make-up and fix her hair. She put on her favorite dresss. She asked for her son to be present, but all three children and one grandchild were there for her. I was present, but did not participate with the preparation or administration of the medicine. I had a few moments alone with her during this day, and I asked her if she was ready and was sure she wanted to do this, and she said yes. She had already had her counseling and doctor visits as required.

She said her good-byes and went back to bed, took the medicine and was gone in 45 minutes.

I realize now that I was wrong, and that she left this life on her own terms, which is paramount. It was not suicide, as she was terminal, but she chose how her last few months were going to be. I gained a tremendous amount of respect of this practice, and now fully support the use of medical aid in dying.

The use of APRN in this practice should be allowed. The patient goes through the process as legally required, and an APRN is fully qualified to oversee this process.

The requirements to qualify someone for this practice fully prepares the patient, and reducing the waiting period to 15 days seems appropriate for the patient to be sure of their rights. No one takes this lightly, and the depth of the seriousness of the participation is managed properly with educated, knowlegdeable practitioners.

Sincerely,

Sandra Toles, RN

HB-1823
Submitted on: 1/31/2022 10:15:51 AM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Leilani Maxera	Individual	Support	No

Comments:

I support HB1823. This bill will improve access to medical aid in dying (MAiD) by allowing APRNs to act as providers for patients' request to access MAiD. This change to the law is crucial, as at this time we are facing a shortage of physicians on our islands, and the ones we do have who will fulfill a MAiD request are not many. It is cruel to pass this law and offer this choice to our community without building the infrastructure to make it possible.

HB1823 would also shorten the waiting period that terminally ill residents must face. As an Licensed Clinical Social Worker who performs the mental health evaluation component for MAiD, I can tell you from experience that people die waiting for the 20 days to pass. By shortening the waiting period by even 5 days we will be making it more likely that people who want to die on their own terms will be able to.

The legislature did a huge service to our community by passing the initial bill to legalize medical aid in dying. Let us continue to improve it as time goes on so that we can best serve the people who choose it.

HB-1823
Submitted on: 1/31/2022 10:24:05 AM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Becky Gardner	Individual	Support	No

Comments:

I strongly support this bill.

I had served the function of primary care taker for my mother during her last 7 months in her passing from an aggressive uterine cancer; and assisted my father (also aging) who provided round-the-clock care for my grandmother who, after several months of hospice care, passed away at home. I therefore understand well the need for compassionate aid-in-dying; particularly the "counseling" that is needed for patients and their families.

I would like to suggest that you include in this bill "marriage and family therapists" to those professionals qualified to provide this counseling - as they may be in the BEST position to navigate all the family dynamics that are at play during the death of a loved one.

Accordingly, I respectfully request that MFTs be added to the language regarding "counseling", and any necessary clarifcations that all the professionals providing this counseling have the requisite training in mental health.

Thank you for the opportunity to provide this testimony on an important matter - that will only become more relevant as our baby boomers age.

-Becky Gardner

TESTIMONY IN OPPOSITION TO HB 1823

My name is Albert Shigemura and I am in opposition to HB 1823 relating to the expansion of the Our Care Our Choice Act.

This bill seeks to: expand the scope of practice of nurse practitioners in medical aid in dying, expand the providers to provide counseling to a qualified patient, decrease the mandatory waiting period between oral requests, and waive any waiting period for those terminally ill individuals deemed unlikely to survive the waiting period.

The OCAC act was passed amidst concerns of abuse that could threaten the lives of the vulnerable, including the frail elderly and the disabled. Therefore, safeguards were put in place, including the mandatory waiting period for individuals to have time to receive hospice and palliative care services and receive the comprehensive support they need, including competent management of their pain. Also, the assessment for the critical piece of whether the individual making the decision was doing this not out of despair, depression, or coercion of any sort was to be done by the most qualified of providers: psychiatrists, psychologists, and clinical social workers. This bill seeking to expand the OCAC act raisers considerable concerns.

Firstly, there already has ample evidence that the professional MOST qualified to assess for assessment and treatment of depression is the psychiatrist. It has been shown that the prevalence of reversible depression in those with advanced illnesses and/or at end of life is around 40%. Yet, only 4-6% of those seeking medical aid in dying per the state of Oregon statistics were referred to a psychiatrist. If the current medical providers are so dramatically underdiagnosing treatable depression, this will only worsen if advanced practice nurses are allowed to assess for mental health.

2ndly, within this climate of increased depression and anxiety, there is therefore good reason for the current mandatory waiting period. This time of processing their decision and the support of good hospice care is valuable in making a final decision regarding their end of life wishes. This waiting period therefore should NOT be shortened.

Finally, waiving the mandatory waiting period for those who would not survive the remaining 2-3 weeks of their life is an oxymoron. As a recently retired hospice physician, I know first-hand that someone in this situation usually has lost a significant amount of their cognitive ability and are often confused and emotionally fragile. Having the cognitive and emotional stability for clear decision making in this context is extremely unlikely and waiving the mandatory waiting period only serves as a gateway for abuse by others who want to prematurely end the person's life.

We are now enduring a prolonged pandemic where we have seen suicide rates, opiate overdoses, and alarming rates of mental health problems among individuals due to feelings of loneliness, isolation, and abandonment. Certainly, this is no time to consider removing the safeguards that have been appropriately in place all this time.

Respectfully submitted,

Albert Shigemura, Pharm. D

LATE *Testimony submitted late may not be considered by the Committee for decision making purposes.

HB-1823
Submitted on: 1/31/2022 1:55:46 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Laurie Field	Planned Parenthood Alliance Advocates	Support	No

Comments:

Planned Parenthood Alliance Advocates supports HB 1823. Thank you for hearing this important bill.

HAWAI‘I PACIFIC HEALTH
KAPI‘OLANI
PALI MOMI
STRAUB
WILCOX

Tuesday, February 1, 2022 at 10:30 AM
Via Video Conference

House Committee on Health, Human Services & Homelessness

To: Representative Ryan Yamane, Chair
Representative Adrian Tam, Vice Chair

From: Michael Robinson
Vice President, Government Relations & Community Affairs

Re: HB 1823 – Testimony In Support
Relating to Health

My name is Michael Robinson, and I am the Vice President of Government Relations & Community Affairs at Hawai‘i Pacific Health. Hawai‘i Pacific Health is a not-for-profit health care system comprised of its four medical centers – Kapi‘olani, Pali Momi, Straub and Wilcox and over 70 locations statewide with a mission of creating a healthier Hawai‘i.

I am writing in SUPPORT of HB 1823 which would authorize advanced practice registered nurses to practice medical aid in dying in accordance with their scope of practice and prescribing authority. The bill also authorizes psychiatric mental health nurse practitioners and clinical nurse specialists to provide counseling to a qualified patient and reduces the mandatory waiting period between oral requests from twenty to fifteen days.

Through the passage of the Our Care, Our Choice Act in 2018, terminally ill individuals with less than six months to live have access to the full-range of end-of-life care options, and may voluntarily request and receive prescription medication that allows the person to die in a peaceful, humane, and dignified manner. Hawaii's unique geography and the State's shortage of physicians create barriers to access for qualified terminally ill individuals. Finding a physician may be burdensome, especially for individuals on the neighbor islands. Hawaii gives advanced practice registered nurses full scope of practice licensure; however, they do not have authority to administer medical aid in dying, thereby further limiting access to care for many individuals. Hawaii has the longest mandatory waiting period amongst all ten medical-aid-in-dying authorized states and the District of Columbia. Many patients are not surviving the mandatory twenty days.

Allowing advanced practice registered nurses to practice medical aid in dying in accordance with their scope of practice and prescribing authority and shortening the waiting period provide greater access for terminally ill individuals to the medical treatment they require at a critical stage in their lives.

Thank you for the opportunity to testify.

DEMOCRATIC PARTY OF HAWAI'I
Health Committee

Jan. 31, 2022

Concerning HB1823

Dear Chair Yamane, Vice Chair Tam, and all committee members,

I am writing on behalf of The Health Committee of the Democratic Party of Hawaii in support of HB1823 which will broaden the number of health professionals who can fulfill the requirements of the “Our Care Our choice Act” and reduces or eliminates the mandatory waiting periods in the original legislation as might be required by the patient requesting assistance in compassionate dying.

The original legislation could not anticipate the lack of access to medical professional who can assist in the prescribed process for terminal individuals who want to take advantage of the act to choose their own time to die with dignity and under their own control. In addition there are very few pharmacies that can or will fill the necessary prescriptions. The most tragic thing of all is how many people die, in pain and distress because of the waiting periods required in the original legislation.

The purpose of the original legislation was to help people who were clear in mind and heart that a gentle, pain free and self-controlled passing. The multiple waiting periods included presumed that anyone who wanted to die was either emotional or mentally challenged and would change their mind given time. In point of fact, even if the person gets through the process and has the necessary medication to take, no one forces them to take it and many have decided not to in the end. However too many others have desperately wanted to end their pain and suffering with assistance but having started the process too late for the legislation and are forced to suffer in shame and pain while waiting for an appointment with a second medical professional, or psychiatrist, or for a pharmacy to bring in the medication.

It is my personal opinion that the most important right in this world is the right to have control over your own body, your life and/or your death. No government should be able to take that right from any person. The Health Committee of the Democratic Party of Hawaii and me personally, supports this bill as correcting and enhancing the essence and spirit of the original “Our Care, Our Choice Act”.

Sincerely

Martha E Randolph
President of Democratic Precinct 4 District 25, Member of Health committee of DPH
DPH Kupuna Caucus Treasurer, DPH Environmental Caucus SCC Representative

HB-1823
Submitted on: 1/31/2022 1:12:33 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Cindy Coleman-Jakubczak	Individual	Support	Yes

Comments:

I would like to share how my brother's experience.

HB-1823
Submitted on: 1/31/2022 4:58:44 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
byron eliashof	Individual	Support	No

Comments:

This testimony is to support the passage of the current bill regarding death and dying.

I have had personal experiances over the years which made it veryu clear to me that in order to ensure death when the quality of life is no longer acceptable, provisions must be made in advance.

One event occured when an aiunt was badly injured in an auto accident. After this, she was completely demented and could only say "that's right" by wayof communication. She remained in this state for 7 years until she passed away from pneumonia.

Another situation involved a close friend who developed dementia and did not recognize her daughter. She required 24 hour support for several years until she passed away from pneumonia.

It is my strongly held opinion that individuals be allowed and/or assisted in dying under these circumstances.

Respectfully Submitted,

Byron A. Eliashof M.D.

LATE *Testimony submitted late may not be considered by the Committee for decision making purposes.

HB-1823
Submitted on: 1/31/2022 6:55:50 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Carolann Biederman	Individual	Support	No

Comments:

Aloha and thank you for considering this bill.

The Our Care, Our Choice Act has been in effect for three years, yet many eligible terminally ill patients are having trouble accessing the law, causing needless suffering.

The physician shortage makes it very difficult for eligible patients to find the two doctors required to assist them, especially on neighbor islands. HB1823 is solution to this problem by allowing Advanced Practice Registered Nurses (APRNs) to fill this gap, as they do in virtually all other areas of care. Yet as the law is written, APRNs are prohibited from helping in this most crucial area. The Our Care, Our Choice Act currently limits their scope of practice, preventing them from supporting their patients who want the option of medical aid in dying. The waiting period is another obstacle, and Hawaii can modify the law to assist qualified patients by reducing the time a patient is required to wait between steps in the process.

Deep health inequities in our state impact people in most local communities, and for patients seeking medical aid in dying, the inability to find a supportive provider means they simply don’t get to have this compassionate option, despite it being their legal right.

Please insure that qualified patients are able to spend their final weeks enjoying their final days with loved ones, and without fear and pain, and ensure everyone here is empowered to choose end-of-life care that reflects their values, priorities, and beliefs.

Thank you for your consideration.

With aloha, Carolann Biederman

LATE *Testimony submitted late may not be considered by the Committee for decision making purposes.

HB-1823
Submitted on: 1/31/2022 9:49:34 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Roxann Rowe	Individual	Support	No

Comments:

This bill will improve access to the Our Care, Our Choice Act in two ways:

- Allow qualified APRNs to provide medical aid in dying
- Shorten the waiting period from 20 days (the longest in the nation!) and allowing a provider to waive it if a person will not survive it

Three years of data from Kaiser Permanente Hawaiʻi and Hawaiʻi Pacific Health show that up to 30 percent of OCOCA patients die before the end of Hawaiʻi's mandatory waiting period – the longest medical aid-in-dying suffering period in the nation.

I have personal experience regarding this very complex and frustrating process. I had a dear friend, age 49 who had a terminal diagnosis. Her hospitalists talked to her about her terminal diagnosis and the choice to have self-determination over her right to choose her own destiny. The problem laid with finding 'willing doctors' to sign any documents. This Bill will allow a person's health care provider, who may well be an APRN, to allow a person to fulfill his/her own wishes for death with dignity. My dear friend suffered a lengthy death, complicated by COVID visiting restrictions, and died alone, at an inpatient hospice, many WEEKS after she requested assistance from her hospitalists to aide her in her right to choose. Unfortunately, hers is not an isolated case. Please support HB1823 which will allow APRNs to aide people in their time of need.

Sincerely and Respectfully,

Roxann Rowe, APRN-Rx, GNP-BC

LATE *Testimony submitted late may not be considered by the Committee for decision making purposes.

HB-1823
Submitted on: 1/31/2022 9:52:35 PM
Testimony for HHH on 2/1/2022 10:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Jeffrey Mermel	Individual	Support	No

Comments:

Aloha esteemed Representatives: I am a 45 year homeowner and resident of the Big Island who votes. I am also a volunteer for 5 years doing bedside care at the facility in Hilo where hospice care is provided. From all that experience,

I am in SUPPORT of HB1823 because I believe that the waiting period that terminally ill residents must endure should be shortened.

I have also come to believe that APRNS should be allowed to act as providers.

Mahalo for your thoughtful consideration of this bill which reduces human suffering.

Sincerely,

Jeffrey Mermel.....PO Box 342, Volcano, HI 96785