DAVID Y. IGE
GOVERNOR OF HAWAII

VIRGINIA PRESSLER, M.D.
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 SB1129 SD2
RELATING TO HEALTH.

REPRESENTATIVE DELLA BELATTI, CHAIR
HOUSE COMMITTEE ON HEALTH

Hearing Date: March 23, 2017 Room Number: 329

Fiscal Implications: Undetermined resources for proposed medical records reviews.

Department Testimony: The Department of Health takes no position on the merits of allowing mentally competent adults with six or fewer months to live to request and be dispensed prescription medication with which to end their life.

SB1129 SD2 proposes in proposed section 13 the sampling of records by the department but defines no purpose or use for the findings thereby generated, nor does this provision appear to be necessary for reporting requirements subsequently described in subsections (b), (c), and (d), and thus recommends subsection (a) be deleted.

This measure also proposes publication of annual statistical reports based on information collected by the department from forms submitted by health care providers that appear to have no meaningful public health or patient safety benefit. Nevertheless, the department acknowledges the public interest in how this Act is carried out.

Offered Amendments: Page 15, lines 5 – 17:

" § **-14 Reporting requirements.** [~~(a) The department shall annually review a sample of records maintained pursuant to this chapter.~~]"

PRESENTATION OF THE
BOARD OF NURSING

TO THE HOUSE COMMITTEE ON HEALTH

TWENTY-NINTH LEGISLATURE
Regular Session of 2017

Thursday, March 23, 2017
8:30 a.m.

WRITTEN TESTIMONY ONLY

TESTIMONY ON SENATE BILL NO. 1129, S.D. 2, RELATING TO HEALTH.

TO THE HONORABLE DELLA AU BELATTI, CHAIR,
AND MEMBERS OF THE COMMITTEE:

My name is Lee Ann Teshima, Executive Officer for the Board of Nursing ("Board"). I appreciate the opportunity to testify on Senate Bill No. 1129, S.D. 2, Relating to Health. The Board takes no position on the intent of this bill but is requesting that advanced practice registered nurses ("APRNs") be included under the definitions of "Counseling", which includes a state licensed psychiatrist or psychologist.

APRNs who hold a practice specialty in psychiatric mental health are qualified to provide consultation to determine if a patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. Including APRNs will also allow more access to health care services that qualified APRNs are able to provide.

Thank you for the opportunity to submit written testimony on Senate Bill No. 1129, S.D. 2.

March 23, 2017@ 8:30am
Conference Room 329
Committee onHealth

TESTIMONY IN SUPPORT:
SB1129 SD2 RELATING TO HEALTH. ESTABLISHING A DEATH WITH DIGNITY ACT

SUBMITTED BY: Amy Agbayani, chair
FILIPINO-AMERICAN ADVOCACY NETWORK (FAN)
3432 B-1 Kalihi St. Honolulu, Hi 96819

Chair Au Belatti, Vice Chair Kobayashi and members of the Committee

The Filipino-American Advocacy Network strongly support SB 1129 SD2 because we believe all individuals should have the right to die with dignity. I was born in the Philippines and raised as a Catholic. I feel that my religious beliefs are consistent with my support for this bill and I also believe in the separation of church and state.

The states who have enacted death with dignity laws can document that there are appropriate safeguards against abuse. The physicians, family members and patients in these states and the state of Hawai'i understand the critical need to respectfully follow strict requirements to enable terminally ill residents to make decisions to end their lives in a peaceful manner.

I respectfully urge you to pass sb1129 sd2.

First Unitarian Church of Honolulu

www.unitariansofhi.org

Written Testimony in Strong Support of SB1129, SD2
From the First Unitarian Church of Honolulu

TO: The House Committee on Health (HLT)
DATE: Thursday, March 23, 2017, 8:30 a.m.
PLACE: Conference Room 329

Aloha e Chair Belatti, Vice Chair Kobayashi, and HLT Committee Members,

My name is Steve Lohse, I am Chair of the Social Justice Council of the First Unitarian Church of Honolulu. Thank you for this opportunity to submit written testimony on behalf of First Unitarian in Strong Support of SB1129, SD2, Relating to Health, establishing a medical aid in dying act.

SB1129, SD2 is about freedom – freedom in our most personal life choices, freedom from unwarranted interference in our most personal beliefs and values, and *freedom from unnecessary suffering*. The First Unitarian Church of Honolulu, affirming and promoting the inherent worth and dignity of all persons and justice, equity, and compassion in human relations,

- advocates the right to self-determination in dying, and the release from civil or criminal penalties of those who, under proper safeguards, act to honor the right of terminally ill patients to select the time of their own deaths;
- advocates safeguards against abuses by those who would hasten death contrary to an individual's desires;
- supports legislation that creates legal protections for The Right To Die With Dignity, in accordance with one's own choice; and
- supports the following statements from the "TIAH and Religious Leaders for Assisted Dying" Position Statement of The Interfaith Alliance Hawaii (TIAH):

"We respect the right of competent adults to make their own decisions concerning end of life choices according to their own beliefs and values . . . . We do not support the indiscriminate taking of one's own life, but rather acknowledge that in certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great . . . . **Just as we should be free to worship according to our individual understanding of faith, we should have the freedom in making our own end-of-life choices** . . . . Those who oppose assisted dying based on their own moral, ethical, or religious beliefs simply need not participate. **We do not believe it is up to any religious leader to dictate how this final and perhaps most intimate decision between a dying person and his or her God should be made.**" (For the full TIAH Position Statement, please see http://www.interfaithalliancehawaii.org/position-statements/assisted-dying/.)

Please, *do not support unnecessary suffering*. Please, pass SB1129, SD2. Thank you!

Aloha no,
Steve Lohse, Chair, Social Justice Council
First Unitarian Church of Honolulu
2500 Pali Highway, Honolulu, HI 96817
Phone: 808-595-4047

ROMAN CATHOLIC CHURCH IN THE STATE OF HAWAII

Hawaii Catholic Conference

The Public Policy Voice of the Roman Catholic Church in the State of Hawaii

Submitted Electronically: March 20, 2017

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

HEARING: Thursday, March 23, 2017 @ 8:30 a.m. in room #329
SUBMITTED BY: Walter Yoshimitsu, Executive Director
POSITION: **STRONG OPPOSITION TO SB 1129 SD 2 Relating to Health**

The Hawaii Catholic Conference is the official public policy voice for the Roman Catholic Church in the State of Hawaii. The above-referenced bill would establish a death with dignity act under which a terminally ill adult resident may obtain a prescription for a lethal dose to end the patient's life. The Hawaii Catholic Conference **opposes** this bill for many reasons.

- It can blur longstanding medical, moral and legal distinctions between withdrawing extraordinary medical assistance and taking active steps to destroy human life. One lets people die a natural death; the other is the deliberate and direct act of hastening death.
- It can undermine the physician's role as healer, forever alter the doctor-patient relationship, and lessen the quality of care provided to patients at the end of life. The American Medical Association has stated that assisted suicide is "fundamentally incompatible with the physician's role" and would be "difficult or impossible to control."
- It can lead to psychological, financial and other pressures for vulnerable persons to end their lives. In today's era of health care rationing and cost-cutting, assisted suicide could easily rise to the level of the most acceptable, and even expected, "treatment" for terminal illness.

Rather than giving the doctors the legal protection to kill their patients, government should be consistent in its efforts to prevent it. It is illogical for the state to promote/facilitate suicide for one group of persons — calling the suicides of those with a terminal illness and a specific prognosis "dignified and humane," while recognizing suicide as a serious statewide public health concern in all other circumstances, and spending enormous resources to combat it.

Assisting in a person's death is not medical treatment, no matter how it is spun. In Hawai'i, everyone, especially our kupuna, deserves better than a doctor who dispenses pills to intentionally cause death. Patients are best served when medical professionals, together with families and loved ones, provide support and care with dignity and respect, not lethal doses of drugs. Improved education and training of physicians in pain management, together with appropriate diagnosis and treatment for depression, would go a long way toward eliminating calls for suicide among the sick and the dying.

Mahalo for the opportunity to testify.

6301 Pali Highway ◆ Kaneohe, Hawaii ◆ 96744-5224 ◆ Phone: (808) 203.6735
www.catholichawaii.org ◆ hcc@rcchawaii.org ◆ wyoshimitsu@rcchawaii.org

ONLINE TESTIMONY SUBMITTAL
Hearing on Thursday, March 23, 2017 @ 8:30 am.

DATE: March 20, 2017

TO: COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

FROM: Eva Andrade, President

RE: Strong Opposition to SB1129 SD 2 Relating to Health

Aloha and thank you for the opportunity to submit testimony in strong opposition to this measure. Hawaii Family Forum is a non-profit, pro-family education organization committed to preserving and strengthening families in Hawaii. We oppose SB1129 SD 1 for several reasons:

Suicide is Contagious! Physician-prescribed lethal-dose "cocktails" are not a medical treatment and we should not promote that message to our keiki**.** Studies have shown that in the few states that have passed this law, suicides increased.[i] In Hawaii, suicide was the most common cause of fatal injuries among Hawaii residents between 2010-2014, accounting for one-quarter of all fatal injuries. In fact, per current statistics, one person dies by suicide in Hawaii every two days. In Oregon where assisted suicide was legalized in 1994, their suicide rate has increased by 35%. SB1129 SD 2 imposes Oregon style suicides on Hawai'i and we simply should not do anything to exacerbate the problem we already have.

Record keeping and a lack of transparency in reporting has been a big problem in the few states where this is legal. Reporting is completed by the physician who prescribed the drugs and then these reports are destroyed. No matter what you try to accomplish with proposed "safeguards," once that patient leaves the pharmacy, all alleged safeguards go away. If there are any problems, there is no mechanism to investigate. In fact, if we look at the Oregon model, we find the following:

> "The identity of participating physicians is coded, but the identity of individual patients is not recorded in any manner. ***Approximately one year from the publication of the Annual Report, all source documentation is destroyed***"[ii] {emphasis mine}

In the end, physicians are forced to falsify death certificates to report the underlying illness as the cause of death. This means they are falsifying historical records and that should cause great concern to both prosecutors and the legal system. This type of law will make it extremely difficult to investigate and prosecute potential cases of abuse.

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It puts the poor, elderly, sick and disabled at risk for abuse – no matter what the proposed safeguards. Per the National Adult Protective Services Association, recent research indicates that elder financial exploitation and abuse is widespread, expensive, and sometimes even deadly. With elder abuse already a major problem in Hawaii (one news story reported a 300% increase)[iii], turning the right to die into a duty to die – creating subtle pressure on the elderly to end their lives early so as not to be a burden to their families – may very well be a consequence of this law.

Claims of "zero" abuse statistics do not make sense. Local physician Dr. Michael H. Plumer recently stated in a letter to the editor, "Actually, this probably proves that the Oregon record-keeping is meaningless. No human endeavor involving sickness and death operates for 20 years without abuse, fraud, complications and difficulty. Oregon's records were deliberately set up by the organization to conceal problems, and they have done so for 20 years.[iv]"

Finally, contrary to conventional wisdom, the contemporary debate in this area is not about a mentally competent adult's legal right to refuse medical treatment. That legal right currently exists. SB1129 SD2 is really about a physician's so-called right to intentionally participate in ending the life of another person by prescribing a 9-10g lethal dose[v] of barbiturates. And that, when it is clearly articulated to the public, is simply not what the people of Hawaii want.

Mahalo for the opportunity to testify.

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i http://sma.org/southern-medical-journal/article/how-does-legalization-of-physician-assisted-suicide-affect-rates-of-suicide/ (accessed 02/11/17

ii https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/faqs.pdf (accessed 02/11/17)

iii http://khon2.com/2016/04/19/more-alleged-victims-come-forward-after-elder-abuse-crimes-come-to-light/ (accessed 02/11/17)

iv http://thegardenisland.com/news/opinion/guest/assisted-suicide-question-requires-some-clarification/article_f3ee7da5-5ac7-5ce5-8e61-23e0c7d3fc48.html (accessed 02/11/17)

v http://www.medscape.com/viewarticle/742070_3 (accessed 02/13/17)

Hearing 8:30 am, March 23, 2017
Committee on Health
Conference Rm 329

TESTIMONY IN SUPPORT OF SB 1129 SD2 RELATING TO HEALTH ESTABLISHING A DEATH WITH DIGNITY ACT

SUBMITTED BY: FAYE KENNEDY, CO-CHAIR
HAWAI'I FRIENDS OF CIVIL RIGHTS
3072 Felix St.
Honolulu, Hi 96816

Chair Au Belatti, Vice-Chair Kobayashi and members of the Committee:

I am writing to urge your support for sb1129 SD2. As an 85 year- old female who has had a very fulfilling, relatively healthy life, I am appalled by the thought of spending my final days in pain and suffering, should I develop a terminal illness. I find it repugnant to think that a physician could be subject to any civil or criminal liability for prescribing a prescription to me to alleviate my suffering, upon my request.

I speak as co-chair of the Hawaii Friends of Civil Rights (HFCR), an organization that promotes justice, equality and human dignity for all. Thank you for doing the right thing on this important, long- overdue issue.

LGBT CAUCUS

FORMED IN 2001

THE FIRST CAUCUS OF THE
DEMOCRATIC PARTY
OF HAWAI'I

March 20, 2017

House's Committee on Health
Hawai'i State Capitol
415 South Beretania Street, Room 329
Honolulu, HI 96813

Hearing: Thursday, March 23, 2017 – 8:30 a.m.

RE: **STRONG SUPPORT for Senate Bill 1129 SD 2** – RELATING TO HEALTH

Aloha Chairperson Belatti, Vice Chair Kobayashi and fellow committee members,

I am writing in STRONG SUPPORT to Senate Bill 1129 SD 2 on behalf of the LGBT Caucus of the Democratic Party of Hawai'i. SB 1129 establishes a medical aid in dying act that establishes a regulatory process under which an adult resident of the State with a medically confirmed terminal disease may obtain a prescription for medication to be self-administered to end the patient's life.

The preamble to the platform of our great party states, "The abiding values of the Democratic Party are liberty…and compassion and respect for the dignity and worth of the individual. At the heart of our party lies a fundamental conviction that Americans must not only be free, but they must live in a fair society."

In recognition of the sanctity of individual rights, especially that most personal and private right to avoid prolonged suffering if terminally ill, last June our party formalized our many years of support for the issue, adding a resolution to our platform urging lawmakers to legalize medical aid in dying in the islands.

HHS 2016-02 On Death With Dignity resolves:

"That the Democratic Party of Hawai'i urge the Legislature to take all measures to affirm the right of dying patients to make informed decisions about their health care, ensure that Hawai'i residents are provided with a full range of end of life options, including a decision to advance the time of death, and provide safeguards to ensure patients are in control if they choose [medical aid in dying]."

The resolution was adopted two weeks before the enactment of California's End of Life Option Act that went into effect June 9, 2016, tripling the percentage of terminally ill Americans who have option to choose medical aid in dying from 4 to 16 percent. Subsequent to that, the voters of the state of Colorado in November 2016 passed a ballot measure authorizing medical aid in dying. Later that same month, the Washington, D.C. City Council passed a resolution to that effect.

A legal, accessible medical aid in dying option for Hawai'i is a top priority for the LGBT Caucus and the Democratic Party of Hawai'i. As we've researched the issue and talked to members, we are struck by the desperate, violent measures some terminally ill kama'aina have been forced to take, alone and in secrecy, to end their suffering. Some have resorted to shooting or hanging

themselves—one person's aunty hung herself from the garden gate—, leaving family members devastated and traumatized at their inability to help a member of their own ʻohana to pass peacefully, surrounded by loved ones.

Some palliative care doctors will say that the pain and anxiety management they provide is sufficient, and for many, it is. However some kamaʻaina perhaps don't wish to be subjected to what's euphemistically known as "terminal sedation," addled by ever increasing doses of morphine until they lose consciousness and eventually stop breathing.

Ironically, some doctors who are opposed to medical aid in dying say it is wrong or immoral to prescribe life-ending medication to anyone, no matter what the circumstance. Yet these same doctors somehow subscribe to the questionable "principle of double effect," which allows them to justify the administration of potentially life-ending doses of medication if their main intent is to end suffering – even if they know the medication will cause death.

How is that moral? How is that right? How is that preferable to allowing an adult who is terminally ill, with six months or less to live, and who is mentally capable of making their own health care decisions, and who is acting under their own free will with no coercion, to have the option to request, obtain and self-administer their own life-ending medication in order to die peacefully, on their own terms?

Our party is the party of personal freedom and liberty. Who are we to deny this most personal liberty to the people of Hawaiʻi?

Thank you, Chair and Members of the Committee, for your thoughtful consideration and of SB 1129 SD 2.

Mahalo nui loa,

Michael Golojuch, Jr.
Chair and SCC Representative
LGBT Caucus for the DPH

Submitted by
David Stevens, MD, MA (Ethics)
President, American Academy of Medical Ethics
Contact Information: 423-844-1000; executive@cmda.org
Statement to the Hawaii House of Representatives, Committee on Health
March 23, 2017 – 8:30 AM
In **OPPOSITION** to **SB 1129, SD2** – "medical aid in dying"

My name is Dr. David Stevens; I am the President of the American Academy of Medical Ethics, a licensed physician and I hold a degree in bioethics. The American Academy of Medical Ethics has members across the islands of Hawaii.

I am passionate about decreasing suffering. I practiced in a bush hospital for 11 years in Africa. I led a relief team in Mogadishu, Somalia for 10 months during the time of "Black Hawk Down." I was in Sudan for 11 months during a civil war and famine while we wiped out an epidemic of relapsing fever that had a 40 percent mortality rate. I led a relief team in Rwanda during the genocide. I've seen more suffering than I ever wanted to see. Frankly, I've stood at patients' bedsides and prayed that God would go ahead and take them.

But allowing doctors to give lethal prescriptions to their terminally ill patients is just too dangerous.

It is dangerous for physicians. It wrongly assumes physicians are always ideal moral agents. They are not. I know doctors I would refer my loved ones to, but I also know doctors I wouldn't let treat my dog. Physicians are under increasing stress, workloads and costs pressures. It takes no great skill and very little time to write a lethal prescription, but it takes consummate skill and lots of effort to provide good end-of-life care. Allowing lethal prescriptions also gives the physician too much power. They would be judge, jury and assistant executioner in end-of-life cases. We don't allow a single judge that amount of power, even in the trials of mass murderers. The power is not in the patient's hands, despite signing a form and giving oral consent. In just how I describe a disease and its prognosis, I could convince someone that taking a lethal prescription was a good idea without ever saying the words "physician-assisted suicide." Remember, suicide is not illegal in Hawaii and can be accomplished painlessly by running a car parked in your garage. This is not about giving patients the so-called "right to die" but giving physicians the right to kill.

It is dangerous for families. Could you imagine visiting your parent in a nursing home and finding their bed empty? When you ask, you find that their physician gave them a lethal prescription and they took it without saying anything to you. I know how I would feel: Guilty—didn't I visit them often enough? Angry—how could their doctor do this without bringing me into the discussion? And I would feel profound sadness. The proposed law does not require family notification.

Allowing this will also cause enormous dissension in families, as had been documented in Europe. It also opens the door to worsening elder abuse. One elderly woman stated, "...when I started losing my hearing about three years ago, it irritated my daughter...She began to question me about my financial matters and apparently feels I won't leave much of an estate for her... She became very rude...Then suddenly, one evening, my daughter said she thought it was okay for old people to commit suicide...So

here I sit, day after day, knowing what I'm expected to do."

It is dangerous for patients. The so-called "right to die" will become the duty to die. When my 87-year-old mother had problems living alone a few years ago, I encouraged her to move into our basement apartment. Like many elderly, she said to me, "Son, I don't want to be a burden." Many elderly will feel a duty to not be a financial burden, a time burden or even an inconvenience.

Did you know some bioethicists are already teaching there is a duty to die in our state? Dr. John Hardwig is a Professor Emeritus at UT. When he taught ethics at East Tennessee State University, some of the medical students gave me his handout in which he advocated that people have a duty to die so to not be a burden to the next generation. I went to one of his lectures and asked when that duty kicked in. Without hesitation, he said at age 75, whether you were sick or not.

Depression is the reason 95 percent of the elderly take their lives. Studies show that doctors recognize the signs of depression poorly, especially in the terminally ill, even though they respond well to anti-depressant drugs. Yet, the so-called, "safeguards" proposed in this amendment don't require a consultation by a psychologist or psychiatrist. In 2014, only 2 percent of the 155 patients in Oregon who killed themselves were referred for evaluation.

It is dangerous for patients because mental or physical suffering precludes rational decision-making. The medical definition for "suicidal" is "impaired cognition and distorted judgment" (incapable of thinking straight or making good decisions), but proponents claim there is such a thing as a "rational suicide." That's an oxymoron, like drinking a glass of "dry water." If we deal with the physical and mental suffering, the suicidal ideation almost always resolves itself. We don't have to kill the patient to kill the suffering.

The cheapest form of treatment for a terminally ill patient is a handful of lethal pills costing less than $100. That is dangerous in a healthcare system with enormous financial challenges. Half of your lifetime costs of healthcare happen in the last year or so of your life. We could handle the cost challenges of our aging baby boomers just by idealizing suicide at the end of life.

Oregon's Medicaid program will not pay for any treatment that doesn't promise a five-year, 5 percent survival rate. When a woman petitioned for access to a drug that could prolong her life for two or three years, the state program responded that they wouldn't pay for it, but they would cover the cost of her suicide if she wanted to take that step.

Allowing doctors to give lethal prescriptions is dangerous for society. If suffering is the criteria, there is no logical place to draw the line. If the terminal patient can't swallow, don't they have a "right" for a doctor to give them a lethal injection? If we are going to allow it for a patient who will suffer for six months, how can we deny it for a chronically ill patient who will suffer more than six years? How can you deny this "right" to severely disabled newborns who will suffer for a lifetime? How could you say psychiatric suffering is any less than physical suffering? In fact, you couldn't deny this "aid in dying" to someone who had no disease at all. In Europe and now Canada, all these people are included and they are working on a protocol to euthanize people on the operating table by harvesting their organs so at least "something good will come out of this."

It is dangerous for society because the so-called "safeguards" don't work. Predicting that patients only have six months to live is impossible. A study in the journal *Cancer* revealed that two out of five patients with cancer lived longer than the six months predicted by their doctors. A study looking at The Netherlands revealed a second opinion was useless because doctors often work together as "consulting pairs" and rubber stamp each other's assessments. The laws in Oregon, Washington and Vermont make the doctor almost immune to malpractice charges. They can miss the diagnosis or botch the suicide, but they only have to meet the lowest legal standard of "good intent." In other words, "I didn't mean for that to happen." We don't allow that flimsy standard anywhere else in healthcare.

There is shroud of secrecy around legalized physician-assisted suicide. There is no protocol or funding to investigate and identify abuses. Reporting is voluntary and any reports submitted are destroyed. Only a statistical summary is published. By law, doctors have to lie on the death certificate and say the patient died of the terminal disease. The only thing we really know in Washington and Oregon is that the doctors submitting the forms are filling them out correctly.

I had a friend who went to live in Ethiopia with his wife and young child. Their rented house was infested with rats he could not eliminate. Concerned their baby would be bitten, he complained to his landlord who promised a solution. The landlord showed up the next day with a cobra to put in the attic, assuring them the rats would be dead in a few days. What do you think my friend said? He refused. The solution would work, but it was more dangerous than the rats.

Physician-assisted suicide is that cobra. It is sure to eliminate suffering in the terminally ill, but along with the harms I've mentioned, it will literally destroy the foundation of the doctor-patient relationship – trust. It will cause much more harm than good. And you should know it is not a new idea; doctors before Hippocrates both cured and killed. The trouble was you didn't know which one they would do to you. If someone paid them more, the doctor would kill you and no one would be the wiser. Hippocrates realized medicine could not thrive like that, so he required medical students to take an oath before their future colleagues and the community to promise how they would use the powerful knowledge their teachers would teach them. Over the next few hundred years, patients voted with their feet and Hippocratic medicine became the standard. It is the foundation on which Western healthcare has grown and prospered. Legalizing physician-assisted suicide would take us back 2,500 years.

We need to pour our efforts into eliminating the suffering—not eliminating the patient. We can do this through pain and symptom control research, better end-of-life care, more physicians with palliative care training and good drug laws, as well as coming alongside patients to support them emotionally, spiritually and physically in their last days. A handful of lethal pills is not compassion; it is an escape from the duty of compassion.

H.L Mencken summed it up, "There is always an easy solution to every problem—neat, plausible and wrong." Let's not go down the path of physician-assisted suicide. It is not only wrong; it is much too dangerous.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 10:28 PM
To: HLTtestimony
Cc: cocpwdhawaii@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Derek Tamura	COC Persons with Disabilities	Support	No

Comments: On behalf of the Chamber of Commerce for Persons with Disabilities - Hawaii, our constituents, friends and families are in complete support of SB 1129, Hawaii's Medical Aid in Dying espousing the very same concerns, compassion and sensibilities as one of the world's most famous scientist, Prof Stephen Hawking. Prof Hawking provides much needed insight in a BBC interview on the right to die: "We don't let animals suffer, so why humans?...If you have a terminal illness, and are in great pain, I think you should have the right to end your life … It is discrimination against the disabled to deny them the right… that able-bodied people have." - Stephen Hawkings References: Professor Stephen Hawking backs right to die for the terminally https://www.theguardian.com/science/2013/sep/17/stephen-hawking-right-to-die? Stephen Hawking: Why I support Assisted Dying http://www.bbc.com/news/health-28337443 Stephen Hawking speaks out about assisted suicide http://www.bbc.com/news/health-24123679 Why Stephen Hawking says he'd consider assisted suicide https://www.washingtonpost.com/news/speaking-of-science/wp/2015/06/04/why-stephen-hawking-says-hed-consider-assisted-suicide/ Stephen Hawking Changes His Mind About Euthanasia. Will You? http://bigthink.com/the-big-brouhaha/stephen-hawking-changes-his-mind-about-euthanasia-will-you Sincerely, Derek Tamura, Vice president, Chamber of Commerce for persons with disabilities - Hawaii cocpwdhawaii.hi@gmail.com

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

Do not reply to this email. This inbox is not monitored. For assistance please email webmaster@capitol.hawaii.gov

Chamber of Commerce For Persons with Disabilities - Hawaii

MarshaRose Joyner
http://www.cocpwdhawaii.com/ * Mrjoy@hawaii.rr.com

HOUSE OF REPRESENTATIVES
THE TWENTY-NINTH LEGISLATURE
REGULAR SESSION OF 2017

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Rep. Sharon E. Har
Rep. Dee Morikawa
Rep. Marcus R. Oshiro
Rep. Chris Todd
Rep. Andria P.L. Tupola

NOTICE OF HEARING

DATE: Thursday, March 23, 2017
TIME: 8:30 AM
PLACE: Conference Room 329
State Capitol
415 South Beretania Street

Testimony in STRONG SUPPORT of SB1129 SD2

In the contentious debate over whether people have a right to die, the staunchest opponents on either side usually agree on one point — that the terminally ill ought to be made as comfortable as possible in their final days.

Terminal Sedation is the most common medical method to keep dying patients, who cannot be made comfortable in any other way, unconscious until they die. As a last resort, such drug-induced sedation is legal in the U.S., and it is widely accepted as a mainstay of end-of-life care. However,

this is the doctor's decision. **Not the patient**. Terminal Sedation does not have all of the safeguards that SB1129 SD2 has.

SB 1129 SD2 "Medical Aid in Dying" allows the terminally ill to decide for themselves what's best for them and to regain control over their illness and the conditions of their death.

Hawaii Martin Luther King Jr., Coalition
MarshaRose Joyner
808-741-4612 * Mrjoy@hawaii.rr.com

HOUSE OF REPRESENTATIVES
THE TWENTY-NINTH LEGISLATURE
REGULAR SESSION OF 2017

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Rep. Sharon E. Har	Rep. Chris Todd
Rep. Dee Morikawa	Rep. Andria P.L. Tupola
Rep. Marcus R. Oshiro	

NOTICE OF HEARING

DATE: Thursday, March 23, 2017
TIME: 8:30 AM
PLACE: Conference Room 329
State Capitol
415 South Beretania Street

Testimony in STRONG SUPPORT of SB1129 SD2

How can the Church stand in the Way of Medical Aid in Dying?

The people who oppose this . . . Have they never felt unbearable pain or seen someone whose body or mind is failing? How can they say, "I think the law should deny *you* the right to manage your own body? Everyone is entitled their own traditions and beliefs which are valid and they should be honored.

The primary opponent to Medical Aid in Dying is the Catholic Church. 41.31% of the people in Hawaii are religious, meaning they affiliate with a religion. Of the 41.31% only 18.38% are Catholic. **Can a true minority demand rules and State laws which affect the majority of the population?**

The Ten Commandments are the basis of most religions. The Eighth Commandment tells us to love our neighbors as ourselves. Therefore, we must honor and respect their wishes and cannot deny them the right to their own way of living and dying, even when it differs from our own. God dignifies us with free will, the power to make decisions of our own rather than having God or fate predetermine what we do.

Even the constitution of the United States in its Bill of Rights gives us the right to determine our future. In the United States form of government, "Majority rules with minority rights" is an important principle in democracy according to which public policy is determined by a majority of citizens, but the minority, in this case, The Catholic Church, may not rightfully use its power to deprive majority groups of their rights. The protection of everyone's rights is an act of self-interest in a democracy. Free will is a precious gift from God, for it lets us love him with our "whole heart"—because we want to.—Matthew 22:37. It lets us love our neighbor and honor their Dignity.

The Bible does teach that God is Almighty, that his power is not limited by anyone other than himself. (Job 37:23; Isaiah 40:26) However, he does not use his power to control everything. So how can the Church seek to control a person's final wishes?

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 3:55 AM
To: HLTtestimony
Cc: annsfreed@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Ann S Freed	Hawaii Women's Coalition	Support	No

Comments: Aloha Chair Belatti, Vice Chair Kobayashi and members, The Coalition supports this measure. Although it is not in this year's package of bills, we have historically supported the right of each person to control their own bodies, including the right to die with dignity. Mahalo, Ann S. Freed, Co-Chair Hawaii Women's Coalition

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 9:00 PM
To: HLTtestimony
Cc: Burdick808@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Alan B Burdick	Progressive Democrats of Hawaii	Support	No

Comments: PROGRESSIVE DEMOCRATS OF HAWAII supports medical aid in dying legislation. This bill incorporates detailed safeguards and should be adopted. People who are dying should not suffer because OTHER PEOPLE believe they should persist in hopeless agony. Thank you for allowing us to testify on this long-overdue remedial legislation.

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TESTIMONY OF

DIANE COLEMAN, JD, PRESIDENT/CEO OF NOT DEAD YET

OPPOSING HAWAII SB 1129

House Health Committee

DATE: Thursday, March 23, 2017
TIME: 8:30 a.m.

Submitted March 22, 2017

I am a severely disabled woman, and head up the national disability group, Not Dead Yet, which has members in Hawaii. I've spent a lifetime advocating for the rights of disabled people, young and old, to control our own lives and not have our choices dictated by doctors and other professionals. So you might wonder why I oppose a bill that is widely portrayed as giving people choice and control over their own death.

But who actually has choice and control under assisted suicide laws? Anyone could ask their doctor for assisted suicide, but the law gives the authority to doctors to determine who is eligible. More importantly, the purported "safeguards" to prevent mistake, coercion and abuse are empty window dressing, with little substance or effect.

One of the most frequently repeated claims by proponents of assisted suicide laws is that there is "no evidence or data" to support any claim that these laws are subject to abuse, and that there has not been "a single documented case of abuse or misuse" in Oregon during the 18 reported years. These claims are demonstrably false. Although SB1129 is actually a euthanasia bill, as explained later below, an examination of the Oregon myth is still relevant and essential to the Committee's deliberations.

Regarding documented cases, please refer to a compilation of individual cases and source materials pulled together by the Disability Rights Education and Defense Fund entitled Oregon and Washington State Abuses and Complications.[1] For an in-depth analysis of several cases by Dr. Herbert Hendin and Dr. Kathleen Foley, please read Physician-Assisted Suicide in Oregon: A Medical Perspective.[2]

The focus of the discussion below is the Oregon Health Division data.[3] These reports are based on forms filed with the state by the physicians who prescribe lethal doses and the pharmacies that dispense the drugs. As the early state reports admitted:

"As best we could determine, all participating physicians complied with the provisions of the Act. . . . Under reporting and noncompliance is thus difficult to assess because of possible repercussions for noncompliant physicians reporting to the division."

Further emphasizing the serious limits on state oversight under the assisted suicide law, Oregon authorities also issued a release in 2005 clarifying that they have No authority to investigate Death with Dignity case.[4] Thus, all of the state reported data is a statistical

summary of self-reports submitted by physicians who prescribe lethal drugs, nothing more.

Nevertheless, contrary to popular belief and despite these extreme limitations, the Oregon state reports substantiate some of the problems and concerns raised by opponents of assisted suicide bills.

Non-Terminal Disabled Individuals Are Receiving Lethal Prescription In Oregon

The Oregon Health Division assisted suicide reports show that non-terminal people receive lethal prescriptions every year.

The prescribing physicians' reports to the state include the time between the request for assisted suicide and death for each person. However, the online state reports do not reveal how *many* people outlived the 180-day prediction. Instead, the reports give that year's median and range of the number of days between the request for a lethal prescription and death. This is on page 7 of the 2015 annual report.[5] In 2015, at least one person lived 517 days; across all years, the longest reported duration between the request for assisted suicide and death was 1009 days. In every year except the first year, the reported upper range is significantly longer than 180 days.

The definition of "terminal" in the statute only requires that the doctor predict that the person will die within six months. There is no requirement that the doctor consider the likely impact of medical treatment in terms of survival, since people have the right to refuse treatment. Unfortunately, while terminal predictions of some conditions, such as some cancers, are fairly well established, this is far less true six months out, as the bill provides, rather than one or two months before death, and is even less true for other diseases. Add the fact that many conditions will or may become terminal if certain medications or routine treatments are discontinued – e.g. insulin, blood thinners, pacemaker, CPAP – and "terminal" becomes a very murky concept.

The state report's footnote about "other" conditions found eligible for assisted suicide has grown over the years, to include:

". . . benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease."

Overall as of 2015, 7%, or 68 individuals across all reported years, had conditions classified as "other". Another 16% had ALS, chronic respiratory or heart disease, or HIV/AIDS. In addition, it should be noted that the attending physician who determines terminal status and prescribes lethal drugs is not required to be an expert in the disease condition involved, nor is there any information about physician specialties in the state reports.

The Only Certifiers of Non-Coercion And Capability Need Not Know the Person

Four people are required to certify that the person is not being coerced to sign the assisted suicide request form, and appears capable: the prescribing doctor, second-opinion doctor, and two witnesses.

In most cases, the prescribing doctor is a doctor referred by assisted suicide proponent organizations. (See, M. Golden, Why Assisted Suicide Must Not Be Legalized,[6] section on "Doctor Shopping" and related citations). The Oregon state reports say that the median duration of the physician patient relationship is 12 weeks. Thus, lack of coercion is not usually determined by a physician with a longstanding relationship with the patient. This is significant in light of well-documented elder abuse-identification and reporting problems among professionals in a society where an estimated one in ten elders is abused, mostly by family and caregivers. (Lachs, et al., New England Journal of Medicine, Elder Abuse.[7])

The witnesses on the request form[8] need not know the person either. One of them may be an heir (which would not be acceptable for witnessing a property will), but neither of them need actually know the person (the form says that if the person is not known to the witness, then the witness can confirm identity by checking the person's ID).

So neither doctors nor witnesses need know the person well enough to certify that they are not being coerced.

No Evidence of Consent or Self-Administration At Time of Death

In about half the reported cases, the Oregon Health Division reports also state that no health care provider was present at the time of ingestion of the lethal drugs or at the time of death. Footnote six clarifies:

"A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010."

While the only specific example mentioned is the "time of death," other "circumstances surrounding death" include whether the lethal dose was self-administered and consensual at the time of death.

Therefore, although "self administration" is touted as one of the key "safeguards" in the Oregon law, in about half the cases, there is no evidence of consent or self-administration at the time of ingestion of the lethal drugs. If the drugs were, in some cases, administered by others without consent, no one would know. The request form constitutes a virtual blanket of legal immunity covering all participants in the process.

What is perhaps most shocking about SB1129 is that it doesn't even purport to require self-administration of the lethal dose. Even if an ill person requests a lethal prescription just in case they want it later, of their own volition or "encouraged" to do so, once the drugs are in the home, the ill person has no protection from unscrupulous family or caregivers. And with no requirement, procedural or enforcement provisions related to self-administration, this is not an assisted suicide bill, but an open and full blown euthanasia bill.

Pain Is Not the Issue, Unaddressed Disability Concerns Are

The top five reasons doctors give for their patients' assisted suicide requests are not pain or fear of future pain, but psychological issues that are all-too-familiar to the disability

community: "loss of autonomy" (92%), “less able to engage in activities” (90%), "loss of dignity" (79%), “losing control of bodily functions” (48%), and "burden on others" (41%).

These reasons for requesting assisted suicide pertain to disability and indicate that over 90% of the reported individuals, possibly as many as 100%, are disabled.

Three of these reasons (loss of autonomy, loss of dignity, feelings of being a burden) could be addressed by consumer-directed in-home long-term care services, but no disclosures about or provision of such services is required. Some of the reported reasons are clearly psycho-social and could be addressed by disability-competent professional and peer counselors, but this is not required either. Moreover, only 5.3% of patients who request assisted suicide were referred for a psychiatric or psychological evaluation, despite studies showing the prevalence of depression in such patients.

Basically, the law operates as though the reasons for suicidal feelings don’t matter, and nothing need be done to address them.

Conclusion

The Oregon assisted suicide data demonstrates that people who were not actually terminal received lethal prescriptions in all 18 reported years except the first, and that there is little or no substantive protection against coercion and abuse. Moreover, reasons for requesting assisted suicide that sound like a “cry for help” with disability-related concerns are apparently ignored. Thus, the data substantiates problems with the implementation of assisted suicide laws and validates the concern that the risks of mistake, coercion and abuse are too great. Well-informed legislators on both sides of the aisle should vote against assisted suicide bills.

Please vote NO on SB1129.

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March 23, 2017

TIM VANDEVEER
Chair

MARGARET WILLE
SEAN SMITH
Legislation Committee Co-Chairs

In Support of SB 1129 SD2 "Relating to Health"

Representative Della Au Belatti, Chair
Representative Bertrand Kobayashi, Vice Chair
House Committee on Health
March 23, 2017 8:30 a.m. State Capitol Conference Room 329

Submitted On Behalf of the Democratic Party of Hawai'i

The Democratic Party of Hawai'i (DPH) strongly supports SB 1129 SD2. The purpose of the bill is to enact a medical aid in dying act, which will allow mentally capable, terminally ill adults in Hawai'i to request and self-administer prescription drugs so they may die in a peaceful, humane manner. **Establishing a legal medical aid in dying option for mentally capable, terminally ill people in Hawai'i is one of DPH's legislative priorities for the 2017 legislative session.**

This legislation is consistent with DPH's platform, which counts "compassion and respect for the dignity and worth of the individual" as one of the "abiding values of the Democratic Party." SB 1129 is also consistent with DPH resolution HHS 2016-02, which was adopted by the Party at its State convention last June. This resolution acknowledges DPH's "long history of support for and endorsement of Death with Dignity for ill patients at the end of life." The resolution also urges state lawmakers to "take all measures to affirm the right of dying patients to make informed decisions about their health care, ensure that Hawai'i residents are provided with a full range of end of life options, including a decision to advance the time of death, and provide safeguards to ensure patients are in control if they choose Death with Dignity[.]"

Within the last year, California, Colorado and Washington D.C. have passed medical aid in dying laws, tripling the number of terminally ill Americans with access to a medical aid in dying option. We believe terminally ill people in Hawai'i should have the same option. DPH is concerned by reports that some in our community have taken desperate, violent measures to end their lives in the absence of such an option. We believe mentally capable, terminally ill people should be allowed to pass peacefully if they choose.

Mahalo for the opportunity to testify on this bill.

Respectfully submitted,

Tim Vandeveer
Chair of the Democratic Party of Hawai‘i

/s/ Margaret Wille
/s/ Sean Smith
Legislative Committee Co-chairs

March 23, 2017

To: Representative Della Au Belatti, Chair
Representative Bertrand Kobayashi, Vice Chair and
Members of the Committee on Health

From: Jeanne Y. Ohta, Co-Chair

RE: SB 1129 SD2 Relating to Health
Hearing: Thursday, March 23, 2017, 8:30 a.m., Room 329

POSITION: Support

The Hawai‘i State Democratic Women’s Caucus writes in support of SB 1129 SD2 Relating to Health.

We believe that a terminally ill person’s end-of-life choices should be his or hers alone, without the interference of government and without the interference of others’ religious beliefs.

This measure enables patients to discuss end-of-life choices with their physicians and to discuss appropriate care for severe pain and terminal illnesses.

This is a bill about personal choice and freedom. Anyone opposed to assisted dying simply need not ask. This bill would give patients with terminal illnesses the power to choose, not life over death, but one form of death over another. This bill gives people the opportunity to have choices at life’s end.

The Democratic Party of Hawai‘i overwhelmingly passed a resolution at the 2010 Convention in support of Death with Dignity and again at the 2016 Convention. The Hawai‘i State Democratic Women’s Caucus is a catalyst for progressive, social, economic, and political change through action on critical issues facing Hawaii’s women and girls.

We ask the committee to pass this measure and thank the committee for the opportunity to provide testimony.

Hawai‘i State Democratic Women’s Caucus, PO Box 2041, Honolulu, HI 96805-2041
hidemwomen@gmail.com

46-063 Emepela Pl. #U101 Kaneohe, HI 96744 · (808) 679-7454 · Kris Coffield · Co-founder/Executive Director

TESTIMONY FOR SENATE BILL 1129, SENATE DRAFT 2, RELATING TO HEALTH

House Committee on Health
Hon. Della Au Belatti, Chair
Hon. Bertrand Kobayashi, Vice Chair

Thursday, March 23, 2017, 8:30 AM
State Capitol, Conference Room 329

Honorable Chair Belatti and committee members:

I am Kris Coffield, representing IMUAlliance, a nonpartisan political advocacy organization that currently boasts over 350 members. On behalf of our members, we offer this testimony in strong support of Senate Bill 1129, SD 2, relating to health.

Medical aid in dying acts, also known as "death with dignity" laws, allow people to die on their own terms. Painful as it may be to discuss, aid in dying empowers terminally ill patients to decide whether or not to use a prescription to avoid life supportive processes that prolong dying without enhancing the patient's quality of life.

Importantly, aid in dying does not replace end-of-life care. Patients may still choose to receive hospice and palliative care as an alternative to hospitalization, and may deal with terminal illness in the comfort of their own homes. Contrary to sensationalized claims from opponents of aid in dying proposals, patients are not coerced into ending their lives prematurely.

Relatedly, while we must continue to fight for universal healthcare to prevent the financial pressure wrought by terminal illness from becoming a debt sentence, there is scant evidence to support the notion that monetary encumbrances incentivize patients to end their lives. As Martin Levin, JD, MPH, MTS, Special Counsel for the Robert F. Kennedy Center for Justice and Human Rights, wrote in "Physician-Assisted Suicide: Legality and Morality" (December, 2012):

> "What is absolutely incredible to me is that someone would honestly argue that we should consider the cost savings to America by killing, or assisting in the suicide, of human beings. It seems almost unfathomable. However, even if we were to consider these figures, the savings only total approximately $10,000 per assisted suicide victim. The total savings of approximately $627 million is less than one percent of the total United States health care expenditures. The reason this figure is so low is because an extremely small percentage of Americans receiving health care would qualify for physician-assisted suicide. We are not

> talking about the withholding or withdrawing of life-sustaining procedures. This is already legal, and widely utilized. We are talking about allowing a competent adult suffering from an incurable illness with less than six months of life to seek the assistance of a physician in actively ending the patient's life. This number makes up less than 1/3 of 1% of Americans each year, and those who do qualify, and who choose to die by assisted suicide, generally end their lives approximately three weeks before their natural death would have occurred."

Merrill Matthews, Director of the Center for Health Policy Studies at the National Center for Policy Analysis, additionally held, in "Would Physician-Assisted Suicide Save the Healthcare System Money?", appearing in *Physician Assisted Suicide: Expanding the Debate* (1998), that:

> "Would Physician-Assisted Suicide Save Money? The answer to the question seems almost certainly no... The primary reason is that the number of people seeking physician-assisted suicide and being granted that asssistance is extremely small...
>
> Most requests for physician assistance come in the last month, or even the last days of life, which would drastically reduce the actual amount of money saved. For example, in the survey of Dutch physicians, 64 percent said they had shortened a patient's life by less than twenty-four hours, and in 16 percent it was shortened less than a week.
>
> ...Even though the various elements that make up the American healthcare system are becoming more circumspect in ensuring that money is not wasted, the cap that marks a zero-sum healthcare system is largely absent in the United States... Considering the way we finance healthcare in the United States, it would be hard to make a case that there is a financial imperative compelling us to adopt physician-assisted suicide in an effort to save money so that others could benefit."

Thus, physician-assisted suicide would not save substantial amounts of money–in absolute or relative terms–for particular institutions, Hawai'i or the nation, negating the argument that financial pressure makes death more appealing.

Patients who seek medical aid in dying do so for many reasons, including loss of autonomy, being less able to engage in routine activities, loss of dignity, loss of bodily functions, inadequate pain control, and combinations thereof. Gallup polls have consistently found that about 70 percent of Americans support doctors using "some painless means if the patient and his or her family request it" of ending the life of someone suffering from an incurable disease.

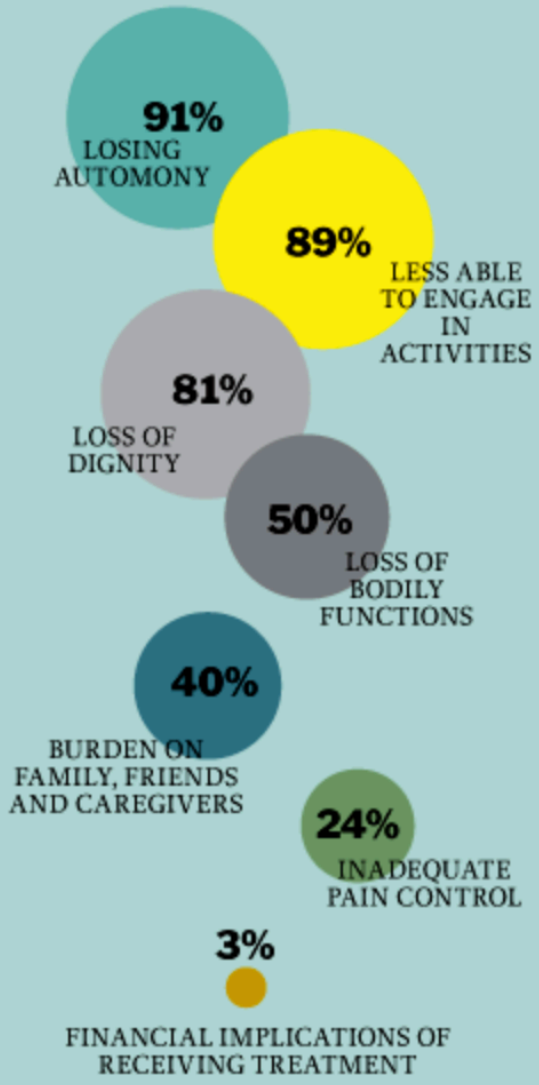
Mahalo for the opportunity to testify <u>in support</u> of this bill.

Sincerely,
Kris Coffield
Executive Director
IMUAlliance

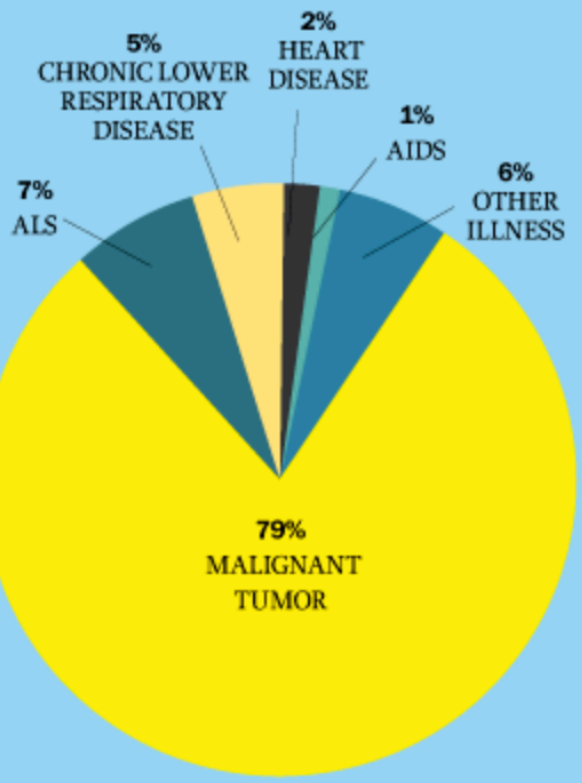
Kris Coffield **(808) 679-7454** **imuaalliance@gmail.com**

WHY PATIENTS SEEK LETHAL MEDICATION

Most people seek a lethal prescription because they worry about becoming a burden or losing autonomy – not because they are experiencing pain from illness or because they can't afford treatment.



CIRCUMSTANCES OF THOSE WHO DIED FROM TAKING THE LETHAL DOSE:



95% of patients died at their own home or a home of a family member or friend

4% died in a long term care facility

45% of patients did not have a health-care provider present at time of death

EDUCATION OF THOSE WHO DIED:

- **6%:** Less than high school
- **22%:** High school graduate
- **26%:** Some college
- **46%:** BA or higher

INSURANCE OF THOSE WHO DIED:

- **35%:** Medicare, Medicaid or other government
- **63%:** Private Insurance, alone or in combination with other insurance
- **2%:** None

Kris Coffield **(808) 679-7454** **imuaalliance@gmail.com**

AMERICAN CIVIL LIBERTIES UNION of HAWAI'I

Committees:	Committee on Health
Hearing Date/Time:	Thursday, March 23, 2017, 8:30 a.m.
Place:	Room 329
Re:	*Testimony of the ACLU of Hawaii in Support of S.B. 1129, S.D.2, Relating to Health*

Dear Chair Belatti, Vice Chair Kobayashi, and Committee Members:

The American Civil Liberties Union of Hawaii ("ACLU of Hawaii") writes in support of S.B. 1129, S.D. 2, which allows competent, terminally ill adults to obtain prescription medication to end their own life. The ACLU of Hawaii strongly supports the right to bodily autonomy, which includes, among other things, the right to refuse treatment, the right to access necessary medical care, and the right to make personal decisions about how to spend one's final days. Six states — Oregon, Montana, California, Vermont, Washington, and Colorado — and Washington, D.C. have legalized medical aid in dying.

While the ACLU of Hawaii is unaware of any documented widespread abuse, it is important that any physician-assisted death legislation include proper safeguards to prevent abuse or coercion. In order for physician-assisted death to truly be a choice, it must not be the only option. Patients must have access to information about pain medication, and palliative care must be readily available. Patients should never be pressured or coerced into requesting life-ending medication, whether by a doctor, spouse, or family member. S.B. 1129, S.D. 2 provides adequate safeguards to address these concerns.

Thank you for this opportunity to testify.

Mandy Finlay
Advocacy Coordinator
ACLU of Hawaii

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

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HAWAII'S PARTNERSHIP
for APPROPRIATE and COMPASSIONATE CARE

"There's no Aloha in suicide."

In Opposition to SB 1129 SD 2 Medical Aid in Dying Hearing on March 23, 20178

Dear Honorable Chair Belatti and members of the House Committee on Health

I am a recently retired longterm care and palliative care physician and spokesperson for Hawaii's Partnership for Appropriate Compassion and Care.. I am opposed to SB 1129, the Medical Aid In Dying Act. In my firsthand experience with caring for those with terminal illnesses, I have found that in virtually all patients, I can, with my expertise, control and manage well all the physical symptoms that accompany the last chapter of a person's life. This scenario of a person writhing in pain tethered to a hospital or nursing home bed is simply not true and is a picture conjured up by the national advocacy group, Compassion and Choices in order to persuade the public to pass such a bill.

Instead, what I have found that a request for dying is often based upon more than the physical symptoms, but involves emotional, psychological, social, spiritual, and existential components. To support an individual who is in such a situation, it takes a team of dedicated and trained individuals in these areas in order to optimally provide cared. If this option of death by ingestion of lethal drugs is made available to the vulnerable elderly, those with advanced illnesses, and the disabled, doctors whose main agenda is to prescribe these drugs will certainly be prone to cause inappropriate deaths.

If one thinks that the safeguards built in to SB 1129 will prevent such a situation from ever happening, please realize that with the inability of the records to be available for investigation or review, as well as the layers of immunity given to the providers as this bill reads, it is hardly plausible that this safety net will protect the vulnerable. The statistics in Oregon and Washington pointedly expose this. 1) treatable depression in this cohort of individuals runs a prevalence rate of at least 25%. Yet less than 4% of the individuals prescribed the lethal drugs were ever referred to a mental health therapist. Elder abuse runs 10% in the United States. To imagine that not one case of abuse has ever been noted points not as much to the magnificent deterrence factor of the safeguards, but rather how loose the safety net really is!

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"Allowing a mentally capable adult with a terminal illness the right to choose his own method of dying by lethal ingestion of oral medication should be allowed because the Oregon experience of legalized assisted suicide has not resulted in a single case of abuse in the 17 year history of its existence."

While that seems to be a clear-cut reason for passage of a bill in Hawaii to allow Medical Aid in Dying, it is much clearer that these so-called safeguards are not safe, and thus puts the much greater population of vulnerable adults such as the elderly, those living with chronic illnesses, the mentally ill, and the disabled at risk for inappropriate, premature ending of their lives. Why?

1. The records are not open to the public, including public safety agencies, the police, etc. for investigation, quality review, or any other reason. Therefore, the reported "absence of abuses" cannot be categorically stated when no means of investigation of suspect cases can even be done!
2. The law protects the providers, not the patients! The layers of immunity against prosecution for undue external influence, misdiagnosis of prognosis, or negligence in lack of recognition of an individual requestor who has a treatable depression, leaves an open door to inappropriate care. As Neal Gorsuch, the recent Supreme Court nominee states in his book, *The Future of Assisted Suicide and Euthanasia*, "It is also rather remarkable that, while physicians in Oregon are held to a standard of professional competence in administering all other treatments they provide, the Oregon assisted suicide statue creates an entirely different regime when it comes to administering this 'treatment', specifically and uniquely immunizing doctors from criminal prosecution, civil liability, or even professional discipline for any actions they take in assisting a suicide, as long as the act in 'good faith'. "
3. Depression is very prevalent, in this group of vulnerable individuals, as you can imagine. And depression is a treatable problem. Yet, according to the most recent available data from the Oregon department of health, at the end of 2015, less than 4% of those prescribed lethal medications were ever referred to a psychiatrist!
4. There is concern of patient harm even to the individual who desires to die by lethal ingestion of the lethal medication.! The most commonly used medication to cause death is Secobarbitol. For the medication to kill, kill quickly and effectively with minimal or no side effects, a dosage of 9 grams is required. As the drug is most available in 100 mg capsules, it would take swallowing 90 capsules to achieve an effective death. Since this is quite impossible even for a healthy person, it requires assistance by others in emptying out the powder of the capsules, making it into a slurry with water and the addition of honey, because of its very bitter taste, and hope that the person can ingest it

in a manner that would ensure no complications with the procedure. Because of the practical difficulty involved with this medication as well as the rapid escalation of its cost, there has been a scramble to come up with combinations of other medications to be more convenient and less expensive. The very method of these rushed attempts to trial these concoctions speak to the lack of quality control that is entirely antithetical to how drugs are developed and tested to ensure public safety.

5. The bill requires two witnesses to be present at the patient's request for the lethal medications, but none at the time of the suicide. Pt's therefore may be coerced into ingesting the drug, or another person may administer the drug, leaving the potential for serious abuse. With the prohibition of not having records be available to the public or agencies for investigation, this scenario allows for a criminal act to occur without the likelihood of the perpetrator ever being subject to discovery and prosecution.

Please understand, therefore, that allowing such a bill to become public policy, while giving rights to a very few, endangers the lives of many, many more; lives for whom if a mistake is made, can never have a second chance.

Therefore, in conclusion, this bill legalizing aid in dying, while perhaps benefiting the few who would appropriately choose this, has the real potential of harming a greater number of vulnerable individuals.

Respectfully submitted

Craig Nakatsuka, MD,
and Hawaii's Partnership for Appropriate Compassion and Care

kobayashi2 - Jessi

From: Judith Eagle <eaglaw2@gmail.com>
Sent: Tuesday, March 21, 2017 11:23 PM
To: HLTtestimony
Subject: Supportive Testimony for SB 1129 SD 2

Hawaii is about personal freedom: the right to live and die how we want as long as we hurt no others. Family experiences, the passage of time, a hope for a wiser future...all these spell asking you, our legislators, to pass this bill. Only with the bill can we look forward to being able to plan an exit with dignity. Thank you.

Judith G. Eagle*
Eagle Employment Consulting
2034 A Pakolu Street
Wailuku, HI 96793

Admitted to Legal Practice, MD, PA, DC

92-954 Makakilo Dr. #71, Kapolei, HI 96707 Email: RainbowFamily808@gmail.com Ph: (808) 779-9078 Fax: (808) 672-6347

DATE: March 21, 2017

RE: SB1129 Relating to Health: Terminally Ill Adults' Choices STRONG SUPPORT

TO: House Health Committee Hearing

Aloha Represtatives Belatti, Kobayashi and Committee Members,

Thank you for the opportunity to STRONGLY SUPPORT SB 1129 relating to Terminally Ill Adult Choices at End of Life. Rainbow Family 808 is a support and resource organization that focuses on reaching out to all families in love, support and advocacy.

Rainbow Family 808 sees SB 1129 as an important choice for Terminally Ill Adults at the End of their lives because we are all terminal, no one escapes this stage of our lives. We believe that all adult humans at this sensitive time in their lives, need to retain control of their choices. None of us completely control our health issues but science has provided a safe, sane manner to relieve pain that exceeds pain tolerance due to cancer and other deadly, terminal medical conditions. After all possible interventions have been expended, terminal adults need to know they have a choice in End of Live decisions. As conscious, mentally sound adults, we are responsible to care for ourselves and should have a choice, one that gives us a humane avenue to address our End of Life Choices.

SB1129 respects our Terminally Ill Adults to use their logic and fact capabilities to make personal decisions regarding their End of Life choices. No one, no church, no religious organization should pressure anyone or obstruct any adult from practicing their Freedom of Choice at the End of their Life. Hawaii needs to respect our Freedom of Choice and SB 1129 provides this. SB 1129 will never force anyone to avail themselves of Compassion and Choices/ Death with Dignity because freedom of choice is our decision to make.

Please pass SB 1129 so that Terminally Ill Adults have the freedom to choose their own Compassionate Choice. Thank you.

Respectfully,

Carolyn Martinez Golojuch, MSW
President and Co-Founder

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Thomas Cook, M.D.

Psychiatry & General Mental Health
1110 University Ave, #302
Honolulu, HI, 96826

3-21-2017

Organization:
Advocates for the Mentally Ill
drcook@varsitydoc.com

Honorable Chair Belatti
& members of the House Committee on Health:

I write as a local psychiatrist in Hawaii and as a clinical expert on suicide.

I urge you to oppose the bill which allows doctors to write lethal prescriptions.

There are a rapidly growing number of psychiatrists who stand in strong opposition to the bill. I write on their behalf to urge you to reject the bill.

Leading studies have demonstrated that depression occurs at high rates among the terminally ill. In one study, over half of all terminally ill patients with a serious desire for hastened death had a diagnosable mental disorder. *Wilson et al, J Support Pall Care, 2014.

Given this fact, we are continually appalled by the data on assisted suicide coming out of Oregon and Washington. The data is very clear: in states which allow lethal prescriptions, referrals to a psychologist are almost *never* made. In 2015, in Washington, out of 213 lethal prescriptions, only 8 referrals were made to a mental health provider. This, according to a DWD Annual Report.

By signing this bill into law, you would be participating in a global movement which trivializes psychiatric care in the terminally ill.

As psychiatrists, we know how hard it is sometimes to recognize a serious depression. For precisely this reason, we have serious doubts that oncologists and palliative care physicians would be less bad at it than we are... and the data confirms our skepticism. In 2007 it was found that non-psychiatrists fail to diagnose real, existing depression about 63% of the time. *Cepoiu et al (JGIM 2007).

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Many national leaders in our field of psychiatry have expressed hesitation at these bills.

Paul Appelbaum, who teaches at Columbia University and is perhaps the foremost expert on psychiatry and the law, has expressed worry that in countries which have legalized euthanasia for psychiatric reasons, such as the Netherlands, there would be less political pressure to improve psychiatric services.

The American Psychiatric Association released in 2017 a formal position statement in opposition to assisted suicide for the non-terminally ill.

Many in our field see these sorts of bills as a slippery slope. Dr. Martin Komrad, of the APA's ethics committee, has stated "*So far, no other country that has implemented physician-assisted suicide has been able to constrain its application solely to the terminally ill, eventually including non-terminal patients as legally eligible as well... this is when psychiatric patients start to be included.*"

Belgium, having first passed bills like our SB1129, is now a place where lethal prescriptions are given for such mental health conditions as autism, anorexia, or sexual abuse.

It means little that American doctors are split on the issue. For half a century, lobotomy had its detractors, but was considered a humane procedure on the whole.

We also wish you to keep in mind that lobotomies were often voluntary. Many patients requested for them. Nevertheless, today's consensus is that lobotomy is a barbaric procedure. In effect, it doesn't matter how badly some patients want a procedure. That is a spurious point, as can be seen from the reflection that if every doctor was unwilling to do it, the whole debate would disappear.

Autonomy is often cited as the most important principle of medical ethics. It is not.

By that standard, we psychiatrists would be the least ethical of all physicians, since we regularly admit patients *against their will* to our treatment wards.

We admit them against their will to ensure their safety and to alleviate their immense suffering.

We ask, why is the bill not extended to cover those with mental illness? Do they not suffer too, like the terminally ill? The terminally ill suffer for only a few months. Those with bipolar depression suffer for a lifetime. They can become suicidal precisely because they suffer so much. The bill you are considering is intrinsically callous towards them.

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We think legislators should not get into the thorny business of telling some patients that their suffering doesn't quite meet the criteria.

Such questions of suffering as they relate to suicide are, on a global scale, almost meaningless anyway. Yes, pain is a small positive predictor for suicide in America, but globally speaking, the third world, where narcotics are not readily available, has the lowest suicide rates, according to the World Health Organization. The highest suicide rates are in countries where narcotics are plentiful.

Allow us to suggest that "pain and suffering" are not the simple concepts inferred by this bill.

And allow us to suggest that when proposed laws set a rift between the mentally ill and other forms of suffering, it is your duty to block such laws.

Cordially,

Thomas Cook, M.D.

Additionally:

Celia Ona, M.D.	Ethan Pien, M.D.
Michael Chang, M.D.	Mark Kang, M.D.
Rachel Sullivan, M.D.	Dennis Mee-Lee, M.D.

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Hawai`i Advocates For Consumer Rights

Working for Hawaii's consumers since 1994
Scott Foster, Communications Director
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Testimony supporting Senate Bill 1129 SD2 "Relating To Health"

HOUSE COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Thursday, March 23, 2017
8:30 AM
Conference Room 329
Hawaii State Capitol

Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members.

My name is Scott Foster and I am testifying as the Communication Director of *Hawai`i Advocates For Consumer Rights* (AFCR) representing our 2000+ members across the state. 2017 begins our third decade advocating for Hawai`i consumers on issues such as car and health insurance reform, medical marijuana and Internet access.

We have also supported *Death With Dignity* for many years and sincerely urge you to pass this long-needed legislation this year. Senate Bill 1129 SD2 is based on the acclaimed Oregon statute and includes all of the proven safeguards to protect patients from misuse. The Oregon law has been in effect since 1997 without a single incident of misuse and Oregon's documented 20-year history and experience with the law has proven this to be fact, despite what vocal opponents may say.

Because of Hawaii's geographical makeup and the growing shortage of doctors especially on the Neighbor Islands, we support Hawaii's Advance Practice Registered Nurses being included

in the list of “providers.” Many APRNs are already engaged in palliative care in Hawaii’s hospices where anyone with a 6-month terminal diagnosis may go to receive end-of-life care.

Please pass this long-needed legislation and let Hawaii’s citizens have the important freedom of choice which is now enjoyed by the citizens of Oregon, California, Colorado, Vermont and Washington State.

Sincerely,
Scott Foster
Communications Director

Testimony supporting Senate Bill 1129 SD2 "Relating To Health"

HOUSE COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Thursday, March 23, 2017
8:30 AM
Conference Room 329
Hawaii State Capitol

Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members.

My name is Scott Foster and I am testifying as the Communications Director for the *Hawai`i Death With Dignity Society,* a position I have held since 2002 when we came close to passing a similar bill but lost that by only three Senate votes. According to the Hawai`i State Department of Health, since 2002, approximately 7% per 1000 people have died annually and one might only imagine how many of those who have passed since 2002 suffered prolonged, painful, hopeless deaths in cold hospitals connected to machines and plastic tubes of all descriptions.

Because of the rural character of our geographically separated islands and the growing shortage of physicians in Hawai`i, we support the addition of Hawaii's Advanced Practice Registered Nurses to the list of "providers."

» It's important to know that Death with dignity laws greatly improves palliative and hospice care. After 20-years, over 90% of Oregonians requesting life-ending medications are in hospice, *twice the US average.*

» This law would allow a person the freedom of choice to die at a time and place of their choosing. Nationally, only 20% of people die at home while 90% of people using *Death With Dignity* die at home surrounded by their family, friends and their loving pets.

» *Death With Dignity* laws allow the terminally ill to decide for themselves what's best for them and to regain control over their illness and the conditions of their death.

» The option to die a peaceful death at the time and place of their choosing provides the terminally ill with invaluable peace of mind at an extremely private time of their lives.

» The latest Hawaii poll (Fall of 2016) revealed that “eight out of 10 Hawaii voters (80%) agreed that a mentally capable adult who is dying of a terminal disease that cannot be cured should have the legal option to request prescription medicine from their doctor, and use that medication to end their suffering in their final stages of dying.” A majority of Catholics (82%) and those associated with the Christian Fellowship (83%) said terminally ill adults definitely or probably should have this legal option.

Some of the many safeguards in SB1129 include:
1) Confirmation by two physicians of the patient's diagnosis, prognosis, mental competence, and voluntariness of the request;

2) Multiple requests by the patient: an oral request followed by a valid written request for medication which must be witnessed by at least two individuals in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request. One of the witnesses shall be a person who is not: A relative of the patient by blood, marriage, or adoption; A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

3) The patient's attending physician at the time the request is signed shall not be a witness.

4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having qualifications specified by the department of human services by rule.

5) Only adult residents of Hawaii who are mentally competent and have a terminal illness that will lead to death in six months or less will qualify. Patients must be capable of taking the medication themselves without assistance. No one will qualify solely based on age or disability.

Similar laws are now in effect in Oregon, California, Colorado, Vermont, and Washington and today, 22 other states are considering *medical aid in dying* legislation.

Please pass Senate Bill 1129 SD1 and give all of Hawaii’s citizens the freedom to choose a Death With Dignity.

Sincerely,

Scott Foster

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Testimony supporting Senate Bill 1129 SD2 "Relating To Health"

HOUSE COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Thursday, March 23, 2017
8:30 AM
Conference Room 329
Hawaii State Capitol

Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members. My name is Scott Foster and I am testifying as the Chair of the Kupuna Caucus of the Democratic Party of Hawai`i (DPH) which currently represents nearly 2000 active Democrats across the state.

As you may know, the Party's unwavering support for Death With Dignity legislation dates back several decades. This year, the issue was selected by the DPH State Legislative Committee as #1 in the list of "Primary Issues."

As a 75-year old kupuna, I've witnessed many tragic, painful, deaths with much prolonged suffering and like 80% of Hawaii's registered voters, I want this freedom of choice when my time comes. The other 20% of Hawaii's registered voters who have philosophical differences with the concept are free to choose to not use the law. It's just that simple.

Senate Bill 1129 SD2 is based on the historic Oregon statute and includes all of the proven safeguards that have served to protect Oregon patients from any misuse. In fact, the Oregon law has been in effect since 1997 without a single incident of misuse and Oregon's documented 20-year history and experience with the law has proven this, despite what opponents in Hawai`i

may say today. Using the law is strictly voluntary for both patients and physicians. Only the patient can make the request for medication, the patient can rescind the request at any time and the patient must self-administer the medication.

Because of the rural character of our geographically separated islands and the growing shortage of physicians in Hawai`i, we support the addition of Hawaii's Advanced Practice Registered Nurses to the list of "providers."

We urge you to pass this legislation and let Hawaii's citizens have this important freedom of choice which is already enjoyed by the citizens of Oregon, California, Colorado, Vermont and Washington State.

Sincerely,
Scott Foster, Chair
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The Twenty-Ninth Legislature
Regular Session of 2017

HOUSE OF REPRESENTATIVES
Committee on Health
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair
State Capitol, Conference Room 329
Thursday, March 23, 2017; 8:30 a.m.

STATEMENT OF THE ILWU LOCAL 142 ON S.B. 1129, SD2
RELATING TO HEALTH

The ILWU Local 142 **supports** S.B. 1129, SD2, which establishes a Medical Aid in Dying Act that establishes a regulatory process under which an adult resident of the State with a medically confirmed terminal disease may obtain a prescription for medication to be self-administered to end the patient's life.

Simply put, this bill allows a mentally competent, terminally ill person to have a **CHOICE**—to die with dignity on the patient's own timetable and at the patient's own volition or to continue to suffer for another few days, weeks, months until death mercifully comes. There is very little quality of life for someone waiting for death and experiencing unbearable pain. Even when the patient can no longer take in food and nutrition, death is slow. In the meantime, the patient loses awareness and is no longer the person he or she once was.

S.B. 1129, SD2 provides for an abundance of safeguards. These safeguards should provide ample reassurance that the process to request the lethal medication is thoughtful, informed, and offers protections against liability for the physician and against abuse of the patient.

Although some will argue that palliative care for terminally patients with severe pain should be sufficient, the reality is that pain medication often dulls the mind and consciousness, leaving a once vibrant and alive human being to wither away into someone even loved ones may no longer recognize. If given the choice, most people would prefer to have their loved ones remember them as they lived, not as they died.

Religious arguments will be made against S.B. 1129, SD2, but the U.S. Constitution protects religious freedom and the separation of church and state. Just as lawmakers must be mindful that laws should not force individuals to abandon their religious views and beliefs, neither should laws be enacted to deny rights to someone who does not subscribe to certain religious beliefs.

S.B. 1129, SD2 does not force any patient to seek to end his or her life nor does it force any physician to prescribe lethal medication to a terminally ill patient. In truth, some patients who ask for and receive the medication may decide not to use it. Most, if not all, terminally ill patients want to live, but S.B. 1129, SD2 will allow a patient the **OPTION** to decide if and when medication to end life will be taken.

The ILWU urges passage of S.B. 1129, SD2. Thank you for the opportunity to share our views and concerns on this important matter.

Testimony on SB 1129 SD2, The Medical Aid in Dying Act
Kat West, National Director of Policy & Programs, Compassion & Choices
Hawai'i House Health Committee
March 23, 2017 at 8:30 am

Introduction
Good morning Chair and Members of the Committee. My name is Kat West, Director of Policy & Programs for Compassion & Choices, the nation's oldest and largest nonprofit organization working to improve care and expand choice at the end of life.[1,2,3,4,5] We are here today to express our full support for SB 1129 SD2, the Medical Aid in Dying Act, and its goals of improving the quality of end-of-life care for Hawaii's terminally ill patients and their families.

What is Medical Aid in Dying?
Medical aid in dying refers to a medical practice in which a mentally capable, terminally ill adult with six months or fewer to live may request from his or her physician a prescription for a medication that the he or she can self-administer to achieve a peaceful death when, and if, their suffering becomes unbearable.

Voter Support for Medical Aid in Dying is Strong
Numerous polls from a variety of sources, both nationally and at the state level, demonstrate that the American public consistently supports medical aid in dying. In 2016, a Lifeway Research survey[6] put national support for medical aid in dying at 67%. Majority support spanned a variety of demographic groups including White Americans (71%), Hispanic Americans (69%), more than half of Black, Non-Hispanic Americans (53%); aged 18 to 24 (77%), 35 to 44 (63%) and 55 to 64 (64%); with some college education (71%), with graduate degrees (73%) and with high school diplomas or less (61%). Majority support also included most faith groups, including Christians (59%), Catholics (70%), Protestants (53%), those of other religions (70%) and those who identified as non-religious (84%).

Physician Support for Medical Aid in Dying is Strong
Among U.S. physicians, support for medical aid in dying is also strong. A December 2016 Medscape poll[7] of more than 7500 U.S. physicians from more than 25 specialties demonstrated a significant increase in support for medical aid in dying from 2010. Today well over half (57%) of the physicians surveyed endorse the idea of medical aid in dying, agreeing that "Physician assisted death should be allowed for terminally ill patients." Most of the medical associations in authorized states currently have neutral positions on medical aid in dying including Oregon,[8] California,[9] and Colorado.[10] Additionally numerous professional medical organizations have recognized medical aid in dying.[11]

For Some, Comfort Care and Pain Management Is Not Enough
While palliative care and hospice programs provide extraordinary comfort to patients and work wonders for many dying people and their loved ones, there are times when even the best palliative options cannot alleviate pain and suffering. And symptoms, like fatigue, breathlessness, nausea, vomiting, rashes and open, draining sores and wounds may be untreatable.

Up to 51% of patients[12,13] experience pain at the end of life. The prevalence of pain has been noted to increase significantly in the last four months of life and reaching as high as 60% in the last month of life.[14] Additionally, breakthrough pain (severe pain that erupts while a patient is already medicated with a long-acting painkiller,) remains a challenge for many patients. It has been estimated that between 65% and 85% of patients with cancer experience breakthrough pain.[15]

Requests for Medical Aid in Dying are not a Failure of Hospice or Palliative Care
Requests for medical aid in dying are not a failure of hospice or palliative care. Good hospice services and palliative care does not reduce the need for medical aid in dying as a concurrent end-of-life care option for some dying people. Terminally ill people should have the full range of end-of-life options, including the right to request medication the patient can choose to self-administer to shorten a prolonged and difficult dying process. Only the dying person can know whether her or his pain and suffering is too great to withstand. The option of medical aid in dying puts the decision-making power where it belongs: with the dying person.

Medical Aid in Dying Is a Personal Decision
Every religion has its own values, tenets and rituals around death. A person's individual beliefs are an important factor in their understanding of and approach to dying. While some faiths counsel their adherents that advancing the time of death to avoid suffering is immoral, others just as strongly counsel the dying and their families to leave this life in the manner most meaningful to them. Choosing medical aid in dying is only one end-of-life care option. Those who are strongly opposed need not choose it. For those who face unbearable suffering, this option can give them both courage and hope, allowing them to live fully as long as possible and to pass peacefully when death is imminent. This is a personal decision that only the individual can make.

Medical Aid in Dying is Not Euthanasia
Medical aid in dying is fundamentally different from euthanasia. Medical aid in dying is authorized in six states as well as the District of Columbia. With medical aid in dying, the terminally ill person must take the medication themselves, and therefore, always remains in control. Euthanasia is commonly given as a lethal injection by a third party. It is often performed on somebody who does not have a terminal diagnoses and is illegal throughout the United States. Compassion & Choices does not support euthanasia because someone else – not the dying person – chooses and acts to cause death.

Medical Aid in Dying is Not Suicide
Factually, legally and medically speaking, it is inaccurate to equate medical aid in dying with suicide or assisted suicide. People who consider aid in dying find the suggestion that they are committing suicide deeply offensive, stigmatizing and inaccurate. The Oregon, Washington, Vermont, California, Colorado, District of Columbia laws as well as this legislation emphasize that:

"Actions taken in accordance with [the Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law."

This is because a person who is choosing medical aid in dying already has a terminal prognosis of six months or less to live. They are not choosing to die; the disease is taking their life. The terminally ill person who chooses medical aid in dying is simply choosing not to prolong a difficult and painful dying process.

SB 1129 SD2

The bill you are considering is modeled after the groundbreaking Oregon Death with Dignity Act, which was drafted over 20 years ago, during a time when no other state authorized the medical practice of aid in dying. In a growing number of jurisdictions, lawmakers like yourselves are
examining the Oregon experience and developing legislative approaches that are appropriate for them. SB 1129 SD2 is sound legislation based on a proven track record.

Established Process: Eligibility Criteria and Core Safeguards

SB 1129 SD2 establishes strict eligibility criteria as well as guidelines that meet the highest standard of care for the medical practice of aid in dying as described in clinical criteria published in the prestigious and peer reviewed Journal of Palliative Medicine. To be eligible for aid-in-dying medication, an adult must be terminally ill, with a prognosis of six months or less to live and mentally capable of making his or her own healthcare decisions. In addition to the strict eligibility criteria, SB 1129 SD2 establishes core safeguards including that the attending physician must inform terminally ill adults requesting medical aid in dying about other end-of-life options including comfort care, hospice care and pain control and the terminally ill adult must self-administer the aid-in-dying medication.

Additional Regulatory Requirements

SB 1129 SD2 requires that a consulting physician must confirm the terminal diagnosis, prognosis of six months or less to live and mental capability of the terminally ill individual requesting this option. If either the attending or consulting physician is unable to determine whether the individual has mental capacity in making the request, a mental health professional (psychiatrist or psychologist) must evaluate the individual and ensure that they are capable of making their own healthcare decisions prior to a prescription being written.

The terminally ill adult must make two verbal and one written request to their doctor that is signed by two witnesses; the doctor must offer the individual multiple opportunities to withdraw their request; and inform the individual that they may withdraw their request at any time or choose not to take the medication.

Voluntary Participation

A healthcare provider may choose whether to voluntarily participate in medical aid in dying. The bill ensures that no doctor or pharmacist is obligated to prescribe or dispense aid-in-dying medication. However, if a doctor is unable or unwilling to honor a patient's request and the

patient transfers his or her care to a new provider, the prior provider must transfer upon request a copy of the patient's relevant medical records to the new physician.

Criminal Conduct
Additionally, SB 1129 SD2 establishes that any person who, without authorization from the patient, willfully alters, forges, conceals or destroys an instrument, a reinstatement, or revocation of an instrument or any other evidence or document reflecting the terminally ill individual's desires and interests with the intent and effect of hastening the death of the individual is guilty of a Class A felony.

A Combined Thirty Years of Experience Demonstrates Medical Aid in Dying is a Safe and Trusted Practice
Medical aid in dying is a safe and trusted practice. Opponents to medical aid in dying legislation try to use scare tactics by painting a dark picture of fraud, coercion, and murdering relatives. These scare tactics includes concerns the law would target the disabled, elderly, frail, uninsured or any vulnerable groups. *These dire predictions simply do not happen.* In the more than 30 combined years of medical aid in dying in authorized states, there has not been a single instance of documented coercion or abuse. The experience in the authorized state shows us the law has worked as intended, with none of the problems opponents had predicted.

Indeed, rather than posing a risk to patients or the medical profession, the Death with Dignity Act has galvanized significant improvements in the care of the terminally ill and dying in Oregon. Surveyed on their efforts to improve end-of-life care since medical aid in dying became available, 30% of responding physicians had increased referrals to hospice care, and 76% made efforts to improve their knowledge of pain management.[16] Hospice nurses and social workers surveyed in Oregon observed an increase in physician knowledge of palliative care and willingness to refer to hospice.[17]

In addition to the improvement of end-of-life care, the option of medical aid in dying has psychological benefits for both the terminally ill and the healthy.[18] The availability of the option of medical aid in dying gives the terminally ill autonomy, control and *choice*, the overwhelming motivational factor behind the decision to request assistance in dying.[19] Healthy Oregonians know that if they ever face a terminal illness, they will have this additional end-of-life option and the peace of mind it provides. And importantly, surviving loved ones of patients who choose medical aid in dying suffer none of the adverse mental health impacts that come when a loved one commits suicide.[20]

Ensuring Equitable Access
If the committee is considering friendly amendments to SB 1129 SD2, we would suggest the following amendment to strengthen SB 1129 SD2. The definition of "Consulting Provider" was amended to include language limiting the consulting provider to a provider who had not previously assumed responsibility for the care of the patient with the attending provider. There is no evidence or belief suggesting that prior shared responsibility of a patient's care would impact a physician's ability to make an independent assessment regarding eligibility for medical aid in dying. Not only is this additional language completely unnecessary, but it creates a

regulatory barrier to access for terminally ill patients seeking this end-of-life option. This unnecessary limitation can substantially impact access to this healthcare option especially in rural or underserved areas given the physician shortage in Hawaii and has the potential to significantly degrade the quality of care provided to the patient by interrupting their continuity of care. In the event the committee is not considering any amendments, Compassion & Choices offers full support for the bill as written.

Conclusion
The bill before you is a responsible piece of legislation that responds to your many constituents who believe that medical aid in dying should be available as a end-of-life care option and that this deeply personal decision should be left to the patient, their family and their doctor.

Thank you again, Chair and Members of the Committee, for your timely leadership on this important issue.

Kat West is the National Director of Policy & Programs for Compassion & Choices.
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Refrences:

1. Compassion & Choices brought landmark federal cases establishing that dying patients have the right to aggressive pain management, including palliative sedation. *Vacco v. Quill, 521 U.S. 793 (1997); Washington v. Glucksberg*, 521 U.S. 702 (1997).
2. Compassion & Choices drafted and sponsored introduction of legislation requiring comprehensive counseling regarding end-of-life options. See, California Right to Know End-of-Life Options Act, CAL. HEALTH & SAFETY CODE §442.5; New York Palliative Care Information Act, N.Y. PUB. HEALTH LAW § 2997-c.
3. For example, Compassion & Choices is pursuing accountability for failure to honor a patient's wishes as documented in a POLST, *DeArmond v Kaiser,* No. 30-2011-00520263 (Superior Court, Orange County, CA). In another case, Compassion & Choices represented a family in bringing into the public eye a situation where patient wishes to forego food and fluid were obstructed. See Span, "Deciding to Die, Then Shown the Door," *The New York Times*, Aug. 24, 2011, available at http://newoldage.blogs.nytimes.com/2011/08/24/deciding-to-die-then-shown-the door/? ref=health; Uyttebrouck, "Couple Transported Out of Facility After Refusing Food," *Albuquerque Journal*, Jan. 08, 2011, available at http://www.abqjournal.com/news/metro/08232859metro01-08-11.htm.
4. Compassion & Choices brought two federal cases to the United States Supreme Court urging recognition of a federal constitutional right to choose aid in dying. *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill, 521 U.S. 793(1997).* Compassion & Choices was in leadership in the campaigns to enact the Death with Dignity Acts in Oregon and Washington. OR. REV. STAT. § 127.800 (2007); WASH. REV. CODE ANN. § 70.245

(West 2011).
5. See supra n. 1, Bergman, Tomlinson, Tolliver, Hargett; See supra n. 3, DeArmond.
6. American Views on Assisted Suicide, Lifeway Research, September, 2016. Available from: http://lifewayresearch.com/wp-content/uploads/2016/12/Sept-2016-American-Views-Assisted-Suicide.pdf
7. Medscape Ethics Report 2016: Life, Death, and Pain, December 23, 2016. Available from: http://www.medscape.com/features/slideshow/ethics2016-part2#page=2
8. Oregon Medical Association. Excerpted from: WWS Section on Hospice-End of life Care-Death & Dying. Date unknown. Available from https://drive.google.com/file/d/0B3IuDjCAxxv7clQwYzdlWjZEb0xqbFE4eWRHbTMzNVhsck00/view?usp=sharing
9. California Medical Association. Excerpted from: CMA changes stance on physician aid in dying, takes neutral position on End of Life Option Act. June 2, 2015. Available at http://www.cmanet.org/news/detail/?article=cma-changes-stance-on-physician-aid-in-dying.
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11. Healthcare Professional Organizations that Recognize Medical Aid in Dying, Compassion & Choices Fact Sheet, Available from: https://drive.google.com/file/d/0B3IuDjCAxxv7UTdKemdGbW81Zms/view
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17. Ganzini et al., *supra,* at 2363.
18. Elizabeth R. Goy et al., *Oregon Hospice Nurses and Social Workers' Assessment of*

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19. Kathy L. Cerminara & Alina Perez*, Empirical Research Relevant to the Law: Existing Findings and Future Directions*, *Therapeutic Death: A Look at Oregon's Law*, 6 PSYCHOL. PUB. POL'Y & L. 503, 512–13 (2000).
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Testimony on SB 1129 SD2, The Hawai'i Medical Aid in Dying Act
Mary Steiner, Compassion & Choices Hawai'i Campaign Manager
House Health Committee
March 23, 2017

Introduction

Good morning Chair Belatti, Vice-Chair Kobayashi and Members of the Committee. My name is Mary Steiner, I'm the Hawai'i Campaign Manager for Compassion & Choices. Thank you for accepting my testimony in strong support of SB 1129 SD2, the Medical Aid in Dying Act, which will provide a desperately needed option for Hawaii's terminally ill patients and their families.

Hawai'i: a Legacy of Leadership

Hawaii's dedication to personal liberty, diversity and tolerance has set a shining example for our nation and established the Aloha State as a fearless and progressive leader. We were the first state to legalize reproductive rights (1970), the first state to require minimum standards of health care by law (1974), an early proponent of equality in marriage, and the third state to raise the minimum wage to $10.

So it's not surprising that the people of Hawai'i overwhelmingly support medical aid in dying, the hallmark of patient-centered care. The most recent poll[1] of Hawai'i voters, completed by Anthology Marketing Group (formerly QMark) in December 2016, shows a supermajority 80 percent in favor of this end-of-life care option, across all demographics including ethnicity, age, economic status and religion.

The support for medical aid in dying is well-established. Indeed, kama'aina have been striving for access to medical aid in dying for more than 20 years, before any other state passed a law to authorize the practice. Spearheaded by the esteemed Ah Quon McElrath, a grassroots effort in the mid-1990s collaborated with Governor Ben Cayetano to convene his visionary Blue Ribbon Panel on Living and Dying with Dignity in 1996. That panel made several recommendations, including an option for medical aid in dying, and proposed a bill to authorize the practice in 2002. Since then, the people have attempted to get a law passed nearly a dozen times.

In December 2016, in an unprecedented show of solidarity, four former Hawai'i governors, Abercrombie, Cayetano, Waihee and Ariyoshi, jointly drafted and signed an opinion piece in the *Honolulu Star-Advertiser*[2] urging lawmakers to act this session. They stated, and I quote: "We do agree on this: A terminally ill person should be able to choose to end his or her own life in the Aloha State. A physician should be able to help

a dying patient obtain a prescription for life-ending medication as part of the medical standard of care."

In the meantime, six states and Washington D.C. now have authorized medical aid in dying, giving 18 percent of the nation's terminally ill adults access to the option. The law and its safeguards work as intended: in these jurisdictions' combined 30 years of closely studied practice, there has been not a single documented case of abuse.

Honoring 'Ohana, Caring for Kupuna

Nowhere else in our nation is the concept of 'ohana more deeply embedded in our social fabric. Extended families gather *en masse*, in celebration or sympathy, for the milestones of life in the islands: births, graduations, marriages, illnesses and, finally, deaths.

Across all cultures in Hawai'i, we have a common respect and love for our kupuna. We take care of them with open arms; our homes are a haven for multiple generations. Should they, or any adult family member, become terminally ill with a prognosis of six months or less to live, being able to honor their wishes for a peaceful death, free of suffering and surrounded by loved ones, is the ultimate gift.

Yet despite waiting for decades, our loved ones in Hawai'i still are not able to access this option at the end of life. While hospice and palliative care are widely available and doing excellent work in the islands, they sometimes are not enough to alleviate the excruciating pain, suffering and anxiety that can come as part of a terminal illness. Some will say, "Just move to Oregon or California if you want medical aid in dying." It is the height of callousness and cruelty to propose that terminally ill island residents should uproot themselves from their home and family at this stage in their life, at their most ill and vulnerable time. Not to mention the prohibitive cost and disruption to relocate 3000 miles away in order to achieve a peaceful death on their own terms. It is clear that Hawai'i residents are distinctly disadvantaged without authorized access to medical aid in dying in our most geographically isolated home state.

Medical Aid in Dying is Not Suicide

I want to make it very clear medical aid in dying is not suicide. Suicide involves people who are so severely depressed that they no longer want to live. Medical aid in dying involves individuals who would love to live. But they can't. They're dying—and soon. These people request aid in dying, not out of despair or depression, but to maintain some dignity and comfort in their final days, to ease their pain and suffering, and to help them die peacefully.

Local Organizations in Support of Medical Aid in Dying

The following organizations have announced their official support of medical aid in dying in Hawai'i:

- ACLU of Hawai'i
- Americans for Democratic Action - Hawai'i
- Chamber of Commerce for Persons with Disabilities - Hawai'i
- Democratic Party of Hawai'i
- Filipino-American Advocacy Network
- First Unitarian Church of Honolulu
- Hawai'i Friends of Civil Rights
- Hawai'i State Democratic Women's Caucus
- Hawai'i State Teachers Association - Retired
- ILWU Local 142
- Interfaith Alliance Hawai'i
- Kupuna Caucus of the Democratic Party of Hawai'i
- Labor Caucus of the Democratic Party of Hawai'i
- LGBT Caucus of the Democratic Party of Hawai'i
- Life of the Land
- Nursing Advocates & Mentoring, Inc.
- Progressive Democrats of Hawai'i
- Rainbow Family 808

Importantly, the **Hawai'i Medical Association** has switched its long-standing opposition to medical aid in dying, recently adopting a neutral stance.[3]

Equally important, the **Hawaii Disability Rights Center** remains neutral on medical aid in dying.

SB 1129

The bill before you is drafted by and for the people of Hawai'i. It is modeled after the groundbreaking Oregon Death with Dignity Act, which has almost two decades in practice with not a single documented case of abuse. The culmination of more than 20 years of dedicated and thoughtful effort in the islands, SB 1129 SD2 is sound legislation based on a proven track record, representing the will of the vast majority of Hawaii's people.

Conclusion

Hawai'i voters overwhelmingly support the practice of medical aid in dying. SB 1129 SD2 will provide a safe, proven end-of-life care option for those with terminal disease and prognosis of six months or less to live who have exhausted all hope for further

curative treatment, and who are facing only increasing suffering before certain death. We should always provide quality end-of-life care for people who have an incurable and irreversible terminal illness. Quality care should include the option—when a person only has months, weeks or even days to live, when there is nothing else that medicine can treat and it becomes impossible to provide relief from extreme pain--of choosing a peaceful death on one's own terms when the time comes.

Thank you, Chair and Members of the Committee, for considering this important issue.

[1] Hawaii Voters Express Overwhelming Support for Medical Aid in Dying Option, November 2016. Polling Summary Available from: https://drive.google.com/a/compassionandchoices.org/file/d/0B9vEXfXcqXuOekF5WGw5cXBmRGc/view?usp=sharing

[2] "Allowing Life-Ending Medication Is a Compassionate Choice," *Honolulu Star-Advertiser*, December 15, 2016: https://www.compassionandchoices.org/allowing-life-ending-medication-is-a-compassionate-choice/

[3] "HMA Shifts Toward Accepting End of Life Legislation," *West Hawaii Today*, January 29, 2017, http://www.westhawaiitoday.com/news/local-news/hma-shifts-toward-accepting-end-life-legislation

Planned Parenthood
Act. No matter what.
Planned Parenthood Votes Northwest and Hawaii

To:	Hawaii State House Committee on Health
Hearing Date/Time:	Thursday, Mar. 23, 2017, 8:30 a.m.
Place:	Hawaii State Capitol, Rm. 329
Re:	Testimony of Planned Parenthood Votes Northwest and Hawaii in support of S.B. 1129, SD2, relating to Health

Dear Chair Belatti and Members of the Committee,

Planned Parenthood Votes Northwest and Hawaii ("PPVNH") writes in support of S.B. 1129, SD2, which seeks to establish a medical aid in dying act.

PPVNH supports S.B. 1129 because it gives people the right to make private, personal decisions about their bodies and lives, which is something that we work to protect and promote every day for the thousands of Hawaii people that come through our doors each year seeking health care.

Thank you for this opportunity to testify in support of S.B. 1129, SD2.

Sincerely,
Laurie Field
Hawaii Legislative Director

HAWAII LIFE ALLIANCE
SUPPORTING LIFE FROM CONCEPTION TO NATURAL DEATH

Hearing on SB1129 SD2, Thursday, March 23, 2017 @ 8:30AM, Room 329

DATE: March 21, 2017

TO: COMMITTEE ON HEALTH

Rep. Della Au Belatti, Chair

Rep. Bertrand Kobayashi, Vice-Chair

Members of the Committee on Health

FROM: Janet Grace, Director

RE: **Strong Opposition on SB1129 SD2**

Hawaii Life Alliance is comprised of many organizations Statewide that uphold the sanctity of human life and believe that life begins at conception and ends at natural death.

We STRONGLY OPPOSE SB1129 SD2 for many reasons, believing that if enacted will send a chilling effect throughout our islands.

Assisted Suicide involves a physician prescribing lethal drugs for a patient with the knowledge that the patient intends to use the drugs to commit suicide. *(the doctor is then removed of any responsibility)* Refusing ventilator, or some other life sustaining machine or treatment is not assisted suicide. The intent of refusing medical treatment is not to end a life, but to allow nature to take its course. With physician assisted suicide the intent is to kill the patient.

If assisted suicide is legalized, it becomes impossible to contain. It becomes impossible to protect the vulnerable and mentally ill. If legalized, it becomes, essentially death on demand.

Supporters of assisted suicide have long maintained that assisted suicide is necessary for

those suffering from intractable pain; however, to date, there is still no documented case of assisted suicide being needed for untreatable pain. In fact, in the list of reasons patients choose to use assisted suicide, pain, or fear of pain, is the least used reason.

Dr. Linda Ganzini, professor of psychiatry at Oregon Health & Science University, surveyed family members of Oregon patients who requested assisted suicide. Her published report emphasizes this truth: "No physical symptoms experienced at the time of the request were rated higher than 2 on a 1 to 5 scale. In most cases, future concerns about physical symptoms were rated as more important than physical symptoms present at the time of the request. The study found that many physicians are surprised at the lack of suffering experienced by a patient who is requesting assisted suicide.

"Those promoting assisted suicide promised Oregon voters that it would be used only for extreme pain and suffering. Yet there has been no documented case of assisted suicide being used for untreatable pain. Instead, patients are being given lethal overdoses because of psychological and social concerns, especially fears that they may no longer be valued as people or may be a burden to their families." Dr. Greg Hamilton, Portland psychiatrist.

Suicide is always a tragedy. For all the rhetoric about dignity, assisted suicide is still suicide. Terminally ill patients need care to address the many aspects of their suffering. We can't allow our medical system to be corrupted by the illusion that suicide is an acceptable response to pain and depression for all. **Please, in the true and unique spirit of aloha and the special way Hawaii's ohana care for our Kupuna, sick and disabled, I urge you to KILL SB 1129, SD2.**

Aloha Place for Women in Waipio ~ Aloha Pregnancy Care & Counseling Center ~ Aloha Life Advocates ~ Hawaii Family Forum ~ Hawaii Family Advocates ~ Hawaii Christian Coalition ~ Hawaii Christian Legal Society ~ The Pearson Foundation ~ PEACE Hawaii ~ PULSE ~ Respect Life Hawaii, Whole Life Hawaii

kobayashi1- Oshiro

From:	AKAMAI GLASS COMPANY, INC. <charijean@aol.com>
Sent:	Tuesday, March 21, 2017 11:08 AM
To:	HLTtestimony
Subject:	Pls support the Medical Aid in Dying Act

Aloha. The last, most personal choice I want to make in my very full and happy life is the choice to ask for aid if necessary. Please support this bill. Mahalo.

Charijean Watanabe
Akamai Glass Company, Inc.
www.akamaiglass.com
1024B Kikowaena Place
Honolulu, HI 96819
Ph: (808) 833-1111 Fax: (808) 834-6177

Mon, TuesThur, Fri - 7:30am to 5pm
Wed - 7:30am to 6pm
Sat & Sun - Closed
Serving Hawaii's families for 50years!

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Stephen O'Harrow
Cameron Sato
George Simson
Emmanuel Zibakalam

MAILING ADDRESS
PO. Box 23404
Honolulu
Hawai'i 96823

March 21 , 2017

TO: Honorable Chair Au Belatti and Members of the Health Committee

RE: SB 1129 SD2 Relating to Health
Support for hearing on March 23

Americans for Democratic Action is an organization founded in the 1950s by leading supporters of the New Deal and led by Patsy Mink in the 1970s. We are devoted to the promotion of progressive public policies.

We support SB 1129 SD2 as it would establish a death with dignity act under which a terminally ill adult resident may obtain a prescription for medication to end the patient's life. This is not a death panel. This is a choice. We must put ourselves in the shoes of those who are suffering and terminally ill. The medical field has developed to alleviate suffering in life. Let us extend this to death.

Thank you for your consideration.

Sincerely,

John Bickel
President

St. Francis
HEALTHCARE SYSTEM OF HAWAII
A Legacy of Caring for Hawaii's People

Testifier's Name:	Gary Simon Director of Corporate Affairs and Advocacy St. Francis Healthcare System of Hawaii
Testimony Is Directed To:	House Committee on Health
Measure:	SB1129 SD2 RELATING TO HEALTH Establishes a medical aid in dying act that establishes a regulatory process under which an adult resident of the State with a medically confirmed terminal disease may obtain a prescription for medication to be self-administered to end the patient's life.
Date & Time of Hearing:	Thursday, March 23, 2017, 8:30 a. m.
Location:	State Capitol Conference Room 329
Position:	**St. Francis Healthcare System of Hawaii strongly opposes SB1129 SD2.**

Dear Chair Belatti, Vice Chair Kobayashi, and Honorable Members of the House Committee on Health:

I am Gary Simon, Director of Corporate Affairs and Advocacy for St. Francis Healthcare System of Hawaii (SFHS).

I am testifying as an individual who has worked in healthcare for over thirty years, including seven years as Executive Director of St. Francis Hospice. I am offering testimony on behalf of SFHS.

SFHS strongly opposes SB1129 SD2.

SFHS values life. Our philosophy and practices of hospice and palliative care are concerned chiefly with the dignity of persons throughout the trajectory of a terminal illness. When symptoms are unbearable, effective therapies are now available to relieve almost all forms of discomfort, distress, and pain during the terminal phase of an illness without purposefully hastening death.

Instead of introducing assisted suicide, as a community we should focus our efforts on improving access to high quality end-of-life care.

Hawaii has made tremendous progress in promoting the value of hospice and palliative are, but there is much more we can do to meet the comprehensive needs of patients/families facing terminal illnesses. We must continue our efforts at:

- professional education,
- public awareness,
- developing our healthcare systems,
- improving public policy to eliminate barriers to hospice and palliative care,
- promoting best practices, and
- research to increase the body of knowledge needed to improve care.

Improving access for all to high quality end-of-life care is imperative and is a strategic goal of SFHS and St. Francis Hospice.

We strongly urge you to oppose SB1129 SD2.

Sincerely,

Gary Simon 03/21/2017

Gary Simon
Director of Corporate Affairs and Advocacy
St. Francis Healthcare System of Hawaii
2226 Liliha Street, Room Number 217
Honolulu, Hawaii 96817

Email gsimon@stfrancishawaii.org

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 3:48 PM
To: HLTtestimony
Cc: wao-hsl@WeAreOne.cc
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Joseph Kohn MD	We Are One, Inc. - www.WeAreOne.cc - WAO	Support	No

Comments: www.WeAreOne.cc

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 9:09 AM
To: HLTtestimony
Cc: jalconjr@panchoalconltd.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Juan M. Alcon, Jr.	Calvary Chapel Molokai	Oppose	No

Comments: God created life, therefore, He alone determines when a persons life should end. Even if a person has terminal illness, that person is NOT God to determine when he/she wants to die by medical means. What if a cure for a terminally ill person is found, the day after this person takes his life by a prescription from a doctor - how would the survivors of the deceased feel as well as the doctor? God is large and in charge of all things! Let God do the godding...he does a better job than us! Praise Jesus!

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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AAPD
American Association of People with Disabilities

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

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

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

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

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

Statement on Assisted Suicide

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

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

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

Hearing 3/23/2017 8:30 AM regarding Senate Bill 1129 SD2

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

Chair Della AuBelatti and members of the House Health Committee,

We are writing to express OPPOSITION to this SB1129. **Obtaining services for our members is hard enough as it is without adding another layer of stress to their lives—wondering if someone will feel they would be better off dead.**

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

Billy Altom

Executive Director, Association of Programs for Rural Independent Living

Hawaii Contact Information for our organization offering up this testimony:

Eliza and Wilmer Galiza wilmergaliza@gmail.com

Wailuku, Maui, Hawaii 96793

DREDF: Doing Disability Justice

To the House Committee on Health
Honorable Representatives of the House Health Committee, Chair Bellatti,

Please accept this **strenuous opposition to Senate Bill 1129 SB2** from our Hawaii Advocate Chris Niemczyk on this Thursday March 23, 2017 at 8:30 AM.

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

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

For any further questions we are at all times available

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

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

EMMANUEL LUTHERAN
CHURCH and SCHOOLS
of Maui

520 W. One Street, Kahului, Maui, Hawaii 96732
(808) 877-3037

Opposition to SB 1129

Aloha members of the Hawaii legislature,

SB 1129, the measure on "medical aid in dying", is not a bill that we should bring to our state. Stripping away any euphemisms, it simply welcomes assisted suicide into our state as an acceptable practice. Seemingly, this is based on the patient's own right to "self-determination" about the course of their own care and treatment at the end of life. We already have provisions in the law for refusing medical treatments that are not beneficial or that are especially burdensome to a patient, so that life is not unnaturally prolonged. This measure, however, aims far beyond that to *seeking one's own death*, and having the "right" to assistance in meeting one's end.

This fundamentally transforms the nature of health care at the end of life. Traditionally, the doctor's Hippocratic oath to *do no harm* superseded a patient's *self-determination*—especially over against their desire to harm themselves. How much more so to take their own life! This is a dangerous switch of ideas to put self-determination first. And no matter how many "safeguards" are in the present law against expanding the supposed "right to die" beyond the terminally ill, the fact remains that there are always going to be a much larger pool of people, who for various reasons *also seek to die*. If *self-determination* becomes the new defining principle, it will only be a matter of time before those safeguards and laws are loosened and the "right to die" is expanded. The grounds for resisting that will already have been significantly eroded by this law.

As an unintended consequence of these laws is that they lay the groundwork for an unspoken "duty to die" on the terminally ill. This is espoused among some ethicists and doctors in what is known as "Futile Care Theory." Also in some parts of Europe, where self-determination has been given priority over the good of the individual, laws have even expanded to allow voluntary suicide of individuals who have no illness.

Once you unplug the hole in the dike, you cannot keep the water from rushing through and opening a much wider hole. Please do not give way to those who tell us that aiding someone's death is a "compassionate act." True compassion is learned and taught in the midst of suffering, and there are many worthy ways of caring for the dying that *ennoble* both the patient and the caregiver, while allowing life to reach its natural end. Thank you for listening. Please vote NO.

Pastor Joshua V. Schneider

Joshua V. Schneider

House Health Chair Belatti and members of the Health Committee,
NDY and I are opposed to Assisted Suicide
Michael Tada, Hawaii Advocate

NOT DEAD YET
The Resistance

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

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

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

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

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

We Don't Need To Die to Have Dignity
In a society that prizes physical ability and stigmatizes impairments, it's no surprise that previously able-bodied people may tend to equate disability with loss of dignity. This reflects the prevalent but insulting societal judgment that people who deal with incontinence and other losses in bodily function are lacking dignity. People with disabilities are concerned that these psycho-social disability-related factors have become widely accepted as sufficient justification for assisted suicide.

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

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

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

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

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

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

Unacceptable Losses

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

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

Predictions that someone will die in six months are often wrong.
People who want to die usually have treatable depression and/or need better palliative care.
Pressures to cut health care costs in the current political climate make this the wrong time to add doctor-prescribed suicide to the "treatment" options.
Abuse of elders and people with disabilities is a growing but often undetected problem, making coercion virtually impossible to identify or prevent.
Despite the frequent claim that Oregon's experience has disproven the concerns of opponents of the Oregon law, the Oregon Reports as well as independent news reports and journal articles show otherwise:
People who are not within six months of dying are getting lethal prescriptions.
Depression is not identified or treated (only 6% have been referred for a psychological consult).
People have been denied prescribed medical treatments by insurers but offered assisted suicide as an alternative.
About half of the assisted suicide deaths in Oregon did not have a health provider present at the time of death, so there is no evidence of self-administration of the lethal dose or consent in those cases.

NOT DEAD YET
The Resistance

Michael Tada, mtada347@gmail.com

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

Lessons From Disability History

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

Suicide v. Assisted Suicide

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

What's Disability Got To Do With It?

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

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

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

Physicians Are Assisted Suicide Gatekeepers

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

Disability is the Issue

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

We Don't Need To Die to Have Dignity

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

Physicians Misjudge Quality of Life

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

Elder Abuse Equals Coercion

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

Door Open for Involuntary Euthanasia

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

Health Care Cuts Severe

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

Involuntary Denial of Care

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

Window Dressing Safeguards, Immunity Law for Physicians

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

ADA Discrimination

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

National Disability Rights Organizations

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

Unacceptable Losses

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

NCIL
National Council on Independent Living

www.ncil.org

Kelly Buckland
Executive Director

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Hays, Kansas

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Region X
Doug Toelle
Fairbanks, Alaska

House Health Hearing 3/23/17 at 8:30 AM regarding SB1129 SD 2
Chair AuBellati, Members Kobayashi, Tupola, Har, Oshiro, Morikawa, Todd
Please consider the below on behalf of all our CIL members in Hawaii who are unable to attend the hearing not because they don't want to; they can't get there.

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

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

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

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

Sincerely,

Kelly Buckland, Executive Director
NCIL
In Hawaii Contact: Linda Toms Barker Hilo, Hawaii
Email: Lindatomsbarker@gmail.com

(202) 207-0334 (Voice)
(202) 207-0340 (TTY)
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2013 H Street NW; 6th Floor
Washington, DC 20006
Email: ncil@ncil.org

New Hope Christian Fellowship

House Health Hearing March 23, 2017 8:30 AM

House Health Chair Belatti and Members of the Health Committee,

I am opposed to Physician Assisted Suicide

Thank you for this opportunity to express my strong opposition to SB 1129

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

1. It gives an inordinate amount of authority to an attending physician (or to two physicians) to make final determination that a person will die within six months. There are several in our congregation who were given three to six months to die, and they are still in our congregation five years later. A physician will have to play to the role of God to conclusively determine the timeline of a person's life, regardless of how conclusive a diagnosis may seem at a given time.

2. Secondly, they will need to conclusively determine that a person is of "sound mind". When persons are diagnosed with a terminal illness, they will many times go through a season where they feel resigned to dying. Then with a lost hope, they have suicidal tendencies. However, once they get through this period, their lives can regain momentum and oftentimes they beat the odds.

3. Physician's assisted suicide preempts this possibility of health. It also might be so premature that we can erroneously make a permanent decision based on a temporary health situation.

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

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

TASH

To House Health Committee 3/27/17 hearing
From Hawaii Representatives Ann Graham Chung, Brent Graham, and Jill Graham
Kailua and Kaneohe Hawaii 96744 email: papiochamp@yahoo.com

Resolution Opposing the Legalization of Physician Assisted Suicide and SB 1129 SD2

Association for Persons with Severe Handicaps (TASH)

In their 1997 resolution opposing the legalization of physician assisted suicide, the Association for Persons with Severe Handicaps (TASH) provides a long list of reasons for their opposition to physician assisted suicide, including the negative aspects of allowing physicians to have such power, the insufficiency of proposed safeguards, and dissatisfaction with the implementation of safeguards in conjunction with euthanasia in the Netherlands. Internet publication URL: www.independentliving.org/docs6/tash199712.html

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WHEREAS, the U.S. Supreme Court has determined that assisted suicide is not a constitutional right, but is an issue to be decided by the states; and

WHEREAS, bills to legalize physician-assisted suicide are currently pending before state legislatures; and

WHEREAS, no bill to legalize physician-assisted suicide applies to all citizens equally, but singles out individuals based on their health status in violation of the Americans with Disabilities Act; and

WHEREAS the legalization of physician-assisted suicide give physicians the power to decide who will be given suicide prevention and who will receive suicide assistance and is, therefore, not based on individual choice and autonomy; and

WHEREAS current trends in managed care and health care rationing threaten to diminish the availability of health care and related services needed by people with disabilities; and

WHEREAS people with disabilities and chronic illnesses may be driven to despair as a result of fear of being forced into a nursing home or institution, fear of being a physical or financial burden on their families, lack of information, about independent living option, and weariness from the daily struggle to get their legal needs met; and

WHEREAS, any proposed legal "safeguard" requiring that physician-assisted suicide only be available to terminally ill individuals who voluntarily request it will not protect people with disabilities from abuse; and

WHEREAS, numerous courts have ruled that people with non-terminal disabilities are the same as terminally ill patients in that the usual state interest in preserving life does not apply to them; and

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

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

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

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

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

info@tash.org

TO:
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair
Rep. Sharon E. Har
Rep. Chris Todd
Rep. Dee Morikawa
Rep. Andria P.L. Tupola
Rep. Marcus R. Oshiro

FROM: David Willweber.
Masters in Family Life Ministry
Husband & Father
Community member on the School Community Council at Kainalu El
Pastor of Mauka Makai Ministries—Windward
Vice President of P.E.A.C.E. HI

RE: Testimony in opposition to SB1129

The measure states, "The purpose of this Act is to enact a death with dignity act."

As I have listened to our kupuna over the years, they are troubled by at least two recurring thoughts, "I feel useless" and "I don't want to be a burden on anyone." At the same time, I have seen them "light up" when I visit or when ohana visits to express love, care, and value to the kupuna.

One significant danger in legalizing a "death with dignity" bill is that it negatively reinforces the above thoughts and feelings they are wrestling with. Legislation will make it easier for them to cave in to the "I'm useless" and "I'm a burden" mindset and give them an option to end it all, when what many are really desiring is relationship and love, particularly from ohana, even in the midst of difficult pain and suffering. Just by having a legal option to end it all, will bring pressure to them to make a choice that they would not have considered had it remained illegal. This kind of "pressure" and reinforcing of negative thinking does not sound like dignity at all to me. Nor is it compassionate. Their's would be an undignified death, the opposite of what is intended in the bill.

What our kupuna need and deserve is honor, respect, and aloha. I have seen beautiful things on deathbeds and with living in the last 6 months before death. I have seen ohana members who had been estranged from one another for years due to offense apologize and make peace with

one another. I have seen children and grandchildren choose to sacrifice sleep and other important tasks just to simply be with their parent/grandparent and express love. THIS is true dignity while dying. This is honor to our kupuna. This builds a legacy of honor, love, life, and ohana. This strengthens everyone's character. This builds lasting healthy and strong generations of value and significance. This is the way of aloha. This is the way of Hawai'i.

Ua mau ke ea o ka aina I ka pono.

The life of the land is perpetuated in righteousness.

Mahalo for your time and working together for the best welfare of our kupuna, ohanas, generations, & life of the Islands and life on the Islands!

Aloha,
Dave Willweber
Kailua, Hawai'i

Stephen Mendelsohn

171 Hartford Road, #19
New Britain, CT 06053-1532
smendelsohn5845@att.net

Testimony in strong opposition to SB 1129 SD1
Hawai‘i Medical Aid in Dying Act
March 22, 2017

Representative Belatti and members of the House Committee on Health:

I am an autistic adult and one of the leaders of Second Thoughts Connecticut, a coalition of disabled people opposed to the legalization of assisted suicide. Our organization works together with national disability rights organizations including Not Dead Yet and the Disability Rights Education and Defense Fund to oppose such legislation. I also serve on the board of directors of the Euthanasia Prevention Coalition USA.

You may wonder why a disability rights advocate 5000 miles away in Connecticut cares so much about legislation in Hawai‘i. To paraphrase the Reverend Dr. Martin Luther King, Jr.’s “Letter from a Birmingham Jail,” I cannot stand by idly in Connecticut and not care about what happens in Hawai‘i. Injustice anywhere truly is a threat to justice everywhere.

Over 200 attempts to pass similar legislation have been rejected by legislatures across the nation. My home state of Connecticut has rejected similar legislation three years in a row without a single committee vote in response to our strong disability-rights opposition. When legislators look at the details of these bills, they understand that legalizing doctor-prescribed suicide diminishes rather than enhances choice. It also poses unacceptable risks to people who have no intention of dying, or who could have lived productive lives with treatment. They have second thoughts and oppose such legislation.

The ostensible safeguards in SB 1129 SD2 are hollow. The act could allow for euthanasia by saying that the patient “may” self-administer (thus implying others can assist) and by not defining self-administration, which in other states such as Washington with similar laws is defined as mere ingestion. The witnesses to the written request for the lethal prescription can be an heir and a close friend of that heir (or a representative of the patient’s health insurer) seeking to pressure someone into ending his or her life. There is no requirement that any of the requests be made in the presence of the physician or nurse who will prescribe the lethal dose, while doctor shopping further weakens any “safeguards.” The heir could pressure the victim to sign the written request at home and mail or fax it to the physician or nurse, who may have no clue that the request was coerced. Moreover, the bill does not require any witnesses at the time the lethal prescription is consumed. Did Grandpa take the 100 Seconal pills voluntarily, or did he change his mind only to have his heir compel him to do it? SB 1129 SD2 has no investigational authority and gives legal immunity to prescribing doctors who act in “good faith.” Furthermore, in § 4 (b), doctors are **required** to falsify death certificates, listing the cause of death as the underlying illness instead of the lethal prescription, as “the attending

provider may sign the patient's death certificate, which shall list the underlying terminal disease as the cause of death," further covering up potential foul play. The mere existence of the lethal prescription serves as an alibi. The possibilities for elder abuse are enormous.

With regard to the falsification of the death certificate, the State of Connecticut Division of Criminal Justice testified in opposition to a similar provision two years ago in Connecticut HB 7015 as having "unintended and very unwelcome consequences," noting that "the actual cause of death would be the medication taken by or given to the patient." Moreover, "[t]he practical problem for the criminal justice system and the courts will be confronting a potential Murder prosecution where the cause of death is not accurately reported on the death certificate." § 4 (b) of SB 1129 SD2 would thus make it impossible to prosecute a murder.

Contrary to claims of proponents, there have been a number of documented abuses in Oregon, in addition to all the ones we will never know about because of the lack of investigational authority. The case of Tami Saywer and Thomas Middleton is instructive. Middleton had ALS and moved into Sawyer's home, where he died a month later under Oregon's assisted suicide law. Two days after the death, Sawyer sold Middleton's house and deposited the proceeds into her account. Sawyer pleaded guilty to fraud and money laundering in a Ponzi scheme. A second case involving Middleton's estate was dropped only because she was already serving jail time. We will never know whether this was merely fraud or murder for profit. Indeed, this story came to light only because of suspicious real estate transactions and in spite of the concealment entailed by Oregon's assisted suicide law.

Oregon also demonstrates the deadly mix between assisted suicide and medical cost-containment. Barbara Wagner and Randy Stroup were denied chemotherapy for their cancers under the Oregon Health Plan (Medicaid) yet offered suicide drugs instead. Chillingly the president of Compassion & Choices, former HMO executive Barbara Coombs Lee, wrote an op-ed in *The Oregonian* defending Oregon's denial of Tarceva to Barbara Wagner, suggesting that government steer people away from curative care and toward less aggressive treatment or suicide.

Another problem in Oregon is suicide contagion. According to the Centers for Disease Control, Oregon's already high suicide rate has increased much more than the national average; from 1999 (shortly after the Oregon Death with Dignity Act took effect) until 2010, the rate of increase for people age 35-64 was 49% in Oregon versus 28% nationally. Given the motto of Compassion & Choices and other "right-to-die" organizations is "My Life. My Death. My Choice." this should come as no surprise.

Mercilessly bullied autistic and LGBT youth can pick up this message that "my death" is "my choice"—a message which Compassion & Choices has displayed on its green stickers and Facebook pages—and act on it. Those of us on the autism spectrum can take messages like this quite literally. Nikki Bacharach, the autistic daughter of Burt Bacharach and Angie Dickinson, committed suicide eight years ago. Her parents issued the following statement, according to Lisa Jo Rudy of About.com: "She quietly and peacefully committed suicide to escape the ravages to her brain brought on by Asperger's." This strange and creepy announcement is the logical product of Compassion & Choices' assisted suicide advocacy, where "peaceful suicide" is glorified and disability is viewed as "ravaging" our minds and bodies. This is disability discrimination and is unacceptable.

About one year ago, Connecticut became the first state to officially recognize the wrongfulness of this discrimination in its state suicide prevention plan. Here is the relevant excerpt from the *State of Connecticut Suicide Prevention Plan 2020*, which explicitly cites legalized assisted suicide as a contributing factor (pp. 43-44):

> People with Chronic Health Conditions and Disabilities
>
> Living with chronic or terminal physical conditions can place significant stress on individuals and families. As with all challenges, individual responses will vary. Cancer, degenerative diseases of the nervous system, traumatic injuries of the central nervous system, epilepsy, HIV/AIDS, chronic kidney disease, arthritis and asthma are known to elevate the risk of mental illness, particularly depression and anxiety disorders.
>
> In these situations, integrated medical and behavioral approaches are critical for regularly assessing for suicidality. Disability-specific risk factors include: a new disability or change in existing disability; difficulties navigating social and financial services; stress of chronic stigma and discrimination; loss or threat of loss of independent living; and institutionalization or hospitalization.
>
> Until recently, the CTSAB [Connecticut Suicide Advisory Board] was considering assisted suicide of the terminally ill as a separate issue from suicide prevention. The active disability community in Connecticut, however, has been vocal on the need for suicide prevention services for people with disabilities. There may be unintended consequences of assisted suicide legislation on people with disabilities. Peace (2012) writes that "Many assume that disability is a fate worse than death. So we admire people with a disability who want to die, and we shake our collective heads in confusion when they want to live."
>
> People with disabilities have a right to responsive suicide prevention services. The CTSAB intends to continue to explore the needs of the disability community for such services.
>
> Targeted Recommendations:
>
> - Develop greater scrutiny of someone's intentions to die.
> - Identify and train practitioners to develop expertise in the work with disabled people who are suicidal.
> - Do not "assume" suicide is a "rational" response to disability.
> - Treat mental health conditions as aggressively as with a person without disability.
> - CTSAB should encourage and increase participation from the disability community and encourage educational presentations.

I would strongly urge Hawai'i to follow Connecticut's lead and fully include disabled people in your state's suicide prevention plan, officially recognizing the discrimination of legalized assisted suicide.

Misdiagnosis and incorrect prognosis are also serious concerns when assisted suicide is legalized. SB 1129 SD2 allows for a prognosis of six months to live, but does not take into

account the effects of treatment. Many people with severe disabilities who need breathing support, or people with diabetes controlled by insulin, would be eligible for suicide under this bill. Even if the bill were to include the effects of treatment, many people have dramatically outlived doctors' expectations. Senator Ted Kennedy was diagnosed with brain cancer and given 2-4 months to live, yet lived 15 very productive months. Actress Valerie Harper was diagnosed with a different form of brain cancer and given 3 months to live; she is alive and fighting her disease more than four years later. Jeanette Hall, diagnosed with cancer and given six months to a year to live, sought to die under Oregon's assisted suicide law. Her doctor persuaded her to accept treatment, and she is alive and well nearly 16 years later. John Norton was diagnosed with ALS at age 18 and given 3-5 years to live. The diagnosis was confirmed by the prestigious Mayo Clinic. Six years later, the progression of his disease suddenly stopped and he is alive at age 79, with a wife, children, and retired from a successful career. He writes that if assisted suicide had been legal at the time, "I would have taken that opportunity."

Rahamim Melamed-Cohen, sometimes called "Israel's most famous terminally ill patient," was diagnosed with ALS over 20 years ago and was also given 3-5 years to live. In spite of the fact that he can only think and blink his eyes, he has said that "if they [the doctors] had let me die, I would have missed out on the best, most beautiful years of my life." He has written 12 books and created beautiful artwork using Microsoft's eye-tracking technology. What makes Dr. Melamed-Cohen a role model for the rest of us is his attitude, which is the complete opposite of the "death with dignity" movement: "Don't despair. Be optimistic and work on joy in your heart. No matter what you're lacking think of what's possible to do in your present situation."

Dr. Melamed-Cohen's attitude reminds us of the importance of our social interconnectedness, that "my death" is not a private, individualistic choice, but affects all around us. In the immortal words of Reverend Dr. Martin Luther King, Jr., "We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly." Yet under SB 1129 SD2, in § 8, family notification is merely recommended, not required. What if one of your relatives took the lethal prescription and you had no idea this was coming? Death is too important to be reduced to six word slogans claiming it is merely a matter of "my choice."

Finally, there is the issue of expansion. Leaders of Compassion & Choices and other "right-to-die" organizations have publicly stated their intent to come back later to expand beyond "six months," "terminally ill," and "mentally competent." At a gathering in Hartford, Connecticut in October 2014, Compassion & Choices president Barbara Coombs Lee declared her support for assisted suicide for people with dementia and cognitive disabilities unable to consent. *CT News Junkie* quoted her saying, "It is an issue for another day but is no less compelling." Dr. Marcia Angell, leading proponent of the defeated 2012 Massachusetts' assisted suicide ballot question, wrote in *The New York Review of Books* that she now favors euthanasia as well as assisted suicide. New Mexico recently rejected legislation (HB 171 / SB 252) that would have allowed for assisted suicide on demand with no second opinions, waiting periods, multiple requests, or reporting requirements, and had an expansive definition of "terminal illness." Oregon is currently debating a bill (SB 893) to allow euthanasia by advance directive as an expansion of its Death with Dignity Act. Other bills filed here in Hawai‘i have similar, extremely expansive provisions.

If SB 1129 were enacted, expansion will move into the hands of judges. While we in the disability-rights community view legalizing assisted suicide as a violation of the Americans with Disabilities Act and the equal protection clause of the Hawai'i Constitution—people with certain disabilities are thus denied the benefit of suicide prevention services—judges could easily use both of these provisions to require extending the "benefit" of "aid in dying" to other disabled people. The limitations of "six months," "terminally ill," "mentally competent," and "self-administration" in SB 1129 all discriminate on the basis of disability. Indeed, back in 1999, former Deputy Attorney General of Oregon wrote this response to state senator Neil Bryant regarding the self-administration requirement in that state:

> "The Death with Dignity Act does not, on its face and in so many words, discriminate against persons who are unable to self-administer medication. Nonetheless, it would have that effect....It therefore seems logical to conclude that persons who are unable to self-medicate will be denied access to a 'death with dignity' in disproportionate numbers. Thus, the Act would be treated by courts as though it explicitly denied the 'benefit' of a 'death with dignity' to disabled people...."

So what about the person with ALS who has a six month prognosis, but has lost the ability to (literally) self-administer? What about the person with Parkinson's disease, who will have tremors for years before dying? What about people with communication disabilities who may not be able to make the request on their own? What about Grandma with dementia, or the person with a severe psychiatric disability? Once the door to assisted suicide is pried open in enough states, Compassion & Choices will seek to open it further through the courts, going from six months terminal to one year, to perhaps five years; from assisted suicide to euthanasia as is already the case with this bill; and from euthanasia for terminal illness, to chronic illness, to mental suffering. This is how we go down the same road as Belgium and the Netherlands, where we see euthanasia for deaf twins who fear going blind, or for someone unhappy with gender reassignment surgery, and where euthanasia is the cause of 1 out of every 50 deaths. This is how we go down the same road as Canada, whose radical Supreme Court decision requiring the legalization of active euthanasia for mental suffering was heartily praised by Barbara Coombs Lee. For Compassion & Choices, these are merely issues for another day, and for them, no less compelling.

For those of us in the disability community, opposition to assisted suicide is an issue of justice and civil rights. Reject SB 1129, which enshrines lethal disability discrimination into law. Instead, let us recall Dr. King's dream, in which we all—regardless of race, religion, gender, sexual orientation, or disability—have inherent dignity, and we do not have to die to get it.

We Shall Overcome!

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Stephen Mendelsohn

Some Oregon and Washington State Assisted Suicide Abuses and Complications

"We are not given the resources to investigate [assisted-suicide cases] and not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves."[1]

Dr. Katrina Hedberg, Oregon Department of Human Services

Under Oregon and Washington State's lax oversight, these are some of the documented abuses and complications that have come to light. This list includes abuses and medical complications, as well as other incidents showing some of the harms and dangers that accompany assisted suicide laws.

Doctor Shopping Gets Around Any "Safeguards"

- **Kate Cheney,**[1] 85, died by assisted suicide under Oregon's law even though she had early dementia. Her physician had declined to provide the lethal prescription. Her managed care provider then found another physician to prescribe the lethal dose. The second physician ordered a psychiatric evaluation, which found that Cheney lacked "the very high level of capacity required to weigh options about assisted suicide." Cheney's request was denied, and her daughter "became angry." Another evaluation took place, this time with a psychologist who insisted on meeting Cheney alone. Disturbingly, the psychologist deemed Cheney competent while still noting that her "choices may be influenced by her family's wishes and her daughter, Erika, may be somewhat coercive." Cheney soon took the drugs and died, but only after spending a week in a nursing home.

- **The first known assisted suicide death**[2] under the Oregon law was that of a woman in her mid-eighties who had been battling breast cancer for twenty-two years. Initially, two doctors, including her own physician who believed that her request was due to depression, refused to prescribe lethal drugs. Compassion & Choices—then operating under the name Compassion in Dying, although originally called The Hemlock Society—became involved in the case and referred the woman to a doctor willing to write the prescription.

  Dr. Peter Goodwin, the group's former Medical Director, said that about 75 percent of those who died using Oregon's assisted suicide law through the end of 2002 did so with the organization's assistance.[3] In one example year, during 2003, the organization was involved in 79 percent of reported assisted suicide deaths.[4] According to Dr. Elizabeth Goy of Oregon Health and Science University, Compassion in Dying sees "almost 90 percent of requesting Oregonians**…**"[5] "In 2008 the proportion of C&C PAS deaths significantly increased to 88 percent (53/60) of all reported deaths**."**[6] And in 2009, 57 of the 59 assisted suicide deaths were Compassion & Choices clients. But then they ceased to provide further information.[7]

Depression and Psychiatric Disability

- **Michael Freeland,**[8] age 64, had a 43-year medical history of acute depression and suicide attempts. Yet when Freeland saw a doctor about arranging an assisted suicide, the physician said he didn't think that a psychiatric consultation was "necessary." But the law's supporters frequently insist that as a key safeguard, depressed people are ineligible. When Freeland chanced to find improved medical and suicide prevention services, he was able to reconcile with his estranged daughter and lived two years post-diagnosis. Oregon's statistics for the years 2011 - 2014 show that each year, only 3% of patients (or fewer) were referred for psychological evaluation or counseling before receiving their prescriptions for lethal drugs.[9]

- **Absence of psychiatric consultation:** This case is about what can happen when competent psychiatric consultation is not provided. [A] woman in her mid-fifties with severe heart disease . . . requested assisted suicide from her cardiologist, despite having little discomfort and good mobility. She was referred to another doctor, who in turn referred her to a physician willing to provide assisted suicide. That doctor determined that the woman had more than six months to live, according to his best estimate. She was eventually dismissed as ineligible. Rather than inquire further into possible causes of [her] suicidal despair [or refer her for psychiatric treatment], the physician apparently considered … his responsibility ended. … [H]e told her to go back and make yet another appointment with her original physician and dismissed her. She killed her self the next day.[10]

Economic Pressures and Coercion

- **Linda Fleming**, the first to use the WA state law, was divorced, had had financial problems, had been unable to work due to a disability, and was forced to declare bankruptcy. Yet the Director of Compassion & Choices of Washington said that her situation presented "none of the red flags" that might have given his group pause in supporting her request for death.[11] But we are told by proponents that financial pressures have never played a role.

- **Thomas Middleton** was diagnosed with Lou Gehrig's disease, was moved into the home of Tami Sawyer in July 2008, and died by assisted suicide later that very month. Middleton had named Sawyer his estate trustee and put his home in her trust. Two days after Thomas Middleton died, Sawyer listed the property for sale and deposited $90,000 into her own account.[12] It took a federal investigation into real estate fraud to expose this abuse. Sawyer was indicted for first-degree criminal mistreatment and first-degree aggravated theft, partly over criminal mistreatment of Thomas Middleton. But the Oregon state agency responsible for the assisted suicide law never even noticed.

Self-Administration

- **Patrick Matheny**[13] received his assisted suicide prescription by Federal Express. He couldn't take the drugs by himself so his brother-in-law helped. Commenting on the Matheny case, Dr. Hedberg of Oregon Department of Human Services said that "we do not know exactly how he helped this person swallow, whether it was putting a feed tube down or whatever, but he was not prosecuted …" The state's official annual report on assisted suicide deaths did not take note of this violation of the Oregon law. Proponents regularly insist that the law's self-administration requirement is a key safeguard against abuse that is scrupulously followed, and that Oregon's reports have thoroughly reflected all key circumstances as the law has unfolded.

- **Another anonymous patient:** Dr. David Jeffrey wrote, "The question of administration is a delicate one, a patient even had a PEG feeding tube inserted solely to allow him to have PAS [physician assisted suicide]."[14] Concern about the fate of unused lethal barbiturates is compounded by the fact that the Oregon law does not necessarily require that the drugs be ingested by mouth. Barbara Glidewell, Patient Advocate at Oregon Health & Science University, said that patients who cannot swallow would "need to have an NG tube or G tube placement … [Then, they could] express the medication through a large bore syringe that would go into their G tube."[15] Kenneth R. Stevens, Jr. MD, former Chairman of Radiation Oncology at Oregon Health & Science University, observed that since the lethal agent can be administered to a willing person through a feeding tube, it is equally possible to administer it to an unwilling person by the same means. Moreover, once injectable pentobarbital leaves the pharmacy, there is nothing to prevent it from being used through an intravenous (IV) line, or as a lethal injection. If a patient or someone assisting appears to have used a feeding tube or an injection, abuse is far more difficult to detect and prove.[16] Yet, supporters of the Oregon law allege that assisted suicide is totally voluntary by virtue of the fact that the individual alone must actually swallow the lethal agents.

Deadly Mix Between Our Broken Health Care System & Assisted Suicide

- **Barbara Wagner** & **Randy Stroup:** What happened to these patients underscores the danger of legalizing assisted suicide in the context of our broken U.S. health care system. **Wagner**, a 64-year-old great-grandmother, had recurring lung cancer. Her physician prescribed Tarceva to extend her life. Studies show the drug provides a 30 percent increased survival rate for patients with advanced lung cancer, and patients' one-year survival rate increased by more than 45 percent. But the Oregon Health Plan sent Wagner a letter saying the Plan would not cover the beneficial chemotherapy treatment "but … it would cover … [among other things,] physician-assisted suicide." **Stroup** was prescribed Mitoxantrone as chemotherapy for his prostate cancer. His oncologist said the medication's benefit has been shown to be "not huge, but measurable"; while the drug may not extend a patient's life by very long, it helps make those last months more bearable by decreasing pain.[17] Yet Stroup also received a letter saying that the state would not cover his treatment, but would pay for the cost of, among other things, his physician-assisted suicide.[18]

  These treatment denials were based on an Oregon Medicaid rule that denies surgery, radiotherapy, and chemotherapy for patients with a less than a five-percent expectation of five-year survival. H. Rex Greene, M.D., retired, former Medical Director of the Dorothy E. Schneider Cancer Center at Mills Health Center in San Mateo, CA and formerly a member of the AMA Ethics Council, called this rule "an extreme measure that would exclude most treatments for cancers such as lung, stomach, esophagus, and pancreas. Many important non-curative treatments would fail the five-percent/five-year criteria."[19] Though called free choice, when insurers won't pay, assisted suicide is a phony form of freedom.

Breakdown in Rules Attendant to Changing the Law

The following cases were caused be **legal erosion and the breakdown in rules and codes of conduct** associated with assisted suicide laws, rules and codes that elsewhere protect health care patients.

- **Wendy Melcher**[20] died in August 2005 after two Oregon nurses, Rebecca Cain and Diana Corson, gave her overdoses of morphine and phenobarbital. They claimed Melcher had requested an assisted suicide, but they administered the drugs without her doctor's knowledge,

in clear violation of Oregon's law. No criminal charges have been filed against the two nurses. The case prompted one newspaper to write, "If nurses—or anyone else—are willing to go outside the law, then all the protections built into [Oregon's] Death with Dignity Act are for naught."[21]

- **Annie O. Jones, John Avery, and three other patients** were killed by illegal overdoses of medication given to them by a nurse, and none of these cases have been prosecuted in Oregon.[22]

Medical Complications

Assisted suicide proponents and medical personnel alike have established that taking lethal drugs by mouth is often ineffective in causing a quick and simple death. The body sometimes expels the drugs through vomiting, or the person falls into a lengthy state of unconsciousness rather than dying promptly, as assisted suicide advocates wish. Such ineffective suicide attempts happen in a substantial percentage of cases—estimates range from 15 percent to 25 percent.[23]

- **Peaceful death?** Speaking at Portland Community College, pro-assisted-suicide attorney Cynthia Barrett[24] described one botched assisted suicide. "The man was at home. There was no doctor there" … . "After he took it [the lethal dose], he began to have … physical symptoms … that were hard for his wife to handle. Well, she called 911." He was taken to a local Portland hospital and revived, then to a local nursing facility. "I don't know if he went back home. He died shortly – some … period of time after that … ."

  Commenting on this botched assisted suicide case, The Oregonian editorial columnist David Reinhard observed, "The Health Division knows nothing [about this case], … through no fault of its own. Why? Because the doctor who wrote the prescription, the emergency medical technicians and the hospital reported nothing. Why? Because [the assisted-suicide law] reporting requirements are a sham."

- **David Prueitt**[25] took his prescribed lethal overdose in the presence of his family and members of the assisted-suicide advocacy group Compassion & Choices. After being unconscious for 65 hours, he awoke. His family leaked the failed assisted suicide to the media. Oregon DHS issued a release saying it "has no authority to investigate individual Death with Dignity cases."[26]

Impacts by Doctors and Their Quality of Care

- **Kathryn Judson** wrote of bringing her seriously ill husband to the doctor in Oregon. "I collapsed in a half-exhausted heap in a chair once I got him into the doctor's office, relieved that we were going to get badly needed help (or so I thought)," she wrote. "To my surprise and horror, during the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. 'Think of what it will spare your wife, we need to think of her' he said, as a clincher."[27] According to prescribing doctors, 40% of people who died by assisted suicide reported feeling like a burden on family and caregivers as a reason for requesting lethal drugs.[28]

- **By contrast: Jeanette Hall** of Oregon was diagnosed with cancer in 2000 and told she had six months to a year to live. She knew about the assisted suicide law, and asked her doctor about it, because she didn't want to suffer. Her doctor encouraged her not to give up, and she decided to fight the disease. She underwent chemotherapy and radiation. Eleven years later, she wrote, "I am so happy to be alive! If my doctor had believed in assisted suicide, I would be dead. …

Assisted suicide should not be legal."[29] Unfortunately, not all doctors are like Jeanette Hall's.

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Sylvia A. Law
Elizabeth K. Dollard Professor of Law, Medicine and Psychiatry

March 22, 2017, 8:20 a.m.
Support for the Medical Aid in Dying Act, SB 1129

Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayahi, Vice Chair
Committee on Health, Hawaii House of Representatives

Dear Representatives Belatti and Kobayashi:

Thank you for moving forward on SB 1129. This bill is solidly grounded in Hawaii's traditions of leadership in health care and respect for individual liberty.

I do not speak for any organization, but rather as engaged, national expert on these issues. Since 1970, I have been a law professor, mostly at NYU Law, teaching, writing, and doing activist work on health law and policy, constitutional law. I served on the national Board of Compassion and Choices from 1997 until 2010. For decades, I have been engaged in the medical, ethical, policy, legislative and constitutional debates in many states.

I also speak as a kamahaina, and a scholar of health care in Hawaii. Since 2000 I have lived most of the year in my home in Kailua, and taught health law and policy, civil rights and constitutional law as a visiting Professor at the Richardson School of Law.

Hawaii has a proud tradition of excellence in providing health care and respecting individual liberty, including the Prepaid Health Care Act, the extraordinary state constitutional protections for privacy, liberty and gender equality.

SB 1129 is squarely within the Hawaii tradition.

The core issue is one of individual liberty and privacy. SB 1129 is narrowly drawn to protect the right of a mentally competent, terminally ill patient to hasten death. It provides multiple protections to avoid abuse. It also promotes ethical medical principles by respecting doctors' obligations to avoid abandoning terminally ill patients.

Decades of experience in Oregon and Washington tell us that the option is rarely used. And, often people seek the option of choice to hasten death and then choose not to exercise it, and die of the underlying disease. Liberty is about choice. Evidence tells us that people value choice, even when they choose not to exercise it.

Experience in states that have adopted end of life choice for mentally competent, terminally ill patients also shows dramatic improvements in general end of life care. When the option is on the table, medical professionals are more likely to have honest conversations with terminally ill patients. The use of hospice and palliative care increases.

If I can be of any help in discussions on this important bill, let me know. Thank you for your good work.

Sylvia A. Law
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Date: March 22, 2017

To: House Health Committee Chair Bella Au Belatti, Vice Chair Bertrand Kobayashi, and other Committee Members

From: Rae Seitz, MD

Subject: Testimony on SB 1129 SD 2

Aloha:

As a palliative and hospice care physician with over 15 years of experience, I have personally been at the bedside of hundreds of patients at their time of death. I also have had the profound honor of journeying with these people as they faced the end of their lives, through the many twists and turns of living with serious medical conditions. I have built home- and hospital-based palliative care programs throughout the state of Hawaii. I have taught palliative medicine locally, nationally, and internationally. I am one of 30 people in the world to have received the American Academy of Hospice and Palliative Medicine's Visionary Award, shared with the likes of Dame Cicely Saunders, Diane Meier, Ronald Reagan, and Atul Gawande. The views that I express here are my own.

But first, let me make this clear: I support individual patient choice. I believe that for a very small minority of people medical aid in dying is an authentic and reasonable choice. My career has been built around learning about who my patients are and honoring their values and choices as fully and effectively as possible. What I offer today in no way diminishes that commitment.

While medical aid in dying is a legitimate choice which should be available to those who want it, there is much to do to ensure the safety and equity of such a service. Legislation such as SB 1129 begins to address the many policies, procedures, and oversight, it merely scratches the surface of what is needed. We have the benefit of learning from the experiments performed in other states, most of which were led by the same forces leading the movement here in Hawaii. Indeed, we should look at these states' experiences because the bill before you is based upon the legislation which were passed there.

Lessons Learned from California: More Information Needed Before Implementation
Let's not be the dog that catches the car then doesn't know what to do with it: although medical aid in dying legislation was passed in California nearly nine months ago, our physician colleagues in that state tell us there are still many uncertainties about the implementation of that law because the focus was so narrowly on simply passing the legislation that there was little thought and planning about how to manage things once the right was legislated. Like the dog that catches the car, California healthcare providers, agencies, facilities, patients, family members, etc. have been scrambling to figure out what to do next. Patients and family members who want to know about medical aid in dying in California do not know who to turn to for accurate and consistent information. Physicians, nurses, educators, administrators and pharmacists, among others, are equally as uninformed.

This can result in three broad categories of harm: 1) those who genuinely want aid in dying either can't get it; 2) there is a likelihood that patients will encounter providers with little or no experience in facilitating an open discussion or managing dying leading to a bad (and uncorrectable) experience; or 3) a person who thinks about but does not authentically choose aid in dying could very well find him/herself on a path where the discussion is low quality and an uniformed choice is made.

To be blunt, and based upon my experience and knowledge, I can honestly tell you that Hawaii's healthcare community is not yet prepared for medical aid in dying. Recent experience showed that many of our providers do not understand, do not facilitate adequate discussions around, and fail to properly execute advance care planning decisions and documentation. Under current conditions we cannot expect that the discussions and planning necessary to genuinely and safely honor a person's choice of medical aid in dying can occur. We need to set standards and guidelines for our providers as well as offer the additional training and skill-building to ensure they are understanding ALL the choices for care that may be available to their patients so that any choice a patient makes is an informed and shared one, based upon the patient's values and beliefs. And we cannot forget all the other healthcare providers who are or will be a part of a person's care at the end of life: there needs to be much more outreach and education to providers all along the delivery channel before this bill becomes law. We need only look at rail and medical marijuana as examples of the consequences of laws that are adopted without appropriate planning and programmatic infrastructure in place.

Patient Safeguards

While I appreciate the House Health Committee's efforts to explore the regulatory processes to establish medical aid in dying in Hawaii, as a clinician I have serious patient concerns about the proposed law. The narrow legal focus on patient autonomy and immunity for physicians involved with aid in dying have overshadowed the practical, clinical issues which are critical to consider. Simply put, medical aid in dying is a complex process, and not anything as clear cut and straight-forward as its proponents have portrayed it to be. For example, the proposed law focuses on legal definitions but fails to consider medical definitions which are important in the world of healthcare providers. Evaluating a patient's mental "competence" may be important in the court of law, but physicians evaluate a patient's decisional "capacity," which is an entirely different metric. Many physicians do not know how to assess decisional capacity and it is only a few specialties which attend to the skills and competencies to enable the objective assessment of this ability. Physician input in the construction of this proposed law is noticeably absent.

Clinical Oversight

Those in favor of medical aid in dying say there have been no reports of abuse in Oregon. That is true. But you must look carefully at the data before you accept that proposition. Does an absence of reports equate to the absence of abuse? The data collected annually in Oregon is sparse. What we do know is that 102 physicians wrote 204 prescriptions in 2016, and five patients (2.5%) were referred for psychological or psychiatric evaluation. Only 20% had a healthcare provider present at the time of death. This is important because Oregon has a new procedure in which information about the time of death and circumstances surrounding death is accepted only if the physician or another healthcare provider is present at time of death. The fact of the matter is that while the data available is reassuring, we have to assume that it does not tell the whole story and we in Hawaii should lead the country in determining, monitoring, and reporting much better data. We certainly owe Hawaii's people a more rigorous approach to data collection and monitoring.

Professional Competency

Hawaii's proposed medical in dying law contains a semblance of safeguards for patients. While they may appear sound from a regulatory perspective, they lack a clinical implementation perspective. The proposed law gives tremendous latitude to physicians to make judgment calls on a patient's diagnosis, prognosis and even an initial mental health assessment. Not all physicians are qualified to make these type of evaluations, and shared decision-making does not provide any reassurance to patients and their families if the physicians involved do not have the required skill-sets.

Medical aid in dying has not been taught in medical schools, and physicians are currently ill equipped to know what to do in granting such a patient request and, more importantly, do not know how to determine if the patient's decision to pursue aid in dying is authentic and is in fact a personal decision, not someone else's decision thrust upon that individual.

Recommendations:
I would like to offer the following (initial) recommendations as a start for the work of planning prior to passing legislation legalizing medical aid in dying.

1. Convene the best and brightest of our palliative medicine experts to oversee the development and implementation of policies, processes, and monitoring/reporting of medical aid in dying.
2. Determine the state body that will hold legal and practical oversight for medical aid in dying.
3. Establish standards of knowledge, skills, and competencies to ensure high quality discussions to facilitate patient-centered, informed and shared decision making.
4. Decide and authorize specific entities to be responsible for the monitoring, collection, and analysis of data as well as annual reporting.
5. Establish a quality oversight committee with adequate funding who will be responsible for monitoring the experience of medical aid in dying to identify opportunities to improve safety, efficacy, patient autonomy, and justice.

Mahalo for your consideration of these concerns as you shape the future direction of healthcare for Hawaii's patients and their families.

Honorable Chair Belatti, Vice Chair Kobayashi and esteemed House Committee on Health Members:

As a palliative medicine specialist, I appreciate the time you have allowed for discussion of this important public health issue. Physician-assisted suicide is a contentious and highly polarizing issue. I recognize there are people of great integrity, compassion, and intelligence that hold contrary opinions. It is certainly easy to understand why polls of the general public find people generally sympathetic to what, on the surface, seems a simple question of personal choice and individual liberty. However, I would like to respectfully share why, after many years of thought and study on the subject, and a medical career that focuses on the care of people living with serious, often terminal illness, I have come to a different conclusion.

Time precludes a full discussion here but, with our shared goal of balancing the needs of the few with the public's health and safety, I humbly ask the committee to address the following safety concerns in any legislation you consider:

1. Proponents of assisted suicide raise the lack of documentation of any abuse under Oregon's Death With Dignity Act as a reassurance. With national estimates of elder abuse at 10%, the lack of documentation of a single case of abuse is far from reassuring: it strongly suggests the lack of an effective system to monitor and prevent abuse.
2. Studies show a strong association between the desire for hastened death and depression. Therapy has been shown to be effective in reducing the desire for hastened death among those with terminal illness. Yet, very few of those requesting assisted suicide in Oregon are even referred for a mental health evaluation, less than 4% in the most recent report. Elsewhere in medicine, when a depressed patient expresses a desire to die, we use all of our resources to prevent it. Why should the seriously ill be provided a lower standard of care?
3. The slippery slope is not an irrational fear: it is inevitable. Canada and some European countries already permit assisted suicide as well as active euthanasia and do not require that one be terminally ill to qualify. For a truly chilling experience, visit the government website for the Netherlands to see that a 12-year-old may petition for euthanasia for unbearable suffering, absent any terminal illness.
4. Understandably, many people take comfort from having lethal medication available and never ingest it but, instead, die naturally. In Oregon, 1,545 lethal prescriptions have been written resulting in 991 (64%) deaths by ingestion. What happens to the other 36% of lethal medication? We have a national suicide epidemic, with suicide now a leading cause of death among youth. None of the other states with assisted suicide laws adequately secure unused medication. When access to lethal medication is increased at the same time that society

sends a clear message that ending one's life in the face of suffering is sanctioned as a rational and personal choice, how can we not expect suicide to continue to rise?

5. These laws give immunity to prescribe lethal medications to all licensed physicians. Yet, few doctors have the added training and skills to attend to the many forms of suffering experienced by those living with terminal illness. I hold my medical colleagues in the highest regard. My dermatologist, orthopedic surgeon and ophthalmologist all provide me with exceptional care within their scope of specialization. Yet, I would not expect them to have the skills to assess or treat suffering in a terminally ill patient. These laws do not distinguish among doctors: all are authorized to prescribe lethal medication. Skills in attending to suffering are not required, just a prescription pad.

Knowing what I know about the amazing, yet flawed, profit-driven US health system, I cannot believe this will be the single decision in healthcare where personal values and autonomy trump all the other factors that guide every aspect of US health care. Despite what we all might wish for, for every other medical decision, personal means, geography, access, and demographics are far more decisive factors. From having a home birth to where and how we die, these are the factors that drive US health care delivery and it is naïve to believe that assisted suicide will be the sole exception to this rule. Those that would entrust the medical industrial complex with the power to take life, cannot possibly appreciate its drivers.

Hawaii has some of the most progressive gun control laws in the nation and, as a result, gun violence in our islands is thankfully rare. Just as the constitutionally protected right to bear arms is not unlimited, so we must recognize that the individual rights of those who want this option should not trump the public safety and our desire for a compassionate and caring society.

Suffering is an inherent part of the human condition: it is not something restricted to the last six months of life. Doctors, especially those that practice palliative medicine, know that suffering can be extreme in non-terminal situations or essentially absent at the end of life. There is simply no correlation between prognosis and suffering. This is why we worry about the slippery slope. Canada and the Netherlands already do not require a terminal diagnosis for assisted suicide or even euthanasia, only "unbearable suffering."

Physician-assisted suicide devalues the existence of all of those with limited time to live by sending the message that as a society we believe that their time left is so insignificant in comparison to their suffering that we condone ending their life. What message does this send to the terminally ill and elderly if we measure the inherent value of a life by its remaining length? Dame Cecily Saunders, the founder of the modern

hospice and palliative care movement, has instilled in us the message to our patients, “You matter because you are you. And you will matter right up to your last breath.”

Again, I thank the committee for its time and thoughtful consideration on this important issue. Only a small number of people would likely use assisted suicide should it become available in Hawaii, about 40 people per year if we extrapolate the Oregon experience to Hawaii. I know the committee joins me in wishing for the most compassionate and highest quality care for all of the approximately 11,000 people that will die in Hawaii this year. There is no law against suicide in any state and, sadly, despite our best efforts, five times as many people will commit suicide in Hawaii next year without physician assistance than would use this law. As much as we can all deeply respect and empathize with the desire for self-determination, giving immunity to physicians for a right the 40 already have, does not make sense if it exposes the 11,000 to these risks.

Respectfully,

Daniel Fischberg, MD, PhD, FAAHPM
Kailua, HI

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March 20, 2017

TESTIMONY IN OPPOSITION TO SB 1129 SD2

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair
Rep. Sharon E. Har
Rep. Chris Todd
Rep. Dee Morikawa
Rep. Andria P.L. Tupola
Rep. Marcus R. Oshiro

HEARING Thursday, March 23, 2017 at 8:30 am Conference Room 329

Dear Chairman, Vice Chairman and Committee Members,

My name is Jim Hochberg and I am a civil rights attorney who has practiced law in Hawaii since 1984 (33 years). I testify in strong opposition to SB 1129 SD2.

A. There are serious problems with the changes made in SD2. The changes made to address concerns expressed to the Senate do not repair the bill. From the SCR No. 893 starting on page 4 where the amendments are listed, the following comments are provided referring to the numbered paragraph in the committee report by amendment:

(4) How is it that the two individuals who witness the signing of a request for medication might or might not be qualified to attest to the sound mind of the requesting patient?

(5) The disqualification of the witness based on the witness being entitled to a portion of the estate, requires that the distribution plan of the estate be known BEFORE the patient obtains the deadly prescription. Often the estate plan is not disclosed until the death of the person whose estate is planned.

(6) Why does the legislature desire to create public documents, death certificates, that fraudulently list the cause of death as the underlying terminal disease rather than the deadly prescription that actually causes the death? Do we want our public records, to contain patently false

information. This has negative implications for the required record keeping and reporting discussed below.

(9) Requiring a person who has custody or control of any unused deadly medication to personally deliver it for disposal to the nearest qualified facility or lawfully dispose of the unused deadly prescription. Would you know which facilities that might be? It does not comfort to believe that in each instance someone is going to take custody of the extra medication (it could be 100 capsules of seconol). My guess is that more often than not no one will. There is no mechanism to enforce this provision. It won't work.

(10) Increasing the immunity to cover even more serious crimes makes no sense at all.

15) Requiring the Department of Health to report annually to the legislature is useless when the public document doesn't list the deadly medication as the cause of the death. The only public record created will fraudulently state that the cause of death was the underlying terminal illness. Why are we hiding from the public record the truth?

B. The amendments in SD2 fail to improve the bill and elimination of the Patient is still not the practice of medicine. The legislature should not change the definition of the practice of medicine (the treatment of disease and maintenance of health) to include now the elimination of the patient by suicide. That is simply not the definition of the practice of medicine and you should not change the definition to include it. The law of unintended consequences should advise you against passing this bill out of your committee. In 1896, the Hawaii Territorial Legislature enacted the statutory definition of the practice of medicine to be the treatment of disease in humans. That concept has been the definition of the practice of medicine since Hippocrates of Kos offered it in the late 5th century BC. For the last roughly 2,500 years, that understanding has led to the trust between medical professionals and their patients that continues to today. The Hawaii definition has only been changed a couple of times since 1896, and all of those changes increased the type of treatment permitted, and permitted those new treatments **only** for maintaining health and treating disease.

Without an accepted medical protocol for suicide by seconol, doctors are guessing on the proposed protocol for medical suicide. In the places that have legalized physician assisted suicide, the suicide medicine often comes with dangers of unintended survival of the patient with new health issues, or organ failure, coma and the like. **MORE IMPORTANTLY**, should the patient not consume the prescribed 100 capsules of the deadly medicine those pills will be left somewhere in the home without doctor supervision. This is **TOO DANGEROUS**!

This is how the process will actually play out if physician assisted suicide become law. The physician writes a prescription for anti-nausea pills and 100 capsules of seconol, a sedative drug.

After giving the patient the prescription, that is the end of the doctor's assistance in the suicide process. All alone and without help from family, the patient must empty the 100 capsules to accumulate nine grams of pure, bitter-tasting seconol. To mask the bitterness of the suicide medicine, it is mixed with something to make it hopefully somewhat easier to swallow.

Before the patient actually consumes the suicide mixture, she must ingest the anti-nausea medication, to avoid rejection of the suicide mixture which would result in failed suicide. The doctor is not present to help with any complications: suffocation or multiple organ failure. On the other hand, in places in Europe when the doctor is present for the suicide, he fixes a failed suicide by lethal injection - which is the ultimate goal of this legislation, euthanasia.

Physician–assisted" suicide is very little assistance from the physician. Just the writing of the prescription for the poison. That is it. The physician does not account for the pills at the death of the patient, either through use of the pills or otherwise. In addition, death by seconol suicide is often quite easily *not* a peaceful and dignified death. Recognize that intentionally taking the life of the patient to alleviate health symptoms is not the treatment of disease or the maintenance of health so not the practice of medicine understood for 2,500 years. Don't radically alter the practice of medicine to include the intentional elimination of the patient.

For the foregoing reasons I oppose the bill and ask that you kill it today in committee. If you have any questions please feel free to call me.

Sincerely,

JAMES HOCHBERG

JH

kobayashi1- Oshiro

From: Nick Niemczyk <czyksix@hotmail.com>
Sent: Tuesday, March 21, 2017 3:55 PM
To: HLTtestimony
Subject: Testimony

Testimony in Opposition to HB 1454, by Christopher Niemczyk.

Good morning Mr. Chairman and members or the Committee.

I appreciate this opportunity in addressing you this morning. Once again, the issue of Physician Assisted Suicide is being debated before the Hawaii State Legislature, more commonly referred to as the Death with Dignity bill. One must ask if anyone exercises this option in hastening their death is any more dignified than those who don't choose this option.

The advocates of Physician Assisted Suicide argue that this bill will only give those who have been declared "terminally ill" and have six months or less to live, the option to end their lives to alleviate pain and suffering and the end of life. No one wants to see anyone suffer undue pain.

Physician Assisted Suicide should never be an option. I believe, as do many others, that there are many other alternatives, which should be considered instead of Physician Assisted Suicide.

Here I would like to thank the Legislators' efforts in past years of making palliative are and pain management more available. This is where the State's focus should remain. The whole emphasis of our society is based on the preservation of life. The Declaration of Independence states that everyone has a right to life, liberty, and the pursuit of happiness.

The whole essence of the medical profession is to save and to preserve life. Legalizing Physician Assisted Suicide, the whole essence of society and the medical profession would change. The advocates argue that this is only a voluntary choice made by themselves and the doctor. In reality, it is ultimately the State making the decision on which groups can live or die, setting a dangerous precedent. Once the decision has been made, society's attitudes towards Physician Assisted Suicide will slowly change. The numbers of people and groups demanding to be included under this law will only continue to grow.

Already in the five years I've been fighting against this bill, I've watched as the emphasis has slowly shifted from concerns over pain management to the issue of being a burden to one's family and the issue of choice.

In some sense, I can empathize with those who are concerned about end of life care, having dealt with the medical profession throughout my life. Sometimes professionals do not always have the best bedside manner. This is particularly true in nursing homes, where one's fears are rightfully so concerned about the loss of one's dignity. On the other hand, it is the professional and their attitude, which must be dealt with, and not the patient with the legal means in which to kill themselves.

Although I know this is not the proposed legislation, these are common arguments that proponents of Physician Assisted Suicide use to advocate their position. Furthermore, these arguments are alarming for many of us in the disability community who may have personal care issues, such as dressing and toilet assistance. For some who have never had to deal with these issues before, this is humiliating, but in the disability community, it is accepted as a fact of life.

These concerns may seem far fetched, but in societies, such as the Netherlands, which have already legalized Physician Assisted Suicide for the terminally ill, the practice very quickly spread to include those who were chronically ill, the elderly suffering from dementia, to those suffering from depression, which now include youth as young as twelve.

In Oregon, which has legalized Physician Assisted Suicide, there is the case of Kate Cheney, who initially sought a physician who would prescribe the lethal medication necessary for suicide. Her family physician refused on the grounds that he felt that family members were coercing her. She found another doctor who prescribed the pills. Initially, Kate refused to take the pills, but after spending time in a nursing home, she thought she had three choices: burdening her family, the hell of a nursing home, or death. So she took the pills. Thus doctor shopping is a very real concern.

Within the last few years, the Netherlands has even gone a step further in legalizing the euthanization of infants born with birth defects. Two years ago, Belgium legalized Physician Assisted Suicide, and already they are considering a bill that would legalize the euthanization of infants born with birth defects. In my mind, this is very disconcerting. As a person born with cerebral; palsy, a birth defect, I find this both appalling and scary. The proponents argue that this could never happen here, however we already have some bioethicists, such as Peter Singer at Princeton, arguing that parents should have the right to kill their children that were born prematurely up to a month after their birth. Of course, these dire predictions will not happen overnight. It took the Netherlands twenty years to get there.

kobayashi2 - Jessi

From: Anthony Lenzer <tlenzer@hawaii.rr.com>
Sent: Monday, March 20, 2017 5:28 PM
To: HLTtestimony
Subject: TESTIMONY IN SUPPORT OF SB 1129 SD 2

To: Committee on Health
From: Anthony Lenzer, PhD
Re: Support for SB 1129 SD 2
Hearing: Thursday, March 23, 2017, 8:30 a.m.
Conference Room 329, State Capitol

Chair Belatti, VC Kobayashi, and Committee Members:

My name is Anthony Lenzer. I am testifying on this matter as an individual, both as a concerned citizen, and one who has studied end of life issues and taught graduate courses on this subject at UH Manoa and at the University's Osher Lifelong Learning Institute.

Death with Dignity legislation, or physician aid in dying, has been on the Hawaii legislature's agenda twelve times since 1998. This year, five bills have been introduced on this subject. Interest in such legislation is a national phenomenon. Nearly half of all state legislatures are considering death with dignity legislation during this session.

Hawaii legislators can be encouraged by the fact that 80% of Hawaii residents support such legislation, according to a 2016 study by the Anthology Marketing Group. Furthermore, the Hawaii Medical Association has indicated that it will not oppose such bills this session. Medical Association neutrality has been critical in every state in which such legislation has been enacted.

Senate Bill 1129 SD 2 is based upon the first such law, enacted in Oregon, which went into effect in 1997. Between 1998 and 2015, the number of people requesting lethal prescriptions under the Oregon law has varied from 24 to 218 per year. During the same time period, the number of deaths associated with the use of such prescriptions has ranged from 16 in 1998 to 132 in 2015. This is a tiny fraction of all deaths in Oregon. However, having this choice has been shown to be of great comfort and value to those terminally ill persons who select this option.

The bill now before you contains one major improvement over the Oregon law and those of other states, I.e., it allows advance practice nurse practitioners, as well as physicians, to prescribe medication under the law. This provision will greatly benefit persons living in those rural areas where there are few, if any, physicians.

Please give Hawaii citizens this choice by passing Senate bill 1129 SD 2 Thank you for the opportunity to testify in support of this bill.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 5:57 PM
To: HLTtestimony
Cc: arvidtadaokitty@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Arvid Tadao Youngquist	Individual	Support	No

Comments: Chair, Rep. Rep. Dela Au Belatti Vice Chair, Rep. Bertrand Kobayashi House Health Committees Honorable Members: Rep. Sharon E. Har, Rep. Dee Morikawa, Rep. Marcus R. Oshiro, Rep. Chris Todd, Rep. Andria P. L. Tupola My name is Arvid Tadao Youngquist and reside in Kalihi Valley. I vote in House District 28. I am a former resident of Kaimuki, Wahiawa, honeymooned on the Big Island, and my mother graduated from Roosevelt High School and Liliuokalani Elementary School in Kaimuki. I am not asking that you vote yes or nay on SB 1129 SD2, relating to Health (Health; Medical Aid in Dying). I ask solely for an honest and fair hearing for the populace and individuals who have tried to have a similar measure introduced and heard here. Thank you, Arvid Tadao Youngquist

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 4:59 PM
To: HLTtestimony
Cc: Bernie@PartridgePhoto.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Bernard Partridge	Individual	Oppose	No

Comments: Opposed to SB1129

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March 20, 2017
Hawaii State Legislature
RE: SB1129 SD2

I am opposed to Senate Bill 1129 for a number of reasons, including:

1) Physician-assisted suicide has led to an increase in total suicides in states where it has been legalized. This is often called the "contagion" effect. Jones & Paton (2015) published a study of the data demonstrating this in the Southern Medical Journal, titled "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?

2) As many clinicians will disclose, it is not possible to accurately determine the length of time that an individual with a terminal diagnosis will live. Many patients given a 6 month prognosis will outlive that time frame. As a former hospice nurse, I have seen firsthand that an individual's time on this earth is unpredictable.

3) The disabled, elderly and infirm are vulnerable to abuse under the proposed Bill. An impatient or greedy family member could influence the disabled or ill elderly to make a decision they would not normally consider.

4) Good, appropriate hospice care can alleviate suffering at the end of life. I have been a nurse for over 40 years. The medications available now are far superior to what was available in the past. Providing a person with pain medication to alleviate suffering, even if it results in a slightly earlier death, is far different from providing a person with lethal doses of medication to assist them in committing suicide many months before their natural death would occur. <u>The intent matters</u>. It matters to society and the culture.

5) The trend in Washington and Oregon is that most people choosing assisted suicide are elderly, solitary (widowed or unmarried), less able to engage in enjoyable activities, dependent and worried about being a burden on family, friends or caregivers. Don't let this happen in Hawaii.

6) Participation in causing the death of patients undermines public and patient trust in their medical providers. I am a nurse practitioner and am well aware that trust is crucial to providing optimal patient care. I have been an educator of nurses for over 20 years. We instruct nursing students to follow the Code of Ethics of the American Nurses Association, which expressly prohibits nurse participation in euthanasia, assisted suicide, and criminal executions.

7) If this bill passes, Hawaii would become the first state to allow Advanced Practice Registered Nurses to participate in assisted suicide; this should not be a source of pride. In the 6 states where assisted suicide is legal it is limited to physicians. The Hawaii State Center for Nursing seeks removal of APRN/Nurse Practitioner practice barriers, but they do not represent us. Don't let this bill negatively define our profession.

Sincerely,
Gayle Early PhD, APRN, FNP-BC

gayleearly@yahoo.com
(808)344-7021

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 6:33 PM
To: HLTtestimony
Cc: jtt.hew@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Janeel Hew	Individual	Oppose	No

Comments: PLEASE VOTE NO ON SB1129 LET IT STAND ON RECORD THAT I, JANEEL HEW HEREBY REQUEST A NO VOTE ON SB1129. I STRONGLY OPPOSE. I HAVE INTIMATELY EXPERIENCED DOCTORS MAKE WRONG DIAGNOSIS FOR PATIENTS THAT THEY THOUGHT WOULD NOT SURVIVE. I MYSELF WOULD HAVE BEEN OFFERED THIS OPTION HAD IT BEEN AVAILABLE TO ME IN THE 1980S, AND I AM STILL HERE TODAY. DOCTORS CAN ONLY MAKE THEIR EDUCATED ASSESSMENTS THAT AT TIMES CARRY DRASTIC ERROR. WE HAVE ENOUGH NEGATIVE ISSUES WITH PHARMACEUTICALS AND SUICIDE WITHOUT HAVING IT BE LEGAL. STATISTICS SHOW THAT THOSE WHO FAIL AT ATTEMPTED SUICIDE MOST OVERWHELMINGLY REGRET IT. I LIVE WITH A PAINFUL AND DEBILITATING PROGRESSIVE DISORDER AND I PLAN ON CONTINUING TO LIVE. LIFE IS HARD...BUT LIFE IS PRECIOUS. MAHALO FOR YOUR TIME AND CONSIDERATION ON THIS IMPORTANT ISSUE. BUT MOST OF ALL MAHALO FOR YOUR NO VOTE THANK YOU IN ADVANCE JANEEL HEW

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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TO: Representative Della Au Belatti, Chair
Representative Bertrand Kobayashi, Vice Chair
Members of the House Health Committee

FR: John H. Radcliffe

RE: Testimony in **SUPPORT** of **Senate Bill (SB) 1129 SD 2** Relating to Health Establishes a death with dignity act under which a terminally ill adult resident may obtain a prescription for medication to end the patient's life.

Dear Chair Bellati, Vice-Chair Kobayashi and Members of the Committee:

My name is John Radcliffe, and this is the forty-first year that I have had the joy and pleasure of working as a lobbyist in these halls. It has been my life, and I am so grateful to have had such a singular opportunity. Thank you and all your colleagues going back to January of 1976.

I am here to testify for justice for doctors, and by so doing permit already terminally ill, adult patients with less than six months to live, and who are mentally competent, to control the time and place of their own death—without having their physician have to face criminal sanctions.

That is what SB 1129 SD 2 does. This bill is a substantial mirror of the Oregon legislation of 1997, the oldest and longest serving law in the country. In short, it is fashioned after the oldest, most conservative, and longest serving model legislation in the country. And there has never been a problem with it.

The medical condition that it ends, shortens the amount and duration of extraordinary, extreme pain and suffering that must be endured. And don't kid yourself, this is no more about morality than was the choice that hundreds of people in the Twin Towers on 9/11 to jump into space rather than be ravaged by fire at their backs. That was about life ending relief. It was about being human. And so is this. That's all it is.

This is about your chance to, if not vanquish death, at least cheat him out of a little extra agony at the end.

Karin Nomura

A quote I grew up with was “we come into the world kicking and screaming, we die the same way…but if we’re lucky, we’ll die in our sleep”. Part of this was meant as the inherit desire to stay alive for as long as we can, if we’re able to live life, the second part was the struggle to be born, and how there’s a struggle when we die…but when I met some people, saw what they went through, and how much suffering they went through, the thought of “death” in a different manner started taking hold. It grew as controversy around Dr. Kevorkian was publicized. We can “pull the plug” if a person is brain dead; a person can be taken off of life support if they’re in a coma; but if someone is in agony, with no chance of recovery, just suffering daily due to a debilitating, terminal illness, that will just worsen as time goes by, and wishes to die, I say they deserve to die with dignity if that is their choice. And the thought of being able to obtain a prescription from the doctor that will allow them to pass without any additional trauma, is something that I hope no one will ever need, but is an option for those who do.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 3:26 PM
To: HLTtestimony
Cc: kaulanad@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Kaulana Dameg	Individual	Support	No

Comments:

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TESTIMONY OF

Ken H. Takayama
5567 Pia Street
Honolulu, HI 96821

ON S.B. NO. 1129, S.D.2
RELATING TO HEALTH

BEFORE THE HOUSE COMMITTEE ON HEALTH

DATE: Wednesday, March 23, 2017, at 8:30 a.m.
Conference Room 329, State Capitol

Chair Au Belatti and Members of the House Committee on Health:

Thank you very much for this opportunity to testify in strong support of S.B. 1129 Relating to Health, which establishes a death with dignity law for the State of Hawaii. If enacted, this measure will establish a law in Hawaii that is similar to the Oregon law that appears to have served the people of that state well for over ten years.

I have long supported the right of people to choose to end their lives in a dignified manner at the time of their own choosing. To me, the idea of choice is a key element, because this is not—and should not be a matter of placing one set of beliefs above another. The ability of people to end their lives in a dignified manner—and the choice to do so, simply make it the right thing to do.

This issue became much more directly personal to me. In February of 2011, two months after I retired from the State, I was diagnosed as having Parkinson's disease. Parkinson's is aptly described by actor Michael J. Fox as "the gift that keeps on taking". In the six years since diagnosis, among other things, my mobility has slowed, I have lost my sense of smell, and my public speaking ability is "shot" (i.e., very degraded). And this is DESPITE my use of several excellent and helpful medications.

Things will get worse. Barring significant scientific breakthroughs, I can expect to become progressively more debilitated until I either die from the disease, or something else gets me first. Death from "complications related to Parkinson's" frequently involves choking, as the throat muscles that control swallowing stop acting in a normal manner.

I haven't given up on living yet. I volunteer part-time at my old office—the Legislative Reference Bureau, I continue to serve on the State Commission to Promote Uniform Legislation, and my wife and I still take ballroom dance lessons, after a fashion. By that I mean that we laugh a lot and hope to dance badly for years to come.

My personal feeling at this point is that I do not fear death, though I'm very concerned about pain. I consider myself fortunate that I have not experienced the pain that affects many people with chronic illnesses. For this reason, I realize that I may never need to end my own life in the manner authorized by this bill—but for the rest of my life, it will be a comfort to know that it is there.

As is the case with any issue of great importance, support for this bill is not unanimous, as any number of persons, including some physicians, have raised concerns. Aside from the fact that none of these persons need to avail themselves of what is being authorized in the bill, I believe the experience of states that have enacted death with dignity laws is instructive—namely, that there have not been huge numbers of people seeking to end their lives under those laws, nor is there indication of people being pressured to do so.

For physicians who are concerned about violating their Hippocratic Oath, my own perspective is that I personally do not see how prescribing medications to an individual who chooses to end their life in a dignified manner, who ingests the medications on their own, and in so doing is able to end a life that they no longer want to live, for example, due to unendurable pain—constitutes "doing harm". Refusing to assist the person in achieving a desired death in an authorized manner is not an extension of living—it is an extension of dying. And it is the latter scenario, in my opinion that does "harm".

I do not believe there are any ultimate, definitive answers to these philosophical and intensely personal questions and beliefs. These can be debated in this community from here to eternity, and will continue regardless of the decision you make today. At this juncture, the important thing is what you do.

I will end with the old Confucian saying that th e best time to plant a tree was 10 years ago. The second best time—is today.

TESTIMONY IN SUPPORT OF SB1129
Hawaii State House
Thursday, March 23, 2017
House Conference Room 329 at 8:30a
Submitted by Lynn B. Wilson, PhD

I Invite Your Strong Support for Medical Aid in Dying (SB1129)
Expanding compassionate choices at end of life

Greetings Senators of the Commerce, Consumer Affairs, and Health Committee,

You may know me from my advocacy in recent sessions on issues related to pesticides and our communities' rights to protect the health of our children and families. While my message to you today is a different one, it also relates to health, quality of life, and to having the right to be informed, to choose—compelling me to share my personal story.

I was diagnosed with an aggressive breast cancer in April 2016. Following surgery and months of chemotherapy infusions, my prognosis is not great: half the women with this type of breast cancer do not survive five years. In the event we do discover my cancer has metastasized to my brain, liver, or lungs, doctors have told me it's incurable.

So now I've been engaging my legal team and my health team to partner with me on this journey. I'm committed to living my life fully— because I love my partner, family, and friends, and because I'm committed to contributing to my community as fully as possible, as long as possible. I am just as committed to living my dying fully, whenever that time comes. I'm thankful to know today I have options of palliative care and hospice to discuss with my health team when I reach my end of life, being able to choose to relieve my pain and suffering in a compassionate way. And, I strongly support Hawaii's efforts to expand my legal options when I arrive at that point—to be able to discuss with my health team medical aid in dying.

Current medical research documents that one out of every two men and one out of three women will receive a cancer diagnosis at some point in our lives. These statistics are astounding! Yet, regardless of whether we discover we have cancer or not, we will all meet our end at some point. The question is: ***will we all have access to a full menu of options for care at end of life so each of us will be able to choose the most appropriate option for our particular end of life circumstances?***

Today's trends in medicine prioritize patient-centered care where patients and their doctors work together in responsive, informed relationship to make decisions about

treatment and care— ultimately, it's all about a patient's right to choose. Here's the definition of patient-centered care from the Institute of Medicine: "Providing care that is respectful of, and responsive to, individual patient preferences, needs, values, and ensuring that patient values guide all clinical decisions." In my cancer experience to date, this standard of care was sorely lacking. I'd like to ensure at the end of my life I have the choice for medical aid in dying rather than submitting myself to prolonged, aggressive medical treatment that extends my life unnaturally.

Hawaii has long been a national leader in policy related to health and compassionate care. Six states and Washington DC have passed similar measures over the past 20 years. I strongly urge your **support of HB 201** and related Senate bills as they make their way through the legislative process this session.

Thank you very much for your time and good energies to support these measures— Aloha plenty.

Lynn B. Wilson, PhD
Waikele, HI 96797

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 3:57 PM
To: HLTtestimony
Cc: mzotentik@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
MARY JANE JACINTO	Individual	Oppose	No

Comments: Exodus 20:13 "You shall not murder."

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March 20, 2017

Chair Representative Della Au Belatti
Vice Chair Representative Bertrand Kobayashi
Committee on Health

TESTIMONY IN SUPPORT OF S.B. 1129, SD2 WITH SUGGESTED CHANGES

I write to offer my support with suggested changes for S.B. 1129 respectfully requesting this Committee to **replace the phrase "terminal disease" with "grievous and irremediable medical condition".**

While the proposed legislation is a step forward and will assist some individuals, it's reach does not extend far enough. For example, many individuals who suffer from debilitating neurological disorders such Alzheimer's Disease, Huntington's Disease, and Parkinson's Disease will be unable to benefit from the proposed compassionate protections.

For 7 years, I provided care for my mother following her diagnosis of Alzheimer's Disease. When Mom's condition transitioned to an advanced stage, she moved to a long-term care nursing facility. For the next 3 years, I helplessly witnessed her gradual decline to a vegetative state and ultimate death. My maternal Grandmother and Aunt both suffered from the same slow, cruel disease for which there is no cure.

Many of us who witness the long-term suffering imposed by degenerative neurological diseases do not wish to endure similar suffering and fear the loss of cognition and the total dependency wrought by these diseases.

The language I propose is excerpted from Canada's newly passed legislation which defines **grievous irremediable medical condition** as follows**:**

> **"Grievous irremediable medical condition" means a serious and incurable illness, disease or disability which cannot be reversed and which causes enduring physical or psychological suffering that is intolerable to the individual and cannot be relieved under conditions that the individual considers acceptable.**

In the absence of the proposed change, many individuals riding the Gray Tsunami will take their own lives, often under horrendous circumstances. They will also be compelled to forego the comfort of family during their last moments, knowing their loved ones could be prosecuted under Hawaii's manslaughter laws.

By extending the reach of the current legislative proposal, this Legislature has an opportunity to express compassion by offering medical aid in dying to residents facing grievous and irremediable suffering.

Thank you for your consideration,

Patricia McManaman

THE House of Representatives
THE TWENTY-NINTH LEGISLATURE
REGULAR SESSION OF 2017

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair
Committee members: Reps. Har, Morikawa, Oshiro, Todd and Tupola

Notice of Hearing
Thursday, March 23rd.
8:30am Rm 329

March 20, 2017

To: Chair Belatti, Vice-Chair Kobayashi and committee members

Re: SB1129 SD2 Relating to Health

Please note that I stand in Strong Opposition to this bill "Health; Medical Aid in Dying aka doctor assisted suicide."

If I may clarify so we are all on the same page, Suicide is not against the law, and this is not what we are looking at with regards to this bill. This bill is focused on making doctor assisted suicide legal and socially acceptable.

This bill is based on the faulty Oregon program. In 20 years since being implemented, they claim no cases of abuse have been reported. This claim in itself should raise an eyebrow or two!

However perhaps we should take a look at their record keeping and reporting methods which tend to be questionable.

According to **"Patient Rights Action"** (like our bill) there are no records allowed to be reviewed. Records that are used in the annual reports in Oregon are destroyed after only one year, making them unavailable if there are questions about the administration of the lethal drugs or an investigation is warranted. https://patientsrightsaction.org/

In Oregon, even law enforcement is denied access to information about cases under Oregon's law.
http://www.hawaiiagainstassistedsuicide.org/2017/01/the-oregon-experience-is-bs_74.html#more

I have questioned this section many times …

§ -4 Attending provider responsibilities.

b) Notwithstanding any other provision of law, an attending provider may sign the qualified patient's death certificate. The death certificate shall list the terminal disease as the immediate cause of death.

Why is the death certificate to be altered, so that it does not state/reflect the true cause of death, "an overdose of legally prescribed lethal drugs?" what are we trying to hide? How accurate will our annual reports be with faulty information?

I see the following has been added (but not identified as such, new/added) under:

§ -15 Disposal of unused medication

> A person who has custody or control of any unused medication dispensed under this chapter after the death of a qualified patient shall personally deliver the unused medication for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means.

By who and how is this to be monitored? And what is meant by lawful means? Claims are that that 30 – 40% of the drugs prescribed are not taken. What department will oversee this and does it work into the existing budget?

I also ask why isn't more being done to consider the ever growing list of alternative option like Cannabis and THC among other new discoveries?

Dr. Michael Plumer on Kauai has done tremendous research on this.

Medical Uses of Cannabis and THC

Pain:

Large clinical studies have proven analgesic properties of cannabis products. Among possible indications are neuropathic pain due to multiple sclerosis, damage of the brachial plexus and HIV infection, pain in rheumatoid arthritis, cancer pain, headache, menstrual pain, chronic bowel inflammation and neuralgias. Combination with opioids is possible.
http://www.cannabis-med.org/english/patients-use.htm

Like Pandora's Box I fear what opening this box will lead to. Shall we then target those with Dementia? Disabilities? the Chronically Depressed? Look at what is happening in the Netherlands!

No, we must stop this bill now, so I strongly encourage you to vote against this bill and others like it.

Respectfully submitted

Rita Kama-Kimura
Mililani, Hawaii
Member of
The Hawaii Federation of Republican Woman

Capt. T. J. Davies, Jr. (Ret.)
909 Kapiolani Blvd # 601
Honolulu, HI 96814-2132
tjdavies@juno.com
808-593-1026

20 March 2017

To: Committee on Health, Rep. Della Au Belatti, Rep. Bertrand Kobayashi, Vice Chair

Date: Thursday, March 23, 2017, 8:30 a.m., Room 329

Re: HB 1129 SD2, RELATING TO HEALTH., Medical Aid in Dying.

Chair Belatti, Vice Chair Kobayashi, and members of the committees:

My name is T. J. Davies Jr. I am 82 years old, retired, handicapped and live in Kakaako. I am writing in STRONG OPPOSITION of HB 1129 SD2, Relating To Health., Medical Aid in Dying.

This is a complex issue. Hospice Care should be available, and people who are suffering from a painful illness should be made as comfortable as they can by whatever means necessary. Any medication for comfort, even if it hastens death, is reasonable. Having a physician prescribe a drug specifically for the purpose of death violates the Hippocratic Oath and is wrong.

Legalizing physician-assisted death pressures patients into considering it even if they do not want to. The bill doesn't properly safeguard against potential abuse. The first issue is the diagnosis itself; about 15 percent of patients are misdiagnosed every year. The bill would allow for disabled people to be taken advantage of. Aid-in-dying laws only work in a perfect world where nobody is corrupt and doctors always make the right decision.

Instead of legalizing physician assisted suicide we should focus on quality of life for those confronted with a terminal illness. Hospice Care not only provides physical relief, but psycho-social and spiritual support for patients. It aims to help patients with issues of loneliness and being a burden to loved ones.

Your OPPOSITION to this legislation is respectfully requested. Mahalo & Aloha

T. J. Davies Jr., Volunteer
Treasurer, AARP Chapter 60 Honolulu
Treasurer, Kokua Council for Senior Citizens of Hawaii Education Fund
Director, Hawaii Alliance for Retired Americans
Director, AOAO of 909 Kapiolani
Kakaako (District 26 / Senate District 12)

Dear Chair Belatti, Vice Chair Kobayashi, members of the House Committee on Health,

My name is Jun Shin, and I am writing this testimony in support of SB1129, related to Health; Medical Aid in Dying. This is because I feel that an individual is in charge of his or her own body, although we should give them the best educated advice possible so that they know all the options available for them while making their decisions. If they are suffering and feeling pain in their last moments on this earth, then we should help them make their final journey in peace, for the sake of the loved ones who will be watching their friend,family member, etc, and the patient who is in pain. We don't want the last moments to be one full of pain and suffering, but one where they remember the life and times of the individual.

We want this to be a time to say goodbye, and isn't it better to remember the peaceful demeanor of your loved one then one of suffering? This is not suicide, these individuals have reached the end of their journey, this is helping them leave from this world to the next without unnecessary pain and suffering. I ask your vote for this in the name of compassion.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 7:13 PM
To: HLTtestimony
Cc: tardend@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Thomas A. Dickey	Individual	Support	No

Comments: I support passage of SB 1129.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 12:52 AM
To: HLTtestimony
Cc: birthpang@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Bobbie Pang	Individual	Oppose	No

Comments: This bill does not have enough safeguards. Terminally ill patients should have a psychiatric consultation to determine depression. A depressed patient might make the wrong choice to end their life. Also doctor's only guess how long Patient's have to live.

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44-391 Nilu Street #4
Kaneohe, HI 96744

March 20, 2017

Aloha,

I am writing in support of SB 1129 because I believe that the people of Hawai‘ i should have the option, together with their ‘ohana and their doctors, to make the end-of-life decisions that are right for them in the final stages of a terminal illness.

The bill would make the option to request a prescription from their doctor to end their dying process painlessly and peacefully possible.

So many people in our ‘ohana have been touched by cancer and recovered…and so many others have passed away from their cancers. I have talked with family members of loved ones who were wasting away with a terminal illness, and hung on until their bodies shut down in painful ways and they could finally let go of this life.

I would like to know the option is available and legal.

Please pass the law so that reasonable adults with a terminal illness can have a choice of dignity as their bodies shut down. The simple fact of knowing the option is available can ease anxiety, whether or not they take action.

SB 1129 would give those who are dying this important option. Thank you very much for your consideration.

Mahalo,

Carolann Biederman

Betts Cruz

Kaunakakai, HI 96748

betts@aloha.net

Senate Bill 1129

This is the face of "Death with Dignity", this is a photo of my sister Nancy, my vibrant, healthy sister Nancy, taken just prior to her finding out she had the beginning onset of ALS (Lou Gehrig's disease). She was living in California at the time and wanted to come to Hawaii, however she chose to move back to Vermont where her children had been born and primarily so that our retired sister Marnie could care for her.

After medical confirmation of ALS, Nancy knew she wanted and needed to return to Oregon, where her children lived. In 2008 she returned so that she could take advantage of the state's Right To Die law. Once there we rallied around her and rented a home near her son. Our whole family and circle of friends, along with Compassion & Choices, Hospice and the ALS society made her final months on this earth a learning lesson for all involved.

Oregon's law is thorough and complete. My sister was able to have control over the most important thing at the end of life: to say when, where and with whom she chose to leave this earth and enter Heaven above. If you or a loved one end up having medical issues that are incurable AND your

doctors agree that you have a terminal illness with less than 6 months to live, why not as an individual have the choice to select how and when we die?

After months of supportive planning and following the appropriate procedures in Oregon, we as a family were able to be with Nancy as she prepared for a peaceful death. She chose the backyard on a Sunday in April, with the sun shining and her children and family around her. She swallowed the contents of the prescribed medication and went into a sleep-like coma. Her wish was for us to dance and blow bubbles, sending her off with love. This happened from many points across the US once we knew she had crossed over.

Nancy's family and friends embraced her decision, supporting her because of the love and respect we all had for her. Nancy had led a life full of love and giving and we wondered why she was taken from us at such an early age. Her life and our story helped change the law in Vermont and we hope to get it accomplished here in Hawaii.

This is such an important right for each one of us and Oregon has set the standard for its thorough process. For some folks just knowing the law is in place is enough, others it might be having the written prescription. For some filling the prescription and having it on hand is sufficient. Others who, like my sister, know they do not want to be on a ventilator or a feeding tube are able to CHOOSE and have the right and freedom to die at home, on their own terms. For my sister this was vitally important. For our family it continues to be an extremely important right of choice for us, our children and our children's children. This is such an important issue. Please pass the bill. Mahalo for your time and energy moving this legislation forward.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 9:55 PM
To: HLTtestimony
Cc: cissyswanson@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Cecilia Swanson	Individual	Support	No

Comments:

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March 20, 2017

To: Representative Della Belatti (Chair), Representative Bertrand Kobayashi (Vice Chair) and the Members of the House Health Committee

From: Cheryl Toyofuku, Pearl City, HI, hjhcnt@gmail.com

Re: Opposition to SB 1129, SD2: Relating to Health, Medical Aid in Dying

Hearing: Thursday, March 23, 2017 at 8:30 a.m., State Capitol, Room 329

My name is Cheryl Toyofuku and I am a daughter, mother, grandmother, registered nurse, former Oncology Certified Nurse, health & life advocate. I am in opposition to SB 1129, which is a legislative, governmental effort to make suicide a legal, medical and healthcare treatment option. Endorsing and legalizing doctor assisted suicide is not patient medical care and is a serious, public health policy concern.

Many years ago, while on the oncology team at a major Honolulu medical center, my role as an oncology nurse was to provide skillful and compassionate patient care, while promoting and assisting in the recovery and healing process. This often included care for the terminally or chronically ill. Our inter-disciplinary team of physicians, nurses, social workers, dieticians, chaplains, physical/occupational therapists and family members collaborated together to support patients physically, emotionally and spiritually in their last days. The goal for patient care and dignity was accomplished through adequate pain & symptom control, palliative care, excellent end-of-life support, diligent identification and treatment of depression, isolation or other socio-emotional issues. Some terminally ill patients recovered, got well and lived productively for many more years.

In some situations, a request to limit life-prolonging treatment was honored, but there was never the suggestion to intentionally cause death. The thought of assisting in a suicide process would have destroyed the trust relationships that were developed between the patient, family, doctor and health team. Assisting in suicide to end the life of a patient would not be considered as a solution to a physical, mental-emotional, social or spiritual challenge that may surface in their health care. Instead, compassionate and palliative alternatives were provided through hospice and other health disciplines to address the multitude of needs for the patient and family.

Dignity is not found in taking away hope and life. It is not found in a handful of lethal pills. This bill is clearly about giving the doctors the dangerous right to assist in the process of suicide. This “right” threatens to destroy the delicate trust relationship between the doctor and patient, along with others on the health care team. It is a reason why major medical, nursing and other health professional associations adamantly oppose it. This coalition caring for Hawaii’s elderly, disabled and dying citizens are against assisted suicide and include the American Medical Association, American Nurses Association, American Psychiatric Association, Disabled Rights Education & Defense Fund and The Not Dead Yet Disability Rights Organization.

Doctor assisted suicide will compound the discrimination experienced by vulnerable people with disabilities, the chronically or terminally ill, or those who are socially marginalized. Although suicide requests are “made voluntarily”, subtle pressure and coercion may play a part to cause the elderly or disabled to feel guilty about healthcare costs or “being a burden”. This suicide or “end of life” option may create a “duty to die” as a cheaper substitute to expensive life saving treatment and/or escalating health-care costs. In Oregon and California, patients were denied payment for treatment by government entities and insurance companies, but they were offered coverage of lethal drugs.

Please do NOT pass SB 1129 out of your Committee. Hawaii deserves better than the mixed messages that suicide is okay.

kobayashi2 - Jessi

From: Christine Weger <cweger@diehlandweger.com>
Sent: Tuesday, March 21, 2017 2:26 AM
To: HLTtestimony
Subject: Medical aid in dying

Please support the bill that will allow medical aid in dying. After seeing my mother-in - law struggle for months, unable to end her pain and fear, before she succumbed to a terminal illness, I know this an option I want for myself. Whether to administer medication that hastens death should be the inalienable right of the patient and NOT the doctor.

Christine Weger
Diehl & Weger Attorneys at Law ALC
6700 Kalanianaole Hwy Suite 208
Honolulu, HI 96825
808-396-4080

Sent from my iPhone

TESTIMONY IN SUPPORT OF SB 1129, Hawaii's Medical Aid in Dying Bill

Tuesday, March 21, 2017

David Atkin
2169 Ahaku Place
Honolulu, HI 96821
oahutran@yahoo.com

I support SB 1129, and encourage you to move it forward for a full vote. Hawai'i residents took a national lead by formally advocating for a medical aid in dying option beginning in the mid-nineties. Since then the law has been successfully implemented in California, Vermont, Montana, Washington State and Oregon, and it is in the process of being implemented in Colorado. In over 30 years of national experience implementing the legislation, there has not been a single incidence of abuse or coercion.

We do not need government intrusion to criminalize a basic right, the right to choose to avoid senseless and needless suffering when certain protections are satisfied. The appropriate position is freedom to allow a deeply personal matter, death with dignity, to be a matter between a patient, their family, and their doctor, without government interference. Those with other views have the same freedom of choice for themselves, but cannot inflict their views on others when it is of no concern of theirs. The knowledge that a terminal patient need not endure suffering and hardship on themselves and their family is tremendously comforting. Please move this bill forward with a recommendation for full approval.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 6:23 AM
To: HLTtestimony
Cc: gus_gustafson@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
David Gustafson	Individual	Support	No

Comments: I support this Bill as written.

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SB1129
Submitted on: 3/20/2017
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Submitted By	Organization	Testifier Position	Present at Hearing
Divina Robillard	Individual	Support	No

Comments: Subject: SB 1129: Establishes a death with dignity act under which a terminally ill adult resident may obtain a prescription for medication to end the patient‘s life. My name is Divina Robillard. I am a private citizen and a recent widow. I am testifying in full support of this bill, citing my personal experiences as: • My husband’s primary caregiver for 31 years. My husband, Professor Britt Robillard, passed away from complications of ALS (Lou Gehrig’s disease) after 31 years of living with the disease. After many years living with ALS, my husband’s care required either institutionalization or bankruptcy resulting from use of our own funds to pay for home care nursing in our own home. Institutionalization was not an option that either of us wanted for my husband. Traditional models of long-term care as practiced by many of our skilled nursing facilities are prepared to care for the elderly whose medical conditions are very different from my husband’s. His mind remained sharp throughout his life. He was vibrantly engaged in the world and we both wanted him to continue being engaged. Our only recourse was for me to resign from my position as Instructor of Nursing at the Kapiolani Community College to take care of him fulltime. I was his voice, arms, legs; in short, I was his other body so he could carry on living the quality of life he deserved. • As a support group facilitator for many years with the MDA as independent contractor. With the help of Muscular Dystrophy Association-Hawaii, my nurse-friend and I established the longest running support group for persons with ALS (pALS) and their families to date. It was in 1998 when my husband’s illness plateaued that I was able to reach out to other families living with ALS (fALS) to help them cope with the disease in their daily lives. Because ALS is still without cure, I have known many who have passed away through complications of this illness. In the course of thorough immersion in my husband’s care, I sought other families living with the same illness, finding strength in sharing stories and helping each other through rough times. I have helped many families make decisions about whether to resort to the use of artificial ventilation or let the pALS just slip into the arms of death. Artificial ventilation extends the lives of pALS but it also exacts a tremendous cost in terms of family resources: time, money, health, and effort. Upon seeing how their daily care demands take enormous toll on their family members, some pALS change their minds and decide to be taken off the vent. When that happens, family members experience mixed feelings – that of relief and at the same time, that of sorrow for their loss, and sometimes, guilt for letting go. And, by the way, while my husband was ill with ALS, I found myself face to face with the possibility of my own death when I was diagnosed with breast cancer 18 years ago. These various experiences of approaching death that I was part of - as a friend giving advice, a shoulder for bereaved family members to cry on, as a witness at the bedside of the dying, as a fellow traveler in the journey with ALS, as a player in an up-

close-and-personal encounter – gave me plenty of opportunity to reflect on life journeys and how we grapple with the idea of death that is merely in the wings, not too far away. With ALS, death was always there, never a stranger. As I approach my twilight years, it is something I am very aware of, but I carry on with life, in spite of its hovering presence. This particular background has allowed me to accept death as truly a part of life and as such, should be taken matter-of-factly. When you take that philosophical stance, there is no reason for a person to be denied death, when in death there is no longer pain and suffering. In our journey with ALS, the deaths that I have witnessed were all marked with a sense of loss. But there was always the comfort that came with the relief of unnecessary suffering for both families and patients. How can we deny Death's comfort to anyone who needs it? What happens when it becomes our turn to benefit from that comfort? Or, someone dear to us? I urge you all to stop thinking of death as something to prevent from happening - particularly as a natural sequela - because this is an impossible goal. Think of allowing people to reach out to death as a viable, thankfully available, option to pain and suffering. Sincerely, Divina Robillard, BSN, RN, MPH

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 6:56 AM
To: HLTtestimony
Cc: egcarson@icloud.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Ellen Godbey Carson	Individual	Support	No

Comments: I strongly support this bill. I am a strong Christian and support this right as a matter of love and compassion to those facing the end.We all should have the right to alleviate pain and determine how to die with peace and dignity. Persons with other religious views should not have the right to impose their own choices on others in regards to how to die. Thank you.

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From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 7:31 PM
To: HLTtestimony
Cc: frankieboy808@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Frances Santos	Individual	Oppose	No

Comments:

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F R A N C O S A L M O I R A G H I

P.O. Box 61708...Manoa Station...Honolulu, Hawai'i...96839...USA...808.955 .3581

20 March 2017

re: Medical Aid in Dying Act (SB 1129)

Dear Members of the Senate Judiciary and Labor Committee

I am writing to urge you to pass the Medical Aid in Dying Act (SB 1129) now.

I am 75 years old and, as with many older people, have experienced the deaths of many friends and family members over the years.

Some of their deaths were good — a swift passing without lingering pain or the horror of life support systems.

And some were bad — very bad — because of their body and mind being in pain and kept alive and breathing against their will and with no hope of an immediate end.

Many of these bad deaths could possibly have been better for the dying person and their family.

It is time for all of us to have the legal option of ending the physical and emotional pain that too often keeps us alive past our natural or desired moment of death.

Please support and pass a bill that will allow each of us to make our determination — and for that decision to be implemented and resolved by our loved ones and caregivers if we are in a painful and terminal situation or unconscious.

Passing this bill is the courageous decision for the Hawai'i Legislature to make — allowing each of us to have a choice regarding the conditions and experience of the last moments of our lives.

Thank you.

Franco Salmoiraghi
Manoa Valley
808-955-3581
francohawaii@yahoo.com

kobayashi2 - Jessi

From: Ginet Hayes <kepalani@gmail.com>
Sent: Tuesday, March 21, 2017 4:50 AM
To: HLTtestimony
Subject: Supportive Testimony for SB 1129 SD 2

Good morning,

I am writing in support of this bill because people need a choice in making their end of life decisions. It's the right thing to do.

Mahalo, Ginet Hayes

Sent from my iPhone

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 11:06 PM
To: HLTtestimony
Cc: glennida@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Glenn Ida	Individual	Support	No

Comments:

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Sent: Monday, March 20, 2017 10:31 PM
To: HLTtestimony
Cc: hokulani15@hotmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Hokulani Lee	Individual	Support	No

Comments: I whole heartedly support SB1129 to help people who is currently suffering and who will suffer from a terminal illness. I believe that it is a human right to be able to leave this earth on your own terms. This will eliminate unessesary suffering for some patients and their family members. I hope that this law will be in place as soon as possible. Please pass SB1129.

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From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 7:19 PM
To: HLTtestimony
Cc: mendezj@hawaii.edu
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

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

Comments:

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kobayashi2 - Jessi

From: Jaymi Edwards <jaymic.edwards@gmail.com>
Sent: Monday, March 20, 2017 11:29 PM
To: HLTtestimony
Subject: Death with Dignity

Aloha, I am in strong support of this bill being passed. My father was diagnosed with kidney cancer at age 82. Despite entering the hospice program with the wonderful professionals involved in the program, and with full access to morphine, his pain needs were not met. He was always in complete agony, and this was very distressing to him as a patient, and to our family to be helpless in supporting his comfort.

This bill just offers terminal patients an added choice. This does not imply that each terminal individual must use this....many will opt not to. It will serve as peace of mind and a level of control when pain medications are no longer effective.

Mahalo, Jaymi Edwarda and the Claybaugh family

Sent from my iPhone

kobayashi2 - Jessi

From: Jim Anthony <drjimanthony77@gmail.com>
Sent: Tuesday, March 21, 2017 4:51 AM
To: HLTtestimony
Subject: SB 1129 SD2

I write in **STRONG SUPPORT** of this Bill.

Its passage is long overdue.

Jim Anthony, PhD.

kobayashi2 - Jessi

From: Kenneth Marcus <kennethben@mac.com>
Sent: Tuesday, March 21, 2017 7:14 AM
To: HLTtestimony
Subject: SB1129 SD2

HOUSE OF REPRESENTATIVES
THE TWENTY-NINTH LEGISLATURE
REGULAR SESSION OF 2017
COMMITTEE ON HEALTH

Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

TESTIMONY SUPPORTING SB1129 SD2
FOR

Thursday, March 23, 2017
8:30 AM
Conference Room 329
Hawaii State Capitol

Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members.

My name is Kenneth Marcus and I'm writing in support of SB1129 SD2 "Relating To Health."

This law accomplishes several important goals:
- itwould allow a person the freedom to die at a time and place of their choosing.
- Death with dignity laws improve palliative and hospice care. Over 90% of Oregonians requesting life-ending medications are in hospice, twice the US average.
- Death With Dignity allows the terminally ill to decide for themselves what's best for them and to regain control over their illness and the conditions of their death.
- The option to die a peaceful death at the time and place of their choosing provides the terminally ill with invaluable peace of mind at an extremely private time of their lives.
- The inclusion of Advance Practice Registered Nurses (APRNs) as "providers" is very important due to Hawaii's geographical makeup and the lack of physicians in the many remote and rural areas of our state.

The bill builds on the examples set by other states, and learns the lessons those states have learned from their experiences. As someone approaching an age where such a right could be important to myself, or other members of my family, it is an especially important issue to me.

Thank you for hearing and passing SB1129, SD2.

Kenneth Marcus
403 Wanaao Road, Kailua HI
T: 808-261-7309

kobayashi2 - Jessi

From: Leina Wender <waiokila@gmail.com>
Sent: Monday, March 20, 2017 10:09 PM
To: HLTtestimony
Subject: SUPPORT SB 1129 SD2 "Health; Death with Dignity"

This legislation is long, long overdue. Please do not delay in enacting this humane measure which will ease suffering.

Mahalo.

Elaine Wender

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 12:08 AM
To: HLTtestimony
Cc: lwongassocs@aol.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Lucien Wong	Individual	Support	Yes

Comments: Intractable Pain...in Hawaii under current law doctors administering palliative sedation would likely be prosecuted. The New England Journal of Medicine Case Records of the Massachusetts General Hospital Case 17-2015: A 44-Year-Old Woman with Intractable Pain Due to Metastatic Lung Cancer Mihir M. Kamdar, M.D., Kathleen P. Doyle, M.D., Lecia V. Sequist, M.D., Todd J. Rinehart, L.I.C.S.W., A.C.H.P.-S.W., Guy Maytal, M.D., Efren J. Flores, M.D., and Mari Mino-Kenudson, M.D. .....Palliative Sedation for Intractable Pain in Terminally Ill Patients Dr. Kathleen P. Doyle: Over the course of many admissions, we had discussions with the patient about her values and goals. She was deeply religious and a dedicated mother. She did not believe that God wanted her to suffer, and she had a sense that there was some greater purpose to her illness. She had hoped to die at home but recognized that it would be too difficult for her family. Her two greatest fears were that she would die in horrible pain and that her children would lose their faith because of her illness and suffering. In the preceding months, she had gently prepared her family for her eventual death. She felt desperate both for more time to care for her family and for pain relief. Palliative sedation is an intervention to relieve intractable pain in terminally ill patients by means of continuous infusion of a sedation medication.21-23 The discomfort of most dying patients can be controlled with state-of-the-art palliative care, but occasionally, there are patients whose symptoms cannot be controlled. In these rare cases, we consider palliative sedation. When this topic had been discussed previously, this patient was comforted that something could be done if the pain became unbearable. On the most recent admission, the patient’s pain was no longer responsive to ketorolac, glucocorticoids, hydrocodone, and intrathecal analgesic agents; the pain prevented her from sleeping, eating, drinking, and even lying still. Relief occurred only when she took lorazepam, which induced deep sleep. However, when the effect wore off, she awoke in agony. She requested that we initiate palliative sedation. Since she had previously expressed understanding and acceptance of this option, we did not think that this decision was made in an isolated moment of distress. The patient could articulate the potential ramifications of palliative sedation and declined artificial nutrition and hydration. Before proceeding, she asked that we meet with her family without her so their concerns could be voiced openly. Members of the palliative care team (including me, Mr. Rinehart, and Dr. Kamdar), ethics team, and nursing team met with the patient’s husband, children, siblings, parents, and pastor. We explained palliative sedation and its likely outcome and invited questions. One question was whether we could sedate her for a period and then stop. We had considered this, but we had no reasonable options to treat the pain that we expected would recur when she awoke. Once they came to the conclusion that the patient had endured immense suffering, they decided that

everything should be done to help her be comfortable. The staff subsequently met alone. The palliative care team discussed how difficult it is to treat a patient in this condition. We emphasized th at anyone who felt uncomfortable providing palliative sedation could verbalize their concerns and excuse themselves from participating in the process. Having witnessed the patient's suffering, every team member was at peace with the decision to participate. Our goal was to use the lowest possible dose of medication required for pain relief, monitor for effect, and adjust the dose only if necessary to achieve comfort. .....For the first 24 hours, the patient was sedated and did not report any pain; however, after 24 hours she awoke in severe pain. She told us that she had no pain while she was sleeping. Despite the administration of additional boluses of lorazepam and an increase in the hourly infusion rate, pain continued. A propofol infusion was begun at the lowest dose, in accordance with this hospital's palliative sedation policy, and the dose was increased in a stepwise manner during the next 36 hours in response to persistent pain. The patient was monitored closely; medications were adjusted only to treat observed evidence of discomfort and were adjusted to the lowest possible dose necessary to achieve comfort, in an effort to minimize respiratory depression. For the next 48 hours, the patient was able to rest comfortably while receiving stable doses of a combination of lorazepam and propofol. She died with no evidence of discomfort, with her family at her side, 4 days after the initiation of palliative sedation Bold added

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From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 10:15 PM
To: HLTtestimony
Cc: lynnehi@aol.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
lynne matusow	Individual	Support	No

Comments: For the LIFE of me, I do not understand what is taking so long to get a bill of this type passed and enacted into law. This is a personal decision, one which should not be influenced by anyone except the person who wishes to die. I was not a sentient human being when the decision was made that I should be born, but I am a sentient human being who should have the right to make a decision to die. I am sick and tired of hearing from the self righteous religious opponents of this legislation who think they should control me. They have no right to impose their religious beliefs or insistence on palliative care which is long and drawn out on me, just as I have no right to impose mine on them.I also object to doctors saying we should not have this choice. If they do not want to participate fine. Just as I will never use them as my doctor. But there are medical professionals who will, who get it. I support John Radcliffe in his struggle to get his bill enacted into law so he may take advantage of it, just as I support all others who too may need to avail themselves of this opportunity. Similar legislation became law in Oregon and other states. It is pending in more than 20 now. Don't control my life. Let me control my life. Let me choice to die on my own terms, if the situation warrants. Fortunately I am healthy now, fortunately I don't have to avail myself of this option now. But we don't know what the future holds. The one thing it should hold is this option be available to those who want and need it. Those who don't want or need it will still be free to die in pain, hooked up to artificial devices, given palliative care with morphine and other drugs, and maybe linger for days, weeks, months, years. I do not want to be in that category. I want the right to choose. Thank you Sen. Rhoads for introducing this legislation. Please support this bill. Lynne Matusow 60 N. Beretania, #1804 Honolulu, HI 96817 531-4260

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Marian Turney

I am writing to support the **Death with Dignity Act, Senate Bill 1129 SD 1, Hawaii's proposed medical aid in dying legislation.**

Medical aid in dying, which some people refer to as death with dignity, is a safe and trusted medical practice for which a terminally ill, mentally capable person who has a prognosis of six months or less to live, has the option to request from his/her doctor a prescription for medication which he or she can choose to self- administer through ingestion to peacefully shorten an unbearable dying process.

I watched my sister who was dying from ovarian cancer, beg for this and cried with her when the doctor was unable to help her. Please support this bill and give peace of mind and comfort to the many who need your help now in shortening a dreadful dying process and for those who will it in the future. It could be you or you're a loved one who will need this comfort in the years ahead.

If you do not support this bill, you are allowing religious groups to impose their beliefs on all of us. They may not agree with this bill but they should stand aside and allow it to pass.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 9:52 PM
To: HLTtestimony
Cc: kahakiki@outlook.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
MARILYN JOHNSON	Individual	Support	No

Comments: Please allow people who are terminally ill to make this most personal decision. I fear horribly painful catatonic last days of life much more than I fear death. We all will die - let the individual legally chose when, not the AMA and government.

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 6:25 AM
To: HLTtestimony
Cc: marilynmick@pobox.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Marilyn Mick	Individual	Support	No

Comments:

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To: HLTtestimony
Cc: Merway@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
marjorie erway	Individual	Support	No

Comments: I urge you to fully support this and get it out of committee and to the floor for a vote. It's time has come now! Mahalo for your consideration.

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Sent: Tuesday, March 21, 2017 6:43 AM
To: HLTtestimony
Cc: mikegolojuch808@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Mike Golojuch	Individual	Support	No

Comments: I strongly support SB1129. Terminally ill patients need choices. Medical aid in dying allows a terminally ill, mentally capable individual who has a prognosis of six months or less to live to request, obtain and—if his or her suffering becomes unbearable—self-administers medication that brings about a peaceful death. This bill needs to become law so terminally ill Hawaii residents will be able to access the full range of care options in making end-of-life decisions that most align with their values for a peaceful death. I have personally seen the difference between those who had a choice versus those who didn't. Those who didn't have a choice suffered pain that medication could not control and in one case the person actually asked a family member to end their life, which didn't happen. Whereas, the individual who had a choice was more at peace and knew they could use self-administered medication if needed. In the case I knew they didn't use it but could have – a choice. SB1129 is needed for individuals to have that choice. Thank you for letting me state my strong support for SB1129. Mike Golojuch, Sr.

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Sent: Monday, March 20, 2017 7:54 PM
To: HLTtestimony
Cc: mhartley03@msn.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Mike Hartley	Individual	Support	No

Comments: People should be able to make their own choices on medical aid in dying. People should not have to move to another state in order to have these choices. Please pass this bill.

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Honorable Legislators and Committee Members,

I am testifying in support of Senate Bill 1129 to authorize medical aid in dying in Hawaii because I firmly believe it is the right of an individual who is terminally ill to be in control of how and when they die.

As patients with an advanced, irreversible illness near the end of life, symptoms accumulate that are progressively more difficult to manage and that may become refractory to standard medical interventions. In other words, more medical treatment isn't always appropriate or helpful. And simply because our technology has advanced to the point that we can keep people alive, doesn't mean it is not their time to die.

In the state of Oregon, where the 1997 Death with Dignity Act legalized assisted dying, only 60% of people who get a lethal prescription actually use it. It is suggested that the knowledge that assisted dying is available may itself aid wellbeing and reassurance (of the facility to control death). Personally, I am currently witnessing the distress that not having this option creates for a friend diagnosed with advanced neck cancer and facing a disease process that will likely involve the loss of autonomy, loss of pleasure, the loss of dignity, and serious pain and suffering.

In addition to the enormous stress of her illness and the impending losses, she is also faced with the reality that to have control over her own dying process would require a move to the mainland where medical aid in dying is available. She would have to leave her home in Hawaii and all of her support, family, and friends, in order to be treated with the humanity and dignity she deserves. The State of Hawaii should not impose this burden on a dying individual. It is cruel.

Previously, I have had the honor to support two individuals, one a good friend, the other my father, in their choice to stop kidney dialysis, which would result in their death within days. They were fortunate, their disease process allotted them a relatively comfortable way to transition out of their bodies, and not be consumed by suffering in the last days

with loved ones. But some are not so fortunate. Some disease processes, such as cancer, will cause great suffering for the patient and their loved ones if they are not afforded medical aid in dying.

Medical aid in dying, at its heart, is reverence for life, for death *is* a part of life, and medical aid in dying is treating death with dignity. Individuals seeking medical aid in dying do not *want* to die, they are not suicidal. Rather, they humbly acknowledge that it is their *time* to die. They are choosing to live their dying process consciously, with awareness. For an individual to approach death in this manner indicates maturity and a deep self-awareness. We should not infantilize the dying person by taking choice away, and making decisions about their dying process for them. Their courage and wisdom should be respected and honored, not thwarted. We help people in to this world, surely we can compassionately help them out, if this is their choice.

Individuals fundamentally have the right to self-determination. We have the right to control our own lives. Dying is a part of life, and it follows that we all fundamentally have the right to manage our dying process.

Lastly, given the current political trajectory of the Federal government to rescind human rights, it is imperative that Hawaii act now to decisively enact legislation that will protect human rights by giving all citizens of our Aloha State access to medical aid in dying. We cannot afford to wait.

Respectfully submitted,

Padmani Brown
150 Hamakua Dr. #754
Kailua, Hawaii, 96734
808 754 6488
Padmani@mac.com

kobayashi2 - Jessi

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Sent: Monday, March 20, 2017 8:41 PM
To: HLTtestimony
Cc: patriciablair@msn.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Patricia Blair	Individual	Support	No

Comments: There is no moral reason to not pass this bill to assist the terminally ill's choice.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 10:01 PM
To: HLTtestimony
Cc: paul@paulklink.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Paul Klink	Individual	Support	No

Comments: HOUSE OF REPRESENTATIVES THE TWENTY-NINTH LEGISLATURE REGULAR SESSION OF 2017 COMMITTEE ON HEALTH Rep. Della Au Belatti, Chair Rep. Bertrand Kobayashi, Vice Chair TESTIMONY SUPPORTING SB1129 SD2 FOR Thursday, March 23, 2017 8:30 AM Conference Room 329 Hawaii State Capitol Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members. My name is Paul L Klink and I'm writing in support of SB1129 SD2 "Relating To Health." Thank you for hearing and passing SB1129, SD2. Paul L Klink 1710 Makiki St #906 Honolulu, HI 96822 808-721-7777

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The Honorable Representative Della Au Belatti, Chair
and Members of the House Committee on Health

RE: In SUPPORT OF SB 1129, SD2 – "RELATING TO HEALTH"
Hearing Date: March 23, 2017, 8:30 a.m., Conference Rm. 329

My name is Pauline Sato. Thank you for the opportunity to submit testimony in support of SB 1129, SD2, which stablishes a death with dignity act under which a terminally ill adult resident may obtain a prescription for medication to end the patient's life.

I recognize that this bill that evokes much consternation and I respect people's differing opinions. My opinion is that the time is now for this bill to become law. Having seen too many of my family and friends suffer from terminal illness, it is not right to force them to hang on indefinitely to ease someone else's conscience.

Some physicians oppose this, which is their choice. They also have a choice not to have to treat patients in this way. They can refuse to treat the patient and suggest that he or she go to another doctor. The doctors' and anyone else's personal feelings and beliefs should not interfere with that of someone who has made the very difficult and excruciating decision to end his or her life due to a terminal illness with less than 6 months to live.

In these dire situations, we should let people make their own decisions about how they want to live out the rest of their lives. That is the moral thing to do.

I humbly ask you to support the passage of SB 1129, SD2. Thank you for the opportunity to testify on this measure.

Aloha,

1173 Alewa Drive
Honolulu, Hawaii 96817

Randolph G. Moore
2445-A Makiki Heights Drive
Honolulu Hawaii 96822

Telephone (808) 778-8832 email rmoore@hawaii.rr.com

March 21, 2017

The Honorable Della Au Belatti, Chair
and members of the Committee on Health
House of Representatives
State Capitol
Honolulu, HI

Dear Representative Belatti and members of the Committee:

Subject: SB 1129 SD 2 (relating to health – medical aid in dying)

I encourage your support of SB 1129, for all the reasons stated in Section 1 of the bill.

Individuals currently have the perfectly legal option of accelerating their death by refusing food or fluids. SB 1129 would afford the terminally ill an alternative that is more humane.

Mahalo for your consideration.

House Committee on Health
March 23, 2017 at 8:30AM
Conference Room 329

RE: Testimony in **SUPPORT** of SB1129

Aloha nui e Chair Belatti, Vice Chair Kobayashi, and Members of the Committee on Health:

I write today in strong support of the Death with Dignity Act, SB 1129, Hawaii's proposed medical aid in dying legislation. I commend your committee on hosting this hearing - I believe it demonstrates leadership and understanding that while this issue touches on many heartfelt issues, the people of Hawai'i believe this is the right thing to do.

Our state has a proud history of diversity, tolerance and support for individual rights. The proposed medical aid in dying legislation supports the rights of terminally ill individuals in Hawai‘i to have the full range of care options and to make end-of-life decisions that most align with their values for a peaceful death. Hawai‘i residents took a national lead by formally advocating for a medical aid in dying option beginning in the mid-nineties. Since then the law has been successfully implemented in California, Vermont, Montana, Washington State and Oregon and it is in the process of being implemented in Colorado. The legislation, written by and for the people of Hawai‘i, builds upon the lessons learned in Oregon, where 19 years of safe and compassionate practice allows policymakers in other states to learn about the law's implementation and the benefits it provides for those who wish to access it as well as how to implement safeguards against feared abuses while still allowing individuals this option.

SB 1129 affirms the right of mentally capable, terminally ill adults to determine their own medical treatment options as they near the end of life. The people of Hawai‘i should have the option, together with their ‘ohana, their doctors, and their faith, to make the end-of-life decisions that are right for them in the final stages of a terminal illness -- including the option to request a prescription from their doctor to end their dying process painlessly and peacefully.

Mahalo for your leadership and please support SB 1129 and give those who are dying this important and compassionate option.

Me ke aloha pumehana,

Rebecca Justine ‘Iolani Soon

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 11:38 PM
To: HLTtestimony
Cc: rickyli99@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Ricky Li	Individual	Support	No

Comments: Because when/if my time comes, and I am of sound mind. I would like the option to decide how I end my life, and don't want my care givers to get in trouble for my choice.

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R.O. Banner, MD, MPH
Bannerhawaii@gmail.com
808-781-2023
Aina Haina, Hawaii

TO: Commerce, Consumer Protection, and Health Committee
HEARING: Wednesday, February 15, 2017, 8:30 am, Room 229
POSITION: As a Physician, I oppose SB1129
FROM: R. O. Banner, MD, MPH

I am testifying against SB1129

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

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

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

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

Thank you for your consideration of my testimony.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 3:23 AM
To: HLTtestimony
Cc: robeanderson@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
rob anderson	Individual	Support	No

Comments: DRAFT ADDRESSING HOUSE OF REPRESENTATIVES THE TWENTY-NINTH LEGISLATURE REGULAR SESSION OF 2017 COMMITTEE ON HEALTH Rep. Della Au Belatti, Chair Rep. Bertrand Kobayashi, Vice Chair TESTIMONY SUPPORTING SB1129 SD2 FOR Thursday, March 23, 2017 8:30 AM Conference Room 329 Hawaii State Capitol Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members. My name is Rob Anderson and I'm writing in support of SB1129 SD2 "Relating To Health." Thank you for hearing and passing SB1129, SD2. Rob Anderson 529 Kekupua St Honolulu, HI 96825 808 375 4634

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 1:46 AM
To: HLTtestimony
Cc: ORFALI@HAWAII.RR.COM
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Robert Orfali	Individual	Support	No

Comments: Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members. My name is Robert Orfali and I'm writing in support of SB1129 SD2 "Relating To Health." I support this bill because I watched my wife Jeri die of Ovarian Cancer on June 19th, 2009 in St Francis Hospice. I can tell your first hand that hospice and palliative care are wonderful, but sometimes death can be too complicated. How does hospice deal with a dying patient who cannot breathe because their lungs collapsed? Remember, there is no intubation in hospice; hence no ventilators. I believe SB 1129 gives dying patients one more option at the end; it's there in case all else fails. Hopefully, they will not have to use it, but it's good to have this type of insurance: it would have given my wife Jeri peace of mind during her last days on this earth. 80% of the people of Hawaii support this option. Why? Probably, they witnessed some painful death somewhere along the line. Yes, our medical system does not have all the answers when it comes to dying: death is messy and may involve a lot of unnecessary suffering. Please vote for this bill to give the people of Hawaii the same option that people in Oregon, Washington, California, Vermont, Colorado and, DC now have. The option of having some type of insurance at the end, in case all else fails. It's life, our death, and our choice. Those who don't believe in this option don't have to use it. It's totally voluntary.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 2:09 AM
To: HLTtestimony
Cc: rontthi@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Ronald Taniguchi, Pharm.D.	Individual	Support	No

Comments:

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kobayashi2 - Jessi

From: Stephanie Fitzpatrick <slfmakiki@gmail.com>
Sent: Tuesday, March 21, 2017 2:32 AM
To: HLTtestimony
Cc: Ms. Stephanie Fitzpatrick
Subject: TESTIMONY - Support - SB 1129 - Medical Aid In Dying - Hearing HI State House Health Cmte - PLEASE CONFIRM RECEIPT of EMAIL, Mahalo

Bill: SB 1129
"Medical Aid In Dying"
HI State House - Health Committee hearing
Hearing - Thurs. Mar. 23, 2017 - 8:30 am
TESTIMONY IN SUPPORT

Aloha Legislators of the House Health Committee,
Hawaii State Legislature 2017,

I am in support of this bill "Medical Aid in Dying." I would like the option to have this available to me if I were terminally ill, yet was not choosing to wait out to the end of a possibly terrible dying process. It would give me the CHOICE and I know it would be properly supervised, and I support it. I hope you do too.

Thank you very much for your support of this issue.

Aloha,
Stephanie Fitzpatrick (Individual)
State House District 24 - Makiki
slfmakiki@gmail.com

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 8:29 PM
To: HLTtestimony
Cc: tbohl8@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Ted Bohlen	Individual	Support	No

Comments: Terminally ill should be able to choose to die with dignity. The law must have proper controls to prevent abuse, which this bill does. Please pass!

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 8:45 PM
To: HLTtestimony
Cc: tia.pearson@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
tia pearson	Individual	Support	No

Comments:

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 8:00 PM
To: HLTtestimony
Cc: valriegriffith@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
valrie griffith	Individual	Support	No

Comments: I am in favor of HB1129 SD2. Pls support this bill. When my mom was dying from cancer she wanted to end her pain and suffering, but there was no relief available. This bill would have been a blessing to her and the entire family. I realize there are those who won't want to use this option and I understand that. But for those who need and want dignity in death I believe the option should be available. thank you Valrie Griffith

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 9:35 PM
To: HLTtestimony
Cc: van_eden@hotmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/20/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Van Eden	Individual	Support	No

Comments: I strongly support this death with dignity bill. I have a personal interest in this, as my sister is dying from cancer and the fear of how she will die is a burden to her. Giving her, and people like her, control over their deaths is a moral, and merciful act.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 1:45 AM
To: HLTtestimony
Cc: vivian_chang@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Vivian Chang	Individual	Support	No

Comments: I am 67. This is a measure that directly affects me. Please allow me to have the option to get medical help when I really need it.

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TO: The Honorable Chair Della Au Belatti, Vice Chair Bert Kobayashi and Members of the Health Committee

RE: SB1129

DATE/TIME: Thursday, March 23rd, 2017 8:30 a.m.

PLACE: Conference Room 329, Hawaii State Capitol

My name is Younghi Overly and a resident of Hawaii. I am writing to you to express my support for the Death with Dignity Act, S.B. 1129, Hawaii's proposed medical aid in dying legislation. Medical aid in dying is a practice in which a mentally capable, terminally ill adult with less than six months to live, may request medication from his or her doctor, if his or her suffering becomes unbearable, to take with water for example to bring about a peaceful death. Medical aid in dying is a safe and trusted medical practice currently authorized in six states, either through statute or court decision. Oregon has 19 years of experience with safe and trusted practice of medical aid in dying.

My mom was bedridden with illness for five years, last three of five years with a terminal lung cancer. She passed six years ago. Toward the end of her life, the pain has reached a point where she begged for help to die; she at times refused food and water in hope that starvation will kill her; she was depressed and often sobbed. Not only was this period difficult for my mom, it was difficult for my dad who wanted to help but couldn't; who found himself force-feeding my mom but wished he could just let her go. My dad was glad that he was able to take care of my mom daily last five years of her life but still regrets not being able to do anything for her when she just wanted to die in peace. I too regret not being able to help my mom.

I support the Death with Dignity Act, S.B. 1129 because I believe we should give a terminally ill person an option to end their pain and suffering when the time comes. This option would give peace of mind to the families which my family never had. I realize that my story is one of similar stories of thousands of citizens of Hawaii. So thank you for taking time to read this letter.

Sincerely,

Younghi Moon Overly
1600 Ala Moana Blvd Apt. 1206
Honolulu, HI 96815

kobayashi2 - Jessi

From: Beverly Bass <beverly@hawaiian-designs.com>
Sent: Tuesday, March 21, 2017 7:02 AM
To: HLTtestimony

Everyone deserves to die in the manner that they chose so I support medical aid in dying.

Thank you, b. Bass-Taylor
Sent from my iPhone

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 7:41 AM
To: HLTtestimony
Cc: aubrey@aubreyhawkpr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
AUBREY HAWK	Individual	Support	No

Comments: Hawaii needs a medical aid in dying option for our terminally ill adults now.

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House Health committee hearing on Thursday March 23rd at 8:30 AM
Regarding SB1129 SD 2 concerning assisted suicide-so called medical aid in dying
I am a physician and I oppose this measure

To the House Committee Chair Della Au Bellati,
Vice Chair Bertrand Kobayashi
Sharon Har
Andrea Tupola
Marcus Oshiro
Dee Morikawa
Chris Todd

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

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

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

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

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

John T. McDonnell, M.D., Ltd.
Allergy and Immunology
46-001 Kamehameha Hwy Suite #401 Kaneohe, HI 96744
Fax: (808) 235-8928 *Telephone: (808) 247-6070*

Representative Della Au Belatti, Chair
House Committee on Health

Re: SB1129 SD2 Hearing on Thursday 23, 2017 Room 329

Dear Chair AuBelatti and Members of the House Committee on Health,

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

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

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

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

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

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

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

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

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

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

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

For House Health Hearing on Thursday 3/23 at 8:30 AM
SB 1129 SD 2
House Chair Belatti, VC Kobayashi and members,

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

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

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

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

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

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

kobayashi2 - Jessi

From: Lisa Vinzant <vinzantlisa@gmail.com>
Sent: Tuesday, March 21, 2017 7:37 AM
To: HLTtestimony
Subject: Supportive Testimony for SB 1129 SD 2

It makes no sense that we are considered cruel if we don't put a suffering pet down, yet we and our family members are not allowed to make this critical and personal decision for ourselves. My stepmother begged my father for months to help her die before he finally respected her wishes. It was excruciatingly difficult for him, and he should not have been the one put in that position. The police wisely declined to prosecute, although they could have. They see this sort of thing all the time with elderly people, and chose compassion. I am asking the legislature to show the same compassion. I sincerely hope that this option will be available to me when my time comes, should I choose to take it.

Lorene Siaw M.D.

Hospitalist
Wailuku, Hawaii 96793

House Heath Chair Della AuBelatti, members of the, House Health Committee
FOR: Hearing on Thursday March 23, 2017
REGARDING: SB 1129 SD 2
POSITION: Opposition

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

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

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

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

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

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

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

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

Reginald G Buesa MD
811 Kolu Street Suite 103
Wailuku, Hawaii 96793
808 242-3023

March 21, 2017

To the House Health Committee hearing on 3/23/2017 at 8:30 AM
From Dr. Reginald Buesa
Regarding the SB1129 SD2 for today's hearing
I am opposed to this bill, please do not move it forward.

Honorable Chair Della AuBellatti, Vice Chair Ben Kobayashi, Antoni Taniola, Marcus Oshiro, Sharon Har and Dee Morikawa,

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

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

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

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

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

Yours truly,

Reginald G. Buesa MD

kobayashi1- Oshiro

From: Robert Marks <rmarks808@gmail.com>
Sent: Tuesday, March 21, 2017 7:37 AM
To: HLTtestimony
Subject: SB 1129, SD 2: testimony in strong support

Chair Au Belatti and members: thank you for hearing this important measure. I write in strong support. Hawaii should be in a leadership role on this important issue. The bill is carefully tailored to address all legitimate concerns of abuse. Those seeking relief under this law should not be deprived of this fundamental choice.

Thank you for considering my testimony.

Robert A. Marks
Honolulu

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 2:50 PM
To: HLTtestimony
Cc: yappygrl1@aol.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Sandra Fujita	Individual	Support	No

Comments:

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 2:46 PM
To: HLTtestimony
Cc: mpoirier808@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Marion Poirier	Individual	Support	No

Comments: Aloha Committee Chair and Members, Marion Poirier, M.A.,R.N. requests passage of this measure which I strongly support. It is a needed option. If people don't want, then they simply opt out. This bill creates an option that is filled with compassion, and has been successful In states who participate in this assisted dying plan. My thirty plus years of Hawaii nursing and healthcare administrator experiences give me give me evidence that this option is valuable to our healthcare delivery system. Thank you for listening.

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March 21, 2017

Regarding Testimony in Support of SB 1129 Medical Aid in Dying

To Whom It May Concern,

I support the passing of SB 1129., Medical Aid in Dying for various reasons.

First, having worked in the medical field for over 30 years. I have seen much suffering, some of which could be considered cruel to have anyone experience. We have more compassion for animals (with euthanasia) than we do for our fellow human beings.

Being able to choose when to end our lives, will ease prolonged and unnecessary suffering for the patient **and** their loved ones. Only *that person* can and should be able to decide when that time is right because only they know.

Second, it would allow the person to be surrounded by loved ones (if so chosen) when they leave this earth, instead of by themselves afraid, suffering and alone. As a survivor of one that passed away when I was not there. I bear that pain in my heart every time I think of them, and it has been years ago. I wish I could have been there to comfort them with word and touch. I would be able to ease their transition and to say a final goodbye. It is the most humane act for everyone involved.

I dream that one day, there is a place that a person can go, when they decide to leave this earth. To be received with loving hands and placed in a comfortable bed or chair, with clean fresh linens. To be surrounded by beautiful sights, smells and sounds. And to fall asleep with no more pain. How humane is that?

Sincerely,
Pat Sasaki

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

SB1129 SD2 Relating to Health being heard Thursday March 23, 2017 at 8:30AM.

I am writing in strong support of this bill that will enable medical aid in dying. I believe that living with a terminal illness should be the choice of the person that is experiencing the illness. The ability to self-determine in the most imminent of situations is extremely important. I could only imagine the fear and anxiety that one must experience when in the situation of terminal illness. The simple ability to decide if one chooses, that they have had enough suffering is an amazing gift. I ask that you please pass this bill and give terminally ill people the power to self-determine in their situation.
Thank you for taking the time to consider my testimony.

Sincerely,
Jaime DeGuzman
jaimebd@hawaii.edu

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 2:05 PM
To: HLTtestimony
Cc: octopus@maui.net
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Rene Umberger	Individual	Support	No

Comments:

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Dear Rep. Della Au Belatti, Chair and Rep. Bertrand Kobayashi, Vice Chair and all other members of the Committee on Health:

I am a medical oncologist in Honolulu and am writing to urge you to support Hawaii's Medical Aid in Dying bill - SB 1129 - which just passed the Senate. In over 40 years of taking care of cancer patients I have seen too many patients forced to experience unbearable and unnecessary suffering at their end of life. While Hospice and Palliative Care are excellent options for many dying patients, they do not meet the needs of all. Over the years many patients have asked me personally to help them end their suffering and I was powerless to answer their entreaties. I have come to believe that it is a physician's duty to support their patient's wishes throughout their lives but especially when they are approaching their end of life. Over 80% of Hawaii voters support aid in dying as do the majority of physicians. Governor Cayatano's Blue Ribbon Health Panel recommended passing medical aid in dying almost 20 years ago. I strongly believe now is the time to give Hawaii's people this choice. Please support SB 1129 and give the people of Hawaii an option that they have been seeking for many, many years.

Thank you for the opportunity to testify in support of this most important legislation.

Mahalo nui Loa

Charles F Miller, MD, FACP
762 Kaulana Place
Honolulu, HI 96821

millerc003@gmail.com
808-561-6014

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 1:58 PM
To: HLTtestimony
Cc: kimcoco@kimcoco.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Kim Coco Iwamoto	Individual	Support	No

Comments: My family lives in the Nuuanu Ahapuaa and, like a majority of this state's residents, we are in strong support of SB1129. Patients who are suffering should be offered a full range of medical options related to their care. The narrow religious beliefs of a few strangers should not limit decision made by a patient after consultation with their physician. I would ask that your committee consider removing the following requirement: "If the patient is an inpatient at a long-term care facility, one of the witnesses shall be an individual designated by the facility." If that particular facility has religious objections to this particular treatment, they should not be allowed to stand in the way of this treatment option. It seems cruel to force the patient, their family, friends, to move the patient out of the facility before that person could get the medical treatment they are requesting. Ultimately I believe that all individuals should have the right to pass with dignity; I support SB1129 with the above mentioned amendment.

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 1:54 PM
To: HLTtestimony
Cc: jrubio0147@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Janice Plumer	Individual	Oppose	No

Comments: Strongly oppose this Bill. We do not need this type of Bill in Hawaii.

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 1:52 PM
To: HLTtestimony
Cc: ahdenny@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Andrew Denny	Individual	Support	No

Comments: Please support Death with Dignity. How can we tell other people what to do with their health? Thank you for hearing my testimony and voting for this common sense bill.

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 1:45 PM
To: HLTtestimony
Cc: dkk@hawaiiantel.net
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Deborah Kimball	Individual	Support	No

Comments: Aloha, I am Deborah Kimball, a “retired” (means unpaid) educator. I strongly support SB1129 SD2, offering under certain conditions a voluntary choice in dying. I will die, and I will be delighted and grateful if this year this committee increases my chance of a “peaceful and humane" death. My father, a dedicated educator, died a slow death he would never have chosen. My previously energetic mother died after ten years of existing in several nursing homes with a feeding tube she had not wanted—even pulled out the first one, only to have another forced on her. Of course we certainly want and deserve control over our life-and-death decisions toward the end! Seeking some serenity about dying, in my mid-seventies I convened a Death & Dying group. We read extensively, ending with the best-selling Being Mortal—Medicine and What Matters in the End by a neurosurgeon who questioned whether another surgery would be the choice of his patient with very little time left. His research transformed his thinking, and mine has been transformed too. On “God’s will,” without brand new penicillin I would have died at age seven and also at age nine, and probably a few decades ago from high cholesterol. So many people in Hawai’i nei—and millions of others—would be dead today without modern medicine. As medicine ends suffering throughout our lives, why not at the end? Death doesn’t frighten us, I think, nearly as much as how we do our dying. Some people with terminal illness are so weary from medical procedures trying to bar their approaching deaths. Others abhor their dependency. If we want a peaceful death, and a choice in when and how to depart our bodies, the State should-- providing excellent safeguards, surely accede to this. This most personal, final life process Is a difficult topic, and I commend you all for taking it up with reason and care. Please move SB1129 forward. Mahalo.

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 1:41 PM
To: HLTtestimony
Cc: abromley@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Allyn Bromley	Individual	Support	No

Comments: Comments: Honorable Chair and Committee Members: I am an eighty-eight year old citizen, with the hope of having the option to minimize pain and suffering at the end of my life if needed. I strongly support SB1129 and respectfully ask for your help in passing this bill. Sincerely, Allyn Bromley

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 1:32 PM
To: HLTtestimony
Cc: boydready@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Boyd Ready	Individual	Oppose	No

Comments: Dear Legislators: I urge you to vote no on proffering poison to the sick. Just as we have a right to life, we have a right to die, and to exercise our rights we have the natural powers of self-defense, and of suicide. Do not presume that if authorities do not take over these matters free individuals will be helpless. They are not. If we linger in pain and indecision and ask a doctor to 'help' us die, and he has the legal authority to do so, as you are about to give, great wrongs will be done: 1) persons who could have survived will die; 2) persons suffering from depression will die when, if treated, they could have survived; 3) the inevitable knot of interested parties, family or otherwise, nearest an elderly and ill individual of property will be enabled to encourage an earlier demise; 4) the elderly themselves, especially may be inclined to take proffered poison early as a benefit to their relatives. Medical doctors should take no part in this sort of thing except as competent advisors and healers and to allay pain. I urge you to vote no to proffering poison, and ask that you kill this bill. With respect, Boyd Ready Haleiwa

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 2:08 PM
To: HLTtestimony
Cc: mikenakas@hotmail.com
Subject: *Submitted testimony for SB404 on Mar 22, 2017 14:15PM*

SB404
Submitted on: 3/21/2017
Testimony for HLT/CPC on Mar 22, 2017 14:15PM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Michael S. Nakasone	Individual	Oppose	No

Comments:

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Sue Salisbury, RN, BSN
Kula, Maui, Hawaii 96790
Sues1111@earthlink.net

Testimony **Opposing** SB1129 that would "Establishes a death with dignity act under which a terminally ill adult resident may obtain a prescription for medication to end the patient's life."

I have been a registered nurse in Hawaii since 1981.

I am very concerned that this bill will have unavoidable, unexpected, and potentially harmful consequences for the people of Hawaii as well as for the very dedicated medical and nursing men and women in this state. It may seem you can anticipate and protect against all the possible things that can go wrong in a bill like this, but human experience is so varied, and so nuanced, harmful effects are certain to occur.

Suicide is always a tragedy with far reaching effects. When suicide is assisted by the medical profession, then it involves countless more people, and countless more negative effects. Doctors and nurses take their calling to help those who are ill or in pain seriously, and it is certain this will impact our profession, and the patients who have trusted us to do just that.

I urge you not to pass this bill. There are excellent and compassionate ways to help people at the end of their lives, but helping a person commit suicide isn't one of them.

Thank you for considering my testimony.

JOHN P. DELLERA
Attorney at Law
619 Ahakea Street
Honolulu, HI 96816
Telephone 808 739 9078

TESTIMONY IN OPPOSITION TO S.B. 1129, S.D. 2, RELATING TO HEALTH

Thursday, March 23, 2017, 8:30 a.m., Conference Room 329

Date: March 21, 2017

The Honorable Della Au Belatti, Chair
The Honorable Bertrand Kobayashi, Vice Chair
Committee on Health

Dear Chair, Vice Chair, and Members of the Committee:

I was Executive Director of the Hawaii Disability Rights Center from 2009-2011 and have served since 2009 as a member of the board of directors of the Autism Society of Hawaii. I have helped care for a young man with autism for the past 20 years. I am testifying IN OPPOSITION to this bill in my individual capacity.

Proponents argue that competent adults should be free to make their own decisions about life, death, and health. The legislature has a responsibility, however, to see that people who are vulnerable to the will of others are protected from abuse. This bill contains "safeguards" that are identical to Oregon's "Death With Dignity" law, but they provide inadequate protection for elderly and disabled individuals who are at risk of abuse.

We are told that 80% of Hawaii residents favor doctor-assisted suicide, but that is unbelievable. Oregon reports only 1,545 lethal drug prescriptions in the 19 years its law has been in effect, and Washington reports only 725 since its law was passed in 2009. The fact is, doctor-assisted suicide is extremely rare in the states that allow it. On the other hand, throughout history, elderly and disabled individuals have been victims of abuse from relatives or caregivers who stand to gain from inheritance, insurance proceeds, or simply shedding the burden of caregiving. Legalization of doctor-assisted suicide would only make matters worse.

This bill adopts the Oregon law and its safeguards for people who are able to handle their own affairs, but it falls far short of protecting those who are subject to the will of others.

- The primary safeguard is a requirement that two physicians determine that the patient is able to make and communicate health care decisions (a very low standard), and that the request for lethal drugs is voluntary. Unless the patient complains that a loved one is trying to kill them, however, doctors may be hard pressed to find that the patient's request was not voluntary.

- The bill excludes patients with "impaired judgment," but that term is vague and undefined, and it is left to the judgment of physicians and advanced practice nurses who may not be competent to diagnose mental illness and disabilities. The physician or nurse may refer the patient to a psychiatrist or psychologist for consultation, but referrals in certain areas of disability and in rural areas of the state may not be possible if professionals are not available.

- Studies have shown that Oregon makes no serious effort to keep patients with treatable depression from committing suicide, and that assisted suicide may actually reduce opportunities to pursue alternatives. Neil Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton Univ. Press 2006); Drum, "The Oregon Death With Dignity Act: Results of a literature review and naturalistic inquiry," *Disability and Health Journal 3* (2010).

- The bill requires that the patient make two oral requests for lethal drugs and one written request with two witnesses. The elderly or disabled may be reluctant, however, to oppose family members who encourage them to end their lives. Worse still, the first witness may be an heir of the patient and the second paid to rubberstamp the first. Since the document may be signed in private, detection of wrongdoing would be unlikely.

Other provisions defeat safeguards that do exist:

- The patient is not required to inform next of kin of the suicide request, which may be shrouded in secrecy.

- The lethal drug may be administered in private and without witnesses by someone who encouraged the suicide and witnessed the written request.

- The Department of Health must issue annual reports of records requesting lethal drugs, but those would not reveal coercion or undue influence or any interest witnesses have as heirs, insurance beneficiaries, or caregivers. Studies have been inadequate to show how assisted suicide affects vulnerable groups. Emanuel, "Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe," *Journal of the American Medical Association* (July 2016).

It does not appear that the "benefits" of suicide for the small number of people who would resort to it come close to outweighing the harm to which it would expose others. The Legislature should defer action on this bill until its impact on elderly and disabled citizens has been evaluated.

Alternatively, the bill should prohibit the prescription of lethal medication to individuals over 75 years of age and those with disabilities who are dependent on others for care and support. In that event, the definition of "Adult" in SECTION 2 of S.B. 1129, S.D. 2, § -1, should be amended to read as follows:

"Adult" means an individual who is eighteen years of age or older, provided, however, that the term shall not include:

(1) An individual over seventy-five years of age who is unable to live independently; or

(2) An individual who is unable to live independently because of a physical or mental impairment that substantially limits one or more major life activities.

Thank you for the opportunity to testify.

s/ John P. Dellera

HLTtestimony

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 5:06 PM
To: HLTtestimony
Cc: lwongassocs@aol.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Lucien Wong	Individual	Support	Yes

Comments: What does the Bible say about medical aid in dying (aka physician-assisted suicide)? Please read the article copied below on page 24 in last week's MidWeek entitled Ethical And Moral Issues, And The Bible by Misfit Spirit Jay Sakashita who teaches religion courses at Leeward Community College and UH Manoa. He points out there is nothing in the Bible which "explicitly condemns or prohibits taking one's own life." He goes on to describe seven clear examples of suicide in the Bible yet he points out there is nothing indicating their actions were disapproved. He writes: "Many people assume the Bible condemns suicide. Students, however, are surprised to learn that the Bible does not explicitly condemn or prohibit taking one's own life." Concluding with: "Therefore, whenever someone quotes a biblical passage either in support of or against physician -assisted suicide, the person is revealing more about what is in his/her heart rather than what is in the Bible. The Bible simply doesn't have anything to say on the matter." (Bold added) Please support SB1129 it is all about personal choice with each of us deciding when that time finally comes how we alone wish to end our lives.

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HLTtestimony

From: Newmat <newmat@aol.com>
Sent: Tuesday, March 21, 2017 4:57 PM
To: HLTtestimony
Subject: SB1129 SD2

I am writing to ask that you approve the subject act. It is just and proper that individuals make choices in the matter of their health just as in other personal matters during their lives. The communal benefits are also important. People are comforted by being able to freely decide that resources can best be used to strengthen social institutions rather than being used up in unproductive and unwanted circumstances.

Aloha,Mathew R. Sgan
Nu'uanu

HLTtestimony

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 2:55 PM
To: HLTtestimony
Cc: richkoob@kalani.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Richard Koob	Individual	Support	No

Comments: Please support SB1129 (SD2). In my own life experience of directing Hawaii's largest educational wellness retreat, and 30 years of living with HIV, plus caring for a life- partner, parents and a sibling in their illnesses and deaths, I witnessed dear love ones and others constrained and pained by not having the medical assistance they wished for at the end of their lives. Please support SB1129 (SD2)as aloha, compassionate respect for our beloved 'ohana who are making choices for a love-based exit at life's conclusion.

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TO: House Committee on Health
Representative Della Au Bellati, Chair; Representative Bertrand Kobayashi, Vice Chair;
Committee Members

DATE: Thursday, March 23, 2017
TIME: 8:30am
PLACE: Conference Room 329, Hawaii State Capitol

FROM: Marti Tom

RE: SB 1129 SD 2 Relating to Health (Aid in Dying)

I strongly oppose this bill for the following reasons:

1) It devalues human life, plain and simple. The bill teaches our children and tells our families that it is redefining the meaning of suicide and normalizing the taking of one's own life. Popo's life is no longer important because she has an arbitrary shelf life of six months remaining according to her doctor.

2) There are no such things as safeguards when it involves health care individuals and families. How does the bill protect an individual from coercion? This can come in the form of subtle hints like, "Hey Popo, you're getting old, we can't take care of you too much longer in your condition." Is any doctor or social worker going to be privy to this? Elder abuse takes many forms and this bill has just added another. Furthermore, the patient doesn't even have to be elderly; maybe poor, disabled, or just plain unwanted.

3) The bill turns our culture on its head. We take care of our loved ones and nurture them through the good times, as well as the bad. Now, the shift will be towards ending one's life rather than walking through the valleys with them. I would hate to think that a family member died alone since the bill says the patient has the option of NOT notifying anyone. Wouldn't you hate to come home and find your beloved in the throes of death and not know what is happening?

4) The bill is misleading as it refers to taking a person's life in a "humane and dignified manner". How can taking your own life with a concoction of pills be described in this way? There is no dignity in taking at least three hours to die, as it points out. Any witness is prevented from intervening and has to watch this slow agonizing death. Where is the humanity? Where is the dignity?

5) This legislation changes the role of doctors and the trust we have in them. Will we soon be turning out a new generation of medical students who are taught just the opposite of what doctors were truly meant to be? Will there be a course on "How to Choose the Best Medication to End Your Patient's Life"?

I am deeply moved by a story about a little boy who could have lost his mother to physician assisted suicide when he was only eight years old if this bill had passed 14 years ago. You see, she was diagnosed with late-stage ovarian cancer and was informed by doctors that she had only a few months to live. Her two children rallied around her when they were only five and eight years of age, massaging her feet and rubbing her hair. Today, ten years later, she has recovered and her children are now teenagers. Her son was named the 2017 Hero of Hope by the American Cancer Society (Star-Advertiser 3.19.17). HOPE gives us reason to live under any circumstance.

I strongly urge you not to pass this bill. Devaluing life and changing what it means to really have compassion is to change the meaning of life for generations to come. This is a deadly quagmire and can lead this state to slipping into depths it has not imagined. Can euthanasia be far behind? Whatever happened to “Do No Harm”?

Thank you for your consideration.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 1:07 AM
To: HLTtestimony
Cc: Alma.Grocki@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Alma Grocki	Individual	Oppose	No

Comments: I am writing in opposition to measure SB1129 SD2. Thank you for your consideration of my position. Alma Grocki 102 Puuloa St., Honolulu, 96818 808-343-1523

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kobayashi2 - Jessi

From: Bob Fontana <culliebarry@gmail.com>
Sent: Wednesday, March 22, 2017 6:43 AM
To: HLTtestimony
Subject: Medical Aid in Dying

Greetings:

I just want to show my support for this bill. Hawaii has been a leader in legislative reform for the nation, and this issue should follow suit. It is important that people be the ultimate decider in matters that involve their own existence, and they should be able to rely on the medical community to aid in their decision, not hamper it. Please vote to ensure that every Hawaiian has this right.

Cordially,
Robert L. Fontana
16 Kaui Place,
Kula, HI 96790
(808) 280-8132

March 22, 2017

RE: SB NO 1129 SD2

Aloha Chair Belatti, Vice-Chair Kobayashi, and Honorable Committee Members,

My name is Darlene Rosolowich and I'm writing in OPPOSITION TO SB 1129 SD2 "Relating to Health".

I request that you vote "NO" on SB NO 1129 SD2.

> Page 26 line 4 - 5: "REQUEST FOR MEDICATION **TO END MY LIFE** IN A HUMANE AND DIGNIFIED MANNER."
>
> Page 26 line 14 – 15: "I request that my attending provider prescribe medication that I may self-administer **to end my life** in a humane and dignified manner."

Merriam-Webster definition of "suicide": Noun 1. The act or an instance of taking one's own life voluntarily and intentionally; Transitive Verb 1. To put (oneself) to death.

The phrase bolded and underlined above, "**TO END MY LIFE**" is the definition of "suicide" even if it is done in a humane and dignified manner**.**

> Page 28 line 14 -18: "SECTION 3. Section 327E-13, Hawaii Revised Statues, is amended by amending subsection (c) to read as follows: "(c) This chapter shall not authorize mercy killing, assisted suicide, euthanasia, …"
>
> Page 28 line 19 – 20: " statutes of this State [-]; provided that this subsection shall not apply to actions taken under chapter ."
>
> Page 29 line 1 – 2: "Section 327H-2, Hawaii Revised Statutes, is amended by amending subsection (b) to read as follows:
>
> Page 30 line 8 – 19: "(E) Causing, or assisting in causing, the suicide, euthanasia, or mercy killing of any individual; provided that it is not "causing, or assisting in causing, the suicide, euthanasia, or mercy killing of any individual" to prescribe, dispense, or administer medical treatment… so long as the medical treatment is not also furnished for the purpose of causing, or the purpose of assisting in causing, death for any reason"
>
> Page 30 line 19 – 20: "…[-]; provided that this subparagraph shall not apply to actions taken under chapter ."

Hawaii Revised Statues Section 327E-13 subsection (c) states, "shall not authorize" "assisted suicide"; and Section 327H-2 subsection (b) E states "so long as the medical treatment is not also furnished for the purpose of assisting in causing, death for any reason of any individual". These subsections goes against the essence of this bill.

Lines 19 – 20, "shall not apply to actions taken under chapter", are being added to the bill to avoid the consequences of said Hawaii Revised Statues.

Please consider all that's stated above when making your decision. Mahalo for your time and consideration.

Darlene Rosolowich
511 Hahaione Street #8D
Honolulu, HI 96825
808-754-2543

Testimony from:

Dr. Ethan CT Pien MD LLC

1010 S. King St. Ste 111

Honolulu, HI 96814

drethanpien@gmail.com

808-597-8765

- To: Hawaii House of Representatives, Committee on Health
- Re: hearing on Thursday, March 23, 2017 at 8:30 a.m.
- Re: Measure number: SB 1129 SD2

Dear Committee on Health,

I strongly oppose this measure for the following reasons:

1. When physician-assisted suicide was legalized in Oregon, the biggest reason it passed was due to the lack of organized opposition by Oregon physicians. After the law passed, it was clear the large majority of physicians opposed the bill, but they never went to the Legislature to voice their opposition.
2. A tremendous amount of misinformation is being broadcast about this bill. Some examples:

a. Advocates for this law claim the majority of Hawaii's citizens are in favor. There is no objective evidence of this. A mainland group called Compassion & Choices, formerly the Hemlock Society, committed more than $500,000 to help pass the law this year. This is all money coming from a mainland organization whose reason for being is to promote legalizing assisted suicide and euthanasia.

b. Testimony at the two Senate hearings held so far have shown the testimony being two to one and four to one opposed to the bill. In spite of these numbers, it is noteworthy that a committee report falsely claimed testimony advocating the bill was greater than that opposed. If this were truly a popular bill, it seems more likely that the actual testimony in favor would far exceed testimony opposed. If it were truly popular, the Senate committees would not have to falsify their reports.

c.Proponents claim the bill has safeguards. This is false on its face. There is no mechanism for accountability in the bill. There is no transparency in record keeping. There is no requirement for a patient to be evaluated for possible depression or coercion. Once the lethal medications are issued, there is no system for making sure they are either used or returned. A simple test for a safeguard: if a provision in the law is not followed, what is the consequence? There are no consequences for failure to comply with the already limited provisions in the bill; therefore, there are no safeguards.

d. Advocates claim there have been no problems with the Oregon law. This is false. Oregon doctors have testified at the Hawaii Legislature in prior years about failures and corruption in the Oregon law. But since there are no safeguards, no consequences to non-compliance, no tracking of medications, no open records, no independent audit and records are not kept but destroyed, there is no way to present uniform accepted data for peer review in Oregon. But there are abundant anecdotal records of abuses of patients as a result of the legalization of physician-assisted suicide in Oregon. These failures and abuses fall disproportionately on the poor, the elderly and those of limited competence and capability—exactly the people who should be protected.

3. This law also threatens the doctor-patient relationship and the concept of what medical treatment is.

a. As one physician aptly put it, this proposed law protects those involved in procuring and providing the suicide drugs, not the patient. The standard of care is the lowest possible, "good faith," rather than the highest.

b. The physician prescribing the suicide drugs need not be the patient's physician – or even a physician the patient has met prior to getting a lethal prescription. Though the closed records in Oregon do not allow a true data review, research by doctors and journalists in Oregon anecdotally estimated that in the first 10 years of the Oregon law, about 75% of lethal prescriptions were written by four doctors affiliated with Compassion & Choices.

c. There is nothing in the bill to prevent doctor shopping, coercion of elderly or vulnerable patients, or impulsive procurement of suicide drugs by a depressed patient who has just received a terminal diagnosis.

d. The proposed law relies on terms and standards which do not exist in the actual practice of medicine: "medical aid in dying", "terminal illness," and the standard for qualifying for getting the lethal prescription, "six months to live." Compassion & Choices' prominent lobbyist for this bill is a cancer patient who was given six months to live - two years ago.

4. This bill requires that the death certificate be falsified. Ingestion of deadly drugs will not appear on the death certificate; instead, the "underlying condition" will be entered as the cause of death, even though there is no verification of a disease state required. So, in addition to corrupting medical practice and the doctor-patient relationship, this bill will also corrupt public records.
5. A provision of the Hawaii bill, which departs from the Oregon model, is that advanced practice nurses will be able to prescribe these lethal medications.
6. Such a sweeping social change has consequences that can be difficult to predict, but there are countries that instituted physician-assisted suicide decades ago, particularly Belgium and the Netherlands. These countries now euthanize people without consent, people without disease but whose presenting complaint is being unhappy with life and newborns who attending doctors consider unfit to live. In other words, they now

practice legal eugenics. Legislation has been introduced in Oregon to expand their "six months to live" provision and eliminate "terminal illness" as a requirement. So, Oregon appears to be following in the path of the Netherlands and Belgium. And anyone who follows the practices of our courts, particularly in equal protection cases, can readily see this bill is one lawsuit away from expanding "medical aid in dying" to the next litigant with a good lawyer.

7. This bill is proposed by and supported by a limited group of well-off people who do not have to worry about being mistreated or being unable to get the medical care they wish when they wish it. Their interest is in self-determination. The long-term consequences of this proposed legislation will fall on those much less fortunate. If a major, disruptive social change like this is proposed, it should be weighed carefully. What is the effect on the medical profession and their patients? What is the effect on medical practice? On state funding for medical care for the poor? On family dynamics? On the attitudes of the elderly who might feel obligated to "get out of the way," just when they are most vulnerable?

Respectfully submitted,

Dr. Ethan Pien

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 5:35 AM
To: HLTtestimony
Cc: gerrainet@excite.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Gerraine Hignite	Individual	Oppose	No

Comments:

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kobayashi2 - Jessi

From: Glenn Sears <gsears@alumni.stanford.edu>
Sent: Wednesday, March 22, 2017 6:33 AM
To: HLTtestimony
Subject: Senate bill 1129 SD2

Senators,

I'm writing to support the death with dignity bill now being considered. For me, this bill is personal.

I've been diagnosed with pancreatic cancer. Fortunately, I am still without symptoms. But when the symptoms start I can look forward to three to six months of suffering. I have personally decided that when I can no longer wipe my ass, I'm going to take an overdose of something. What to take is a question. How much to take is a question. What are the side affects if I'm not successful?

Why can't I decide when I'm too sick to continue? Please support a bill that will allow terminally ill people to decide when it is time to die. It is the humane thing to do. It is the courageous thing to do. It is the right thing to do.

Glenn

Glenn A. Sears, P.E.
343 Hobron Lane Apt. 3503
Honolulu, HI 96815
GSears@Stanfordalumni.org
Mobile (808) 373-6140

Hawaii Men's Shed Association
SHOULDER TO SHOULDER

Our motto is "Men don't talk face to face, they talk shoulder to shoulder." It is often this simple insight that resonates with people new to the concept of the Men's Shed.

kobayashi2 - Jessi

From: globor@aol.com
Sent: Wednesday, March 22, 2017 5:49 AM
To: HLTtestimony
Subject: testimony supporting SB1129 SD2

HOUSE OF REPRESENTATIVES
THE TWENTY-NINTH LEGISLATURE
REGULAR SESSION OF 2017

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

TESTIMONY SUPPORTING SB1129 SD2
FOR
Thursday, March 23, 2017
8:30 AM
Conference Room 329
Hawaii State Capitol

Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members.

I am Gloria Borland a resident of Manoa and I'm writing in support of SB1129 SD2 "Relating To Health."

Both of my parents passed away in 2011 at the age of 83.
I wished they had the option to "die with dignity" as a choice.
Instead, their final days were painful and they are both buried here on Oahu.

Thank you for hearing and passing SB1129, SD2.

Gloria Borland
3037 Kahaloa Drive
Honolulu, Hawaii 96822
808-781-4472

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 4:30 AM
To: HLTtestimony
Cc: camikjmj@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Camille Adams	Individual	Oppose	No

Comments: Please kill this bill! Please do not make Hawaii into a assisted suicide destination. It will be so extremely embarrassing for our citizens -- Hawaii will no longer be able to call itself the Aloha state because our politicians will make it the murdering state. Please do not allow this to happen!!!!!! Besides saving your eternal salvation -- here are some facts to help you to destroy this evil bill: FACTS ON ASSISTED SUICIDE 1. Terminal prognoses are often wrong. Many individuals outlive their diagnoses by months and even years. Assisted suicide legislation is discouraging and leads people to give up on treatment and lose good years of their lives. 2. Assisted suicide is not popular. Assisted suicide legalization has failed significantly more times than it has succeeded. There have been more than 140 legalization attempts in the past 20 years, yet only 3 states have actually legalized it through legislative or voter action. 3. Opens the door to abuse of the elderly or infirm. Once a lethal prescription is written, an abusive caregiver or relative who stands to inherit from the patient can pick it up and give it to the patient in food or drink. Since no witness is required at the time of death, who would know if the patient consented? 4. Cheapens life. If assisted suicide is made legal, it quickly becomes just another form of treatment. It will always be the cheapest option, especially in a cost-conscious healthcare environment. Two Oregon residents, Barbara Wagner and Randy Stroup, were each denied coverage for their cancer treatments but received letters from the Oregon Health Plan stating the plan would cover their assisted suicides. 5. A threat to the most vulnerable. Those living with disabilities or who are in vulnerable healthcare circumstances have justifiable concerns should assisted suicide become an option. Financial pressure, peer pressure, and even pressure from uncaring family members can be placed on these individuals to take the suicide option. In fact, nothing in the Oregon or Washington style laws can protect from explicit or implicit family pressures to commit suicide, or personal fears of “being a burden.” There is NO requirement that a doctor evaluate family pressures the patient may be under, nor compel the doctor to encourage a patient to even notify their family. 6. Bad data puts patients at risk. Oregon’s data on assisted suicide is flawed, incomplete, and tells us very little. The state does not investigate cases of abuse, and has admitted, “We cannot determine whether physician assisted suicide is being practiced outside the framework of the Death with Dignity Act.” The state has also acknowledged destroying the underlying data after each annual report.1 7. “Safeguards” don’t work. Experience in Washington and Oregon has shown that the mental health and other safeguards are easily circumvented. Patients seeking a lethal prescription are not required to receive it from their attending physician and, thus, can “doctor-shop” to find someone who will. This is especially troubling for the families of patients diagnosed with depression. 8. Can turn treatable depression deadly. Most cases of depression

among the terminally ill can be successfully treated. Yet, lethal prescription requests from terminally ill individuals are often based on fear and depression. Primary care physicians are not generally expert in diagnosing or treating depression, and nothing in the Oregon or Washington assisted suicide laws compels doctors to refer patients for evaluation by a licensed psychologist or psychiatrist to s creen for depression or mental illness. 9. An often painful death. Barbiturates are the most common substances used for assisted suicide in Oregon and Washington, but barbiturates do not assure a peaceful death. Overdoses of barbiturates are known to cause distress and have associated issues like: extreme gasping and muscle spasms; vomiting and inhaling vomit while losing consciousness; panic and feelings of terror and assaultive behavior from the drug-induced confusion; failure of the drugs to induce unconsciousness; a number of days elapsing before death occurs; and sometimes death does not occur. 10. A slippery slope. Countries such as the Netherlands, where assisted suicide has been legal for decades, show that assisted suicide cannot be contained or limited to the terminally ill. (See Dr. Herbert Hendon commentary, click here: http://www.psychiatrictimes.com/articles/ commentary-case-against-physician-assisted-suicide-right-end-life-care) For more information visit www.HPACC.org 1. Dr. Katrina Hedberg, 9 December 2004, House of Lords, Select Committee on the Assisted Dying for the Terminally Ill Bill, Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence, (London: The Stationery Office Ltd., 2005), 262.)

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 4:46 AM
To: HLTtestimony
Cc: adamsk4@hawaii.edu
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Kari Adams	Individual	Oppose	No

Comments: Please kill this bill! Please do not make Hawaii into a assisted suicide destination. It will be so extremely embarrassing for our citizens -- Hawaii will no longer be able to call itself the Aloha state because our politicians will make it the murdering state. Please do not allow this to happen. Besides saving your eternal salvation -- here are some facts to help you to destroy this evil bill: FACTS ON ASSISTED SUICIDE 1. Terminal prognoses are often wrong. Many individuals outlive their diagnoses by months and even years. Assisted suicide legislation is discouraging and leads people to give up on treatment and lose good years of their lives. 2. Assisted suicide is not popular. Assisted suicide legalization has failed significantly more times than it has succeeded. There have been more than 140 legalization attempts in the past 20 years, yet only 3 states have actually legalized it through legislative or voter action. 3. Opens the door to abuse of the elderly or infirm. Once a lethal prescription is written, an abusive caregiver or relative who stands to inherit from the patient can pick it up and give it to the patient in food or drink. Since no witness is required at the time of death, who would know if the patient consented? 4. Cheapens life. If assisted suicide is made legal, it quickly becomes just another form of treatment. It will always be the cheapest option, especially in a cost-conscious healthcare environment. Two Oregon residents, Barbara Wagner and Randy Stroup, were each denied coverage for their cancer treatments but received letters from the Oregon Health Plan stating the plan would cover their assisted suicides. 5. A threat to the most vulnerable. Those living with disabilities or who are in vulnerable healthcare circumstances have justifiable concerns should assisted suicide become an option. Financial pressure, peer pressure, and even pressure from uncaring family members can be placed on these individuals to take the suicide option. In fact, nothing in the Oregon or Washington style laws can protect from explicit or implicit family pressures to commit suicide, or personal fears of “being a burden.” There is NO requirement that a doctor evaluate family pressures the patient may be under, nor compel the doctor to encourage a patient to even notify their family. 6. Bad data puts patients at risk. Oregon’s data on assisted suicide is flawed, incomplete, and tells us very little. The state does not investigate cases of abuse, and has admitted, “We cannot determine whether physician assisted suicide is being practiced outside the framework of the Death with Dignity Act.” The state has also acknowledged destroying the underlying data after each annual report.1 7. “Safeguards” don’t work. Experience in Washington and Oregon has shown that the mental health and other safeguards are easily circumvented. Patients seeking a lethal prescription are not required to receive it from their attending physician and, thus, can “doctor-shop” to find someone who will. This is especially troubling for the families of patients diagnosed with depression. 8. Can turn treatable depression deadly. Most cases of depression

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kobayashi2 - Jessi

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Sent: Wednesday, March 22, 2017 4:48 AM
To: HLTtestimony
Cc: kirkcjmj@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Kirk Adams	Individual	Oppose	No

Comments: Please kill this bill! Please do not make Hawaii into a assisted suicide destination. It will be so extremely embarrassing for our citizens -- Hawaii will no longer be able to call itself the Aloha state because our politicians will make it the murdering state. Please do not allow this to happen. Besides saving your eternal salvation -- here are some facts to help you to destroy this evil bill: FACTS ON ASSISTED SUICIDE 1. Terminal prognoses are often wrong. Many individuals outlive their diagnoses by months and even years. Assisted suicide legislation is discouraging and leads people to give up on treatment and lose good years of their lives. 2. Assisted suicide is not popular. Assisted suicide legalization has failed significantly more times than it has succeeded. There have been more than 140 legalization attempts in the past 20 years, yet only 3 states have actually legalized it through legislative or voter action. 3. Opens the door to abuse of the elderly or infirm. Once a lethal prescription is written, an abusive caregiver or relative who stands to inherit from the patient can pick it up and give it to the patient in food or drink. Since no witness is required at the time of death, who would know if the patient consented? 4. Cheapens life. If assisted suicide is made legal, it quickly becomes just another form of treatment. It will always be the cheapest option, especially in a cost-conscious healthcare environment. Two Oregon residents, Barbara Wagner and Randy Stroup, were each denied coverage for their cancer treatments but received letters from the Oregon Health Plan stating the plan would cover their assisted suicides. 5. A threat to the most vulnerable. Those living with disabilities or who are in vulnerable healthcare circumstances have justifiable concerns should assisted suicide become an option. Financial pressure, peer pressure, and even pressure from uncaring family members can be placed on these individuals to take the suicide option. In fact, nothing in the Oregon or Washington style laws can protect from explicit or implicit family pressures to commit suicide, or personal fears of “being a burden.” There is NO requirement that a doctor evaluate family pressures the patient may be under, nor compel the doctor to encourage a patient to even notify their family. 6. Bad data puts patients at risk. Oregon’s data on assisted suicide is flawed, incomplete, and tells us very little. The state does not investigate cases of abuse, and has admitted, “We cannot determine whether physician assisted suicide is being practiced outside the framework of the Death with Dignity Act.” The state has also acknowledged destroying the underlying data after each annual report.1 7. “Safeguards” don’t work. Experience in Washington and Oregon has shown that the mental health and other safeguards are easily circumvented. Patients seeking a lethal prescription are not required to receive it from their attending physician and, thus, can “doctor-shop” to find someone who will. This is especially troubling for the families of patients diagnosed with depression. 8. Can turn treatable depression deadly. Most cases of depression

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 4:42 AM
To: HLTtestimony
Cc: kirstyadams6@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Kirsten Adams	Individual	Oppose	No

Comments: Please kill this bill! Please do not make Hawaii into a assisted suicide destination. It will be so extremely embarrassing for our citizens -- Hawaii will no longer be able to call itself the Aloha state because our politicians will make it the murdering state. Please do not allow this to happen. Besides saving your eternal salvation -- here are some facts to help you to destroy this evil bill: FACTS ON ASSISTED SUICIDE 1. Terminal prognoses are often wrong. Many individuals outlive their diagnoses by months and even years. Assisted suicide legislation is discouraging and leads people to give up on treatment and lose good years of their lives. 2. Assisted suicide is not popular. Assisted suicide legalization has failed significantly more times than it has succeeded. There have been more than 140 legalization attempts in the past 20 years, yet only 3 states have actually legalized it through legislative or voter action. 3. Opens the door to abuse of the elderly or infirm. Once a lethal prescription is written, an abusive caregiver or relative who stands to inherit from the patient can pick it up and give it to the patient in food or drink. Since no witness is required at the time of death, who would know if the patient consented? 4. Cheapens life. If assisted suicide is made legal, it quickly becomes just another form of treatment. It will always be the cheapest option, especially in a cost-conscious healthcare environment. Two Oregon residents, Barbara Wagner and Randy Stroup, were each denied coverage for their cancer treatments but received letters from the Oregon Health Plan stating the plan would cover their assisted suicides. 5. A threat to the most vulnerable. Those living with disabilities or who are in vulnerable healthcare circumstances have justifiable concerns should assisted suicide become an option. Financial pressure, peer pressure, and even pressure from uncaring family members can be placed on these individuals to take the suicide option. In fact, nothing in the Oregon or Washington style laws can protect from explicit or implicit family pressures to commit suicide, or personal fears of “being a burden.” There is NO requirement that a doctor evaluate family pressures the patient may be under, nor compel the doctor to encourage a patient to even notify their family. 6. Bad data puts patients at risk. Oregon’s data on assisted suicide is flawed, incomplete, and tells us very little. The state does not investigate cases of abuse, and has admitted, “We cannot determine whether physician assisted suicide is being practiced outside the framework of the Death with Dignity Act.” The state has also acknowledged destroying the underlying data after each annual report.1 7. “Safeguards” don’t work. Experience in Washington and Oregon has shown that the mental health and other safeguards are easily circumvented. Patients seeking a lethal prescription are not required to receive it from their attending physician and, thus, can “doctor-shop” to find someone who will. This is especially troubling for the families of patients diagnosed with depression. 8. Can turn treatable depression deadly. Most cases of depression

among the terminally ill can be successfully treated. Yet, lethal prescription requests from terminally ill individuals are often based on fear and depression. Primary care physicians are not generally expert in diagnosing or treating depression, and nothing in the Oregon or Washington assisted suicide laws compels doctors to refer patients for evaluation by a licensed psychologist or psychiatrist to screen for depression or mental illness. 9. An often painful death. Barbiturates are the most common substances used for assisted suicide in Oregon and Washington, but barbiturates do not assure a peaceful death. Overdoses of barbiturates are known to cause distress and have associated issues like: extreme gasping and muscle spasms; vomiting and inhaling vomit while losing consciousness; panic and feelings of terror and assaultive behavior from the drug-induced confusion; failure of the drugs to induce unconsciousness; a number of days elapsing before death occurs; and sometimes death does not occur. 10. A slippery slope. Countries such as the Netherlands, where assisted suicide has been legal for decades, show that assisted suicide cannot be contained or limited to the terminally ill. (See Dr. Herbert Hendon commentary, click here: http://www.psychiatrictimes.com/articles/ commentary-case-against-physician-assisted-suicide-right-end-life-care) For more information visit www.HPACC.org 1. Dr. Katrina Hedberg, 9 December 2004, House of Lords, Select Committee on the Assisted Dying for the Terminally Ill Bill, Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence, (London: The Stationery Office Ltd., 2005), 262.)

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 1:49 AM
To: HLTtestimony
Cc: lsatojkl@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Laurie Sato	Individual	Oppose	No

Comments: Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members, My name is Laurie Sato and I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health." Thank you for your consideration. Laurie Sato 330 Anolike St 808-398-7036

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 12:37 AM
To: HLTtestimony
Cc: gary@onelove.org
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
gary rosolowich	Individual	Oppose	No

Comments: I oppose this bill because the unintended consequences are potentially catastrophic with undesired life ending results. This bill gives too much power to those who are not in a position to properly evaluate the choices or worse have an agenda which, under any other circumstance would be unlawful.

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Testimony in favor of SB 1129

Joe Herzog, DVM

808-366-8650

jherzogdvm@yahoo.com

I am a veterinarian and not a human physician. Much of my decision, made years ago, to pursue veterinary medicine over human medicine, was based on my belief that all humans should be able to determine the course of their final days in this realm. Now, as a stage IV prostate cancer patient, I believe that I have a very good idea of when my life should end; no one knows better than I do. In the end, I will seek a peaceful death, as covered by SB 1129.

As a veterinarian, I do not see myself as a killer when I help an ancient, decrepit, suffering pet via euthanasia. I see it as a service to the client and a kind thing to do for that pet. We say it is the last loving thing that a pet owner can request for their beloved pet. It is never easy. Yet, for those pets in need of relief from the inability to function, euthanasia does give the owner some comfort while giving the pet release from ongoing frustration, pain and decreased quality of life.

If this approach to the end of life is good for my beloved pets, it is good for me, too. When my quality of life diminishes so greatly that I am unable to function, I hope to have a "peaceful death" option available.

Please vote in favor of SB 1129.

kobayashi2 - Jessi

From: Lily Pu <lilypu2@cs.com>
Sent: Wednesday, March 22, 2017 4:56 AM
To: HLTtestimony
Subject: Medical aid in dying

I support Medical Aid in Dying for a Hawaii, because it is all about choice . One should have choice in all matters of living as well as dying.
Lily Pu
Kailua

Sent from my iPhone

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 1:34 AM
To: HLTtestimony
Cc: lydialing03@hotmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Lydia Ling	Individual	Oppose	No

Comments:

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Marcella Alohalani Boido, M. A.
Hawaii State Judiciary Certified Spanish Court Interpreter
Telephone: 808/946-2558 **E-mail: boido@hawaii.edu**

TO: Rep. Della Au Belatti, Chair; Rep. Bertrand Kobayashi, Vice-chair
Members, House Committee on Health

HEARING: March 23, 2017, 8:30 a.m., Rm. 329

RE: **SUPPORT, with amendments, SB 1129, SD 2**, Establishes a medical aid in dying act

Good morning. I am Marcella Alohalani Boido, the daughter of a physician, and the descendent of several generations of physicians, going back to the 1800s. I am also a person who has witnessed the death of a family member from cancer, as well as being part of a team of caregivers for a close personal friend who died of cancer. These deaths took place before living wills became common.

To describe those deaths as miserable would be an understatement. Traditionally, when people are ready to die, they stop taking food and liquids. My friend had explicitly rejected being nasally intubated for the purpose of being fed. As soon as she could not speak, and when I was not present, the hospital intubated her. When she tried to pull out the tube, they tied her hand to a bed rail. She was a person who highly valued her freedom and independence. I can never forget how they violated her wishes and deprived her of her last freedoms.

This act does two essential things. 1) It puts control of the death process where it belongs: in the hands of the person who is dying. It reassures the patient that if they want a quick and painless exit, they have one. They do not have to use it. There are multiple safeguards in this bill that protect a person from making an abrupt, impulsive, coerced or forced decision. 2) It safeguards the patient's physician(s) from legal liability.

Amendments: Not everyone can read or write. Not everyone communicates "orally." Some people use ASL, or Braille, or other means. Provisions for the functionally illiterate, and deaf or deaf-blind, should be written into this act.

Physicians have been helping their patients escape a lingering, painful death for as long as there have been physicians, and even longer, back to when priesthood encompassed medicine. This act both protects and empowers patients and their physicians in dealing with one of the most difficult life passages possible: death itself. **Please pass SB 1129, SD 2, with two amendments to include the communication methods of the functionally illiterate, and the deaf or deaf-blind.** Thank you.

SB 1129, Hawaii's Medical Aid in Dying bill - 3/22/17- Nancy Elliott – Former 3 term New Hampshire State Representative – Chair Euthanasia Prevention Coalition USA

The three groups that are the target for Assisted Suicide are the sick, the elderly and the disabled. While there are many other problems with this kind of law, I am going to focus in on these three today.

It is said this is only for the sick and dying. One of the biggest problems is people who qualify for Assisted Suicide are not necessarily dying. Think of a 21-year-old otherwise healthy insulin dependent diabetic. He qualifies if he rejects his insulin. This would be the same for many other people with serious conditions, who take prescription medications. What about all the curable cancers? They qualify. What about the 5% of incorrect medical diagnosis? With Assisted Suicide on the table these mistakes can be deadly.

I was at an oral submission on Assisted Suicide in Massachusetts a few years back when a gentleman named John Norton gave evidence, that as a young man he was diagnosed with ALS. He stated that had Assisted Suicide been legal at that time he would have used it. A few years in, the disease's progression just stopped. Now in his late 70's he stated he has had a great life with children and a grandchild. With Assisted Suicide on the table he would have lost all of that.

Steering is a big deal with all three of the groups that I mentioned. At that same Massachusetts proceeding, a doctor stated that Assisted Suicide laws were something he was in favor of. He continued with his points and ended by saying that He felt it was the responsibility for a good doctor "to guide people to make the right choice". I do not think he intended to say that, but is there any doubt that this pro suicide doctor would try to persuade his patients to follow his wishes concerning their Assisted Suicide.

These laws are abusive in their very nature. To suggest to someone that they should kill themselves is abuse. My husband was terminally ill and I went to a lot of doctor appointments with him. If medical personnel were to suggest Assisted Suicide to him, he would have been devastated. While he never would have done that, it would be like saying to him, "You are worthless and should die. That is

abuse! The proponents say that would never happen, but that did happen to an Oregon to a woman named Kathryn Judson. She had gone to a doctor's appointment with her seriously ill husband and exhaustedly sunk into a chair where she overheard the doctor pitching Assisted Suicide to her husband with the clincher, "Think of your wife." They left and never came back. The husband went on to live another five years

Next seniors are at risk and very easily fall victim to coercion as the process is very open to that. In most states, heirs can be there for the request and even speak. Anyone can pick up the lethal dose. Once in the house all oversight is gone, there is no witness required at the death. Even if they struggled who would know. If that is not enough, the death certificate is falsified to reflect a natural death. All the information is sealed and unavailable to the public. Even if someone suspected foul play, the death certificate says no crime here. Taking advantage of seniors is epidemic in the States. Look at the case of Thomas Middleton. He made Tami Sawyer his trustee and moved into her home. Within a month he was dead by Oregon's Assisted Suicide law. Two day after his death Ms. Sawyer listed his house and sold it and deposited the money into three companies she owned with her husband. We will never know how much coercion or foul play took place in this case.

Finally those with a disability are at risk. Most people that "qualify" for Assisted Suicide at that point in their life have a disability. Many with long term disabilities have been labeled terminal all their lives. Without meds, treatments, and assistance they would not survive. This is about disability. If you have a disability you are encouraged to give up, commit suicide. If, on the other hand, you are young and healthy, you are given suicide counselling. This is discrimination against people with disabilities. Why should they trust that they will not be coerced into Assisted Suicide, when they are already discouraged to seek treatments and are not treated fairly? When you think about it this is a law that is written just for them. It is a "special" carve out, for the sick, elderly and disabled.

In closing, I just want to add that Assisted Suicide has been rejected in over 100 legislative, ballot initiative and judicial attempts in the USA, including my state

New Hampshire, where the last time the bill came up three years ago, it was rejected by a bipartisan vote of 216 – 66. The more it is studied the more uncomfortable people become with it.

Nancy Elliott – Chair Euthanasia Prevention Coalition USA

603-424-4566 mmknhrep@gmail.com

70 Island Drive, Merrimack, NH 03054

kobayashi2 - Jessi

From: Nancy Valko <nancyvalko@sbcglobal.net>
Sent: Wednesday, March 22, 2017 5:41 AM
To: HLTtestimony
Subject: Valko written submission for the Committee for Health hearing on SB 1129, SD2, scheduled for 8:30 am March 23, 2017

Importance: High

March 22, 2017
Nancy Valko RN, ALNC
1740 Seven Pines Dr.
St. Louis, Mo. 63146
PH: 314-434-5208
Code: 9322256

I am a nurse, legal nursing consultant and spokesperson for the National Association of Pro-Life Nurses (www.nursesforlife.org)
As a nurse and legal consultant with 47 years of experience in the most challenging areas of medicine such as critical care, oncology, burn unit and hospice, I have seen many of the most difficult cases in medicine. I also have professional and personal experience with suicidal people, including my own 30 year old daughter Marie who died using an assisted suicide technique that she found searching the internet and after a 16 year struggle with drug addiction. I have worked with many suicidal people, including some with terminal illness. To my knowledge, my daughter was the only one lost to suicide.

I would like to make three points.

1. Physician-assisted suicide empowers doctors, not patients.

Society has long insisted that health care professionals adhere to the highest standards of ethics as a form of protection for society. The vulnerability of a sick person and the inability of society to monitor every health care decision or action are powerful motivators to enforce such standards.

However in physician-assisted suicide, unlike any other medical intervention, any licensed doctor of any experience or specialty is granted immunity from "civil or criminal liability or professional disciplinary action for participating in good faith compliance "with an assisted suicide law. The doctor or doctors involved are the ones to decide whether or not the patient is eligible, not the patient.

All the doctor is required to do is fill out a prescription and state forms. The usual standards for caring for a suicidal person including intensive management(1) are changed in Hawaii's physician-assisted suicide bill to a referral the patient for counseling if " **If, in the opinion** of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression **causing impaired judgment,** either physician shall refer the patient for counseling". (Emphasis added). Not surprisingly, only 3.8% of people using physician-assisted suicide in Oregon were referred for psychiatric evaluation in 2016(2).

This is dangerous medical discrimination in treatment standards for suicidal people.

In addition, since the doctor is not required to be present or examine the patient after death, any complications or other problems must be self-reported by the doctor to the state. In states with assisted suicide laws, even the death certificate must report the death as from natural causes rather than the lethal overdose(3). This violates the standards set by the Centers for Disease Control which require accuracy because, among other issues, "The death certificate is the source for State and national mortality and is used to determine which medical conditions receive research and development funding, to set public health goals, and to measure health status at local, State, national, and international levels(4)."
The immunity protections and the secrecy of even the minimal self-reporting standards in US assisted suicide laws eliminates the possibility of future potential lawsuits or prosecutions and keeps the myth of "no problems, no abuses" alive.

2. A Nurse's Perspective

The dangers of the legalization of physician-assisted suicide are especially acute for us nurses. Unlike doctors, we nurses cannot refuse to care for a patient in a situation like assisted suicide unless another willing nurse can be found which can be impossible. If we do refuse, that is considered abandonment and cause for discipline and even termination. And we are necessarily involved when the assisted suicide act occurs in home health, hospice or health care facility even though the prescribing doctor is not required to be there.

And these deaths are not guaranteed quick, painless or even possible in some circumstances. As a new December 21, 2016 Kaiser Health News article revealed, doctors are trying new drugs because the old drugs are becoming too expensive and taking too long to work. Unfortunately, some new alternative drugs have "turned out to be too harsh, burning patients' mouths and throats, causing some to scream in pain"(5).

Like most nurses, I have worked over the years with a variety of doctors who are at various points on the spectrum on competency and integrity.
Years ago, I was threatened with termination after I refused to increase a morphine drip "until he stops breathing" on a man who would not stop breathing after his ventilator was removed and no other nurse was available to take over the patient. The patient was presumed to have had a stroke when he did not wake up from sedation after 24 hours. I reported the situation up the chain of command at my hospital but no one supported me. I loved my profession and at that time, I was the sole support of three young children but I knew that nothing was worth betraying the trust of my patients.

I escaped termination that time but I refused to back down. Soon after, every nurse on a medical division of nurses refused to give an overdose to a patient and told the doctor that he would have to give it himself. The doctor cancelled the order.
Legalizing physician-assisted suicide can force nurses like us to leave healthcare, leaving no reliable safe haven for people who don't want to end their lives.
Does anyone really want to entrust our healthcare system just to people who are comfortable with ending lives? I don't.

3. Physician-assisted Suicide cannot be a Civil Right

Although groups like Compassion and Choices insist that assisted suicide is a civil right(6) despite the 1997 US Supreme Court unanimously finding no constitutional right to assisted suicide(7), this is a

recipe for disaster. Civil rights means equality under the law so equality in assisted suicide means that the "right" to assisted suicide logically cannot remain limited to just people with a prognosis of 6 months and able to give themselves lethal overdoses. What about the non-terminally ill person with paralysis who can't take the lethal overdose by himself or herself? What about the person with Alzheimer's who will not die in 6 months and is not capable of making the decision by himself or herself? What about the frail elderly person who doesn't want to burden his or her family either financially or personally?

It is inevitable that that assisted suicide must necessarily expand to anyone using any prescribed method for any situation deemed intolerable.

We have already seen this happen in European countries like Holland and Belgium as well as the current lethal injection assisted suicides in Canada(7)

This must not be Hawaii's future.

FOOTNOTES

1 "Evaluation and Treatment of the Suicidal Patient" . American Family Physician. Online at http://www.aafp.org/afp/2012/0315/p602.html

2 "Oregon Death with Dignity Act Date Summary" .Online at https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf

3 "Washington state "Death with Dignity Act". Online at http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathCertificateInstructions

4 CDC Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting". CDC. Online at https://www.cdc.gov/nchs/data/misc/hb_me.pdf

5 "Docs In Northwest Tweak Aid-In-Dying Drugs To Prevent Prolonged Deaths" by JoNel Aleccia. Kaiser Health News. February 21, 2017. Online at http://khn.org/news/docs-in-northwest-tweak-aid-in-dying-drugs-to-prevent-prolonged-deaths/

6 "Death with Dignity: the Last Great Civil-Rights Crusade" by RJ Brimmings.. Compassion and Choices News. December 15, 2012. Online at https://www.compassionandchoices.org/death-with-dignity-the-last-great-civil-rights-crusade/

7 "VACCO, ATTORNEY GENERAL OF NEW YORK v. QUILL". Argued: January 8, 1997 Decided: June 26, 1997. Online at http://caselaw.findlaw.com/us-supreme-court/521/793.html

8 "'Euthanasia kits' are prepared for Quebec doctors as palliative care centres rebel on right to die". The BMJ, September 7, 2015. Online at http://www.bmj.com/content/351/bmj.h4801

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 6:24 AM
To: HLTtestimony
Cc: rriikk07@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Ranette	Individual	Oppose	No

Comments: Please kill this bill! Please do not make Hawaii into a assisted suicide destination. It will be so extremely embarrassing for our citizens -- Hawaii will no longer be able to call itself the Aloha state because our politicians will make it the murdering state. Please do not allow this to happen!!!!!! Besides saving your eternal salvation -- here are some facts to help you to destroy this evil bill: FACTS ON ASSISTED SUICIDE 1. Terminal prognoses are often wrong. Many individuals outlive their diagnoses by months and even years. Assisted suicide legislation is discouraging and leads people to give up on treatment and lose good years of their lives. 2. Assisted suicide is not popular. Assisted suicide legalization has failed significantly more times than it has succeeded. There have been more than 140 legalization attempts in the past 20 years, yet only 3 states have actually legalized it through legislative or voter action. 3. Opens the door to abuse of the elderly or infirm. Once a lethal prescription is written, an abusive caregiver or relative who stands to inherit from the patient can pick it up and give it to the patient in food or drink. Since no witness is required at the time of death, who would know if the patient consented? 4. Cheapens life. If assisted suicide is made legal, it quickly becomes just another form of treatment. It will always be the cheapest option, especially in a cost-conscious healthcare environment. Two Oregon residents, Barbara Wagner and Randy Stroup, were each denied coverage for their cancer treatments but received letters from the Oregon Health Plan stating the plan would cover their assisted suicides. 5. A threat to the most vulnerable. Those living with disabilities or who are in vulnerable healthcare circumstances have justifiable concerns should assisted suicide become an option. Financial pressure, peer pressure, and even pressure from uncaring family members can be placed on these individuals to take the suicide option. In fact, nothing in the Oregon or Washington style laws can protect from explicit or implicit family pressures to commit suicide, or personal fears of “being a burden.” There is NO requirement that a doctor evaluate family pressures the patient may be under, nor compel the doctor to encourage a patient to even notify their family. 6. Bad data puts patients at risk. Oregon’s data on assisted suicide is flawed, incomplete, and tells us very little. The state does not investigate cases of abuse, and has admitted, “We cannot determine whether physician assisted suicide is being practiced outside the framework of the Death with Dignity Act.” The state has also acknowledged destroying the underlying data after each annual report.1 7. “Safeguards” don’t work. Experience in Washington and Oregon has shown that the mental health and other safeguards are easily circumvented. Patients seeking a lethal prescription are not required to receive it from their attending physician and, thus, can “doctor-shop” to find someone who will. This is especially troubling for the families of patients diagnosed with depression. 8. Can turn treatable depression deadly. Most cases of depression

among the terminally ill can be successfully treated. Yet, lethal prescription requests from terminally ill individuals are often based on fear and depression. Primary care physicians are not generally expert in diagnosing or treating depression, and nothing in the Oregon or Washington assisted suicide laws compels doctors to refer patients for evaluation by a licensed psychologist or psychiatrist to s creen for depression or mental illness. 9. An often painful death. Barbiturates are the most common substances used for assisted suicide in Oregon and Washington, but barbiturates do not assure a peaceful death. Overdoses of barbiturates are known to cause distress and have associated issues like: extreme gasping and muscle spasms; vomiting and inhaling vomit while losing consciousness; panic and feelings of terror and assaultive behavior from the drug-induced confusion; failure of the drugs to induce unconsciousness; a number of days elapsing before death occurs; and sometimes death does not occur. 10. A slippery slope. Countries such as the Netherlands, where assisted suicide has been legal for decades, show that assisted suicide cannot be contained or limited to the terminally ill. (See Dr. Herbert Hendon commentary, click here: http://www.psychiatrictimes.com/articles/ commentary-case-against-physician-assisted-suicide-right-end-life-care) For more information visit www.HPACC.org 1. Dr. Katrina Hedberg, 9 December 2004, House of Lords, Select Committee on the Assisted Dying for the Terminally Ill Bill, Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence, (London: The Stationery Office Ltd., 2005), 262.)

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kobayashi2 - Jessi

From:	Richard Diehl <rdiehl@diehlandweger.com>
Sent:	Wednesday, March 22, 2017 3:39 AM
To:	HLTtestimony
Cc:	Christine Weger
Subject:	SB 1129 SD 2 Medical Aid in Dying

Ii support this Bill. This is without doubt a personal decision that ought to be made by the individual. It is a matter of choice that ought to have bipartisan support .

We live in a secular society which is comprised of Christians Buddhists and those who identify with Islam or are Jewish agnostics or those of us who are not associated with any particular tradition.

I was raised Catholic any my Church likely opposes this type of legislation but that ought to be irrelevant to me and if you do ,in fact, represent ALL of us it ought to be irrelevant to our elected official as well.

I urge you to support this Bill.

Richard J Diehl
7920 Makaaoa Place
Honolulu Hawaii 96825
808-255-3265

Sent from Mail for Windows 10

kobayashi2 - Jessi

From: Ronald Guerrero <808guerrero@gmail.com>
Sent: Wednesday, March 22, 2017 1:16 AM
To: HLTtestimony
Subject: Death with Dignity bill

>
>>>
>>>> I support this bill. I believe the terminally ill or the like should have a choice. I've lived through it watched a love one suffer, lose all physical /mental abilities and in the end suffer with great pain. It might not be perfect but give us a choice.
>>>>
>>>> Respectfully,
>>>> Ronald B. Guerrero
>>>>
>>>> Sent from my iPhone

Testimony to House Committee on Health

Regarding: S.B. 1129 SD2

Date: March 23, 2017
Time: 8:30 a.m. – State Capitol Conference Room 329

Submitted in OPPOSITION by: Ruth Prinzivalli, Senior Citizen residing in Kaneohe, HI 96744

TO: Chair Della AuBelatti, Vice Chair Bert Kobayashi and Committee Members

From: Ruth Prinzivalli, 45-255 Haunani Pl. , Kaneohe, HI 96744 808-349-2223, ruthprinz1@aol.com

I strongly oppose SB1129.

As a resident of Hawaii for 48 years, I consider this bill a threat to my husband and myself and all senior citizens or terminally ill persons in this state. When faced with a severe medical condition, perhaps Cancer, we may well be facing an Insurance Company or Medicare unwilling to treat the disease with expensive drugs and only offering to cover a much cheaper lethal drug. This has already been the case in both Oregon and California.

Passage of this bill may soon create a dangerous "duty to die" that pressures older people and those with disabilities or depression into ending their lives. Especially, with our ethnic population here in Hawaii and the love for family, a feeling of guilt emerges and so they commit to these barbiturates as Death becomes a reasonable substitute to treatment and care that is more costly in both time and money for their families.

Assisted Suicide does not stop with the Doctor and willing patient who request it. Elder abuse is already a major problem in our country. Legalizing Assisted Suicide will place lethal drugs into the hands of abusers. A greedy heir or an abusive caregiver can pick up the drugs and coerce the person or put the drug into his/her food. There is no supervision or tracking of the drugs once they leave the pharmacy.

Very importantly, on record as being strongly opposed to assisted suicide are the American Medical Association, the American Psychiatric Association, the American Nurses Association, Disabled Rights Education and Defense Fund and Not Dead Yet Disability Rights Organization as well as many religions that believe it is morally wrong. These organizations work with the targeted people of this bill on a daily basis.

Much more humane, are pain management techniques that lessen pain and treat other symptoms. Palliative care through hospice is one that addresses the physical, emotional, and spiritual needs of dying patients and their families.

As our elected representatives, you have the responsibility to pass legislation that is good and right for **everyone** in our state, not one that just benefits the state and special interests financially. It will be on your conscience to do so.

Respectively submitted, Ruth Prinzivalli

Committee on Health
Representative Della Au Belatti, Chair

Re: SB1129 SD2, RELATING TO HEALTH-MEDICAL AID IN DYING

Date: Thursday, March 23, 2017
Time: 8:30 a.m.

Honorable Chair Belatti and Members of the Committees:

My name is Simone C. Polak, and I'm a resident of Maui. My comments are based on my personal experiences and beliefs. As a caregiver to my life partner Leticia who at age 43 was diagnosed with an aggressive form of Multiple Myeloma, an excruciatingly painful, incurable blood cancer, I helplessly watched a vibrant, physically active, and healthy woman turn into a mere shadow of her former self. Despite best efforts of pain control by her doctors and a specialized pain management team, Leticia at times endured almost unbearable pain. Unfortunately, Leticia did not have the opportunity to consider the option of Medical Aid in Dying (MAID).

I strongly believe in core values like personal, liberty and individual autonomy. A terminally ill person should have the right to control when it is better to end their lives by MAID than to continue living and suffering. MAID gives individuals a chance for a good death. They can request, obtain and ultimately self-administer lethal medication that will end their life peacefully. They can do so surrounded by their family and friends in the comfort of their own home. In an authoritative textbook in Palliative Care (Emanuel, L. & Librach, S.L. (2011). Palliative Care: Core Skills and Clinical Competencies. 2nd Edition. Philadelphia, PA: Saunders/Elsevier), the authors state, "the most enduring requests for PAD [Physician Assisted Death]… arise not from inadequate pain management and symptom control <u>but from a patient's belief about dignity, autonomy, and control over the circumstances of one's death</u>.(p. 297, emphasis added)

This bill honors those core values and affords terminally ill, mentally capable Hawaii residents, acting of their own free will, the opportunity to make an informed decision with respect to their health care and their available end of life options (hospice, palliative care including terminal sedation). It gives control to the patient to exercise the option to advance death.

I am grateful that the Hawaii Legislature has recognized the need for terminally ill Hawaii residents to have access to MAID. I certainly would want to have this option available to me, if I were terminally ill.

I am in strong support of SB 1129 SD2.

Thank you for the opportunity to submit written testimony.

Aloha,
Simone C. Polak
Wailuku, Maui, HI 96793

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 6:50 AM
To: HLTtestimony
Cc: psalm3704@msn.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Susan M Michihara	Individual	Oppose	No

Comments: SOCIAL WORKERS IN OPPOSITION TO SB 1129 MEDICAL AID IN DYING Dear honorable legislators: My name is Susan Michihara. I am a licensed social worker in the medical field, and I, as well as my fellow social workers listed below, are opposed to SB 1129 Medical Aid in Dying. The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. (National Association of Social Work Mission Statement). As a social worker attending to the needs of patients and caregivers, I am witness to the enormous burdens that come with illness. There are physical, economic, psychological, social, and spiritual needs that require our support in coordinating care for the individuals and their caregivers during this very vulnerable period in their lives. I support and assist patients in these areas because this has been my training, this has been my calling, this has been my passion. The core values of a medical social worker are to value the dignity and worth of each person a and promote their wellbeing in the context of an environment where there may be marginal resources in care support, housing, language barriers, transportation, etc. Through our eyes, I find this bill alarming and dangerous. While we respect the rights of individuals to have options of care, even in dying, it is very obvious that the provisions of this bill do NOT protect the very large group of individuals who, in their time of illness, especially in the last chapter of their lives, are so prone to discouragement, despair, and depression. It is appalling that, according to this bill, any healthcare provider, including nurse practitioners, are allowed to prescribe these drugs for lethal ingestion. I am witness to the fact that a cry of despair to have one's life ended by assisted suicide is often one that arises out of not only physical symptoms, but worries about being a burden on others, and the uncertainty of how care will go when one gets progressively disabled. I find it very hard to believe that a provider who is not trained in the basics of palliative care, can comprehensively and competently assess the context of an individual's re quest for a prescription of lethal drugs. It is known that the prevalence of treatable depression is high in this group, at least 25%. Yet, according to the latest Oregon death with dignity data, less than 4% of those receiving a prescription for lethal medications were referred to a psychiatrist. Furthermore, the rate of elder abuse in the United States, according to recent Harvard study, runs about 10%, and it is acknowledged that it is higher due to underreporting. That there has not been a single case of abuse reported in the 18 year history of the Oregon experience of legalized assisted suicide stretches the boundaries of credibility. Clearly, this bill does not protect the vulnerable elderly, chronically ill, and disabled. The safeguards are NOT safe. The definition of compassion is "to suffer with". I, as a social worker come alongside the patient, their family, and caregivers, in doing everything I can to support

and assist them in all the areas of suffering that I mentioned above. Therefore, this bill goes against the core value of what I stand for as a medical social worker. Thank you very much for your kind attention. Susan Michihara, LSW The following Social Workers also oppose SB1129: Jamie Detwiler Faith Furugen Gale Sugiyama Jay Yukumoto Marcus Pang

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 6:04 AM
To: HLTtestimony
Cc: tifftawata@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Tiffany Tawata	Individual	Oppose	No

Comments: This bill would allow people to play God; no human should have that right. Please consider all the negative effects this bill could bring about.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 4:13 AM
To: HLTtestimony
Cc: dr_toby_smith@lcca.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Toby Smith	Individual	Oppose	No

Comments: I am a board certified physician in geriatrics, hospice and palliative care and internal medicine and I strongly oppose this bill. This law threatens the doctor-patient relationship and the concept of what medical treatment is. As we are already limited in being able to provide for the medical needs of our community in Hawaii, this bill changes our role in how we provide care especially to those who have a terminal illness. We are supposed to provide hope, guidance and treatment and not decide when someone should commit suicide. We are working hard to address the needs of suffering patients and their conditions and I think this bill with only cause more confusion and detract from determining how we can provide better care.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:36 PM
To: HLTtestimony
Cc: buck@tiki.net
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Buck Joiner	Individual	Support	No

Comments: Some 20 years ago I conducted a petition drive on BOTH sides of Medical Assisted Termination of Life issue on Maui. SUPPORT outnumbered OPPOSE by 4 to 1. I remain a supporter.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 11:03 PM
To: HLTtestimony
Cc: celine_0617@yahoo.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Carm Akim	Individual	Oppose	No

Comments:

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:53 PM
To: HLTtestimony
Cc: cheraloha@hawaii.rr.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Cherie Tsukamoto	Individual	Oppose	No

Comments:

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Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members,

My name is Chris Caoagdan and I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health." Thank you for your consideration.

Chris Caoagdan
975 Ala Lilikoi St. Apt. 301
Honolulu, HI 96818
(808) 489-2571

Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members,

My name is Christine Morrice and I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health."

To allow doctors to break the Hippocratic Oath to first Do No Harm is unconscionable. There are already legal processes in place to provide compassionate hospice care and "do not resuscitate" measures to ease suffering at the end of life.

My husband works in healthcare, and we believe this measure stems not from a desire to provide compassionate care, but to ease the burden of healthcare workers and save money for insurance companies in an already taxed healthcare system. Cutting costs is always a smart thing, but not at the cost of human life.

Compassionate hospice care is labor-intensive and much more expensive to healthcare than simply ending a life. However, the cold hard calculations of money simply do not apply when ourselves or a loved one is in jeopardy.

From a personal perspective, I shudder to think of how many errors and miscommunication can occur when a healthcare worker manipulates a terminal patients, who are probably already very vulnerable and depressed, without the consent of family who are there to protect them. The elderly, especially, do not want to be a burden to their family and this measure takes advantage of this. My elderly parents do not live in Hawaii, but I worry about bringing them here should this measure pass.

From a wider perspective, this measure sends a confusing message to practicing doctors and to a new generation of doctors in medical school that the Hippocratic Oath, in fact, can be violated in "certain situations." I believe this bill will only lead to further measures allowing the Oath to be violated in other situations that would continue to profit healthcare corporations and desecrate the sanctity of the individual, which is the bedrock of the US Constitution.

Immigrants have always come to America to seek protection from other government systems that did not respect the right of the individual. Here, we are at risk that the "rights" of insurance corporations supersede those of the individual, much like sweat shops that put profit above people.

I believe that when you or I are put in a situation where ourselves or a loved one (child, parent etc.) has their life on the line, and the best care becomes dependent on how much it "costs" the healthcare system, we will come to realize how much we desire the sacredness of life to be respected and honored.

Opposing this measure is about celebrating life and letting nature take it course (with compassionate hospice care) as it always has for as long as humans have lived, and not artificially ending lives with medication.

Thank you for taking the time to read this testimony.

Christine Morrice
510C Kuliouou Rd. Honolulu HI 96821
808 255 7130

Testimony in Opposition – SB 1129 Medical Aid in Dying
Hearing: Thursday, March 23, 2017

Dear: Honorable Members of the House Health and Judiciary Committees

Aloha,
I am a registered nurse with 36 years of experience at a major Oahu health care organization. I am respectfully submitting testimony in OPPOSITION to the above bill. While the intent of the bill may sound noble, the bill does NOT address specific criteria and safeguards to prevent premature death and ensure proper execution nor prevent future amendments that could lead to euthanasia.

Reasons:

- Medicine is a science/practice and not perfect. **Humans cannot accurately predict terminal conditions and life expectancy** in 100% of patients. The "miracle" recovery, longer than predicted life expectancy, and increased purpose and productivity of patients in this stage of life is fairly common – e.g. John Radcliffe, Charlie Wedemeyer.
- Each stage of illness, grief, dying, and death holds unique characteristics, challenges, and beauty. Multiple physical and psychological health conditions can cause despair. These are often temporary with therapy/intervention but can lead to the request of these medications. **As a nurse, I have seen and helped multiple patients and families to cope and forge bonds of peace, love, and create plans for positive life memories that would not have been possible with an early death.** Conversely, it would be easy for a nurse and other clinicians with unconscious bias to influence the premature death of a patient.
- Safeguards are not outlined and the **same issues we have with opioid abuse** that has high financial and life costs could easily happen. E.g. inadvertent child or non-patient use or elder abuse by stressed caregivers.
- Unconscious bias already causes multiple **health disparities**. This bill could easily lead to the **risk for discrimination, abuse, or the premature death of the poor, indigent, disabled, and kupuna** (elderly). The higher than national average number of Hawai'i kupuna makes this population especially vulnerable. Our elderly do not want to be a burden to their families. This bill would make it too easy for them to "opt out" and not be treated with the dignity, respect, and love they deserve.
- **National best practices do not exist** for clinician education and implementation. Research and long term experience are minimal at best. Are we willing to open the doors to have the eventual "amended" laws, such as in the Netherlands, enacted and cause the death of our loved ones without our ability to intervene?
- **Proper medical care already includes standards and requirements to provide patient-centered, end-of-life care** that includes the provision of medications to alleviate pain and suffering. Can we improve upon these requirements vs. adding new ones to an already burdened health care system?

If we cannot address all of these issues, we prematurely open a Pandora's Box that will likely require amendments, create lawsuits, and worse of all, the knowledge that premature deaths may be on our hands. Thank you for serving us and for your kind consideration. **Please vote NO.**

Cindy R Ajimine

Digitally signed by Cindy R Ajimine
DN: cn=Cindy R Ajimine, o, ou, email=cajipang808@hawaii.rr.com, c=US
Date: 2017.03.21 22:39:30 -10'00'

Cindy Ajimine, RN
3227 Paliuli Street, Honolulu, HI 96816
(808) 396-1654)

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 12:27 AM
To: HLTtestimony
Cc: d.ginoza@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

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

Comments: I took care of my Dad last year who was diagnosed with stage 4 liver cancer and it quickly spread to his back and spine. He suffered so much and we cared for him at home until we could no longer do it on our own and needed to place him in a hospice facility where he passed away10 days later. He suffered so much and it was the most difficult thing to watch a loved one suffer in pain and you cannot do anything for them. I will never forget what he went through. Cancer has affected everyone in my family and this bill will be very helpful to many families who will have the choice to end their lives with dignity.

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 11:16 PM
To: HLTtestimony
Cc: ogyechan@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Donni Gye Corrow-Sanchez	Individual	Support	No

Comments: It's a matter of compassion and kindness to allow people to choose a death with dignity rather than force them to continue with pain and despair. This bill provides people with a humane alternative and will be a great comfort to so many. Please, please, please vote YES!

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kobayashi2 - Jessi

From: EdGeller <hanggel@aol.com>
Sent: Tuesday, March 21, 2017 11:09 PM
To: HLTtestimony
Subject: Medical aid in dying

I am in favor of medical aid in dying.

Six months ago I moved to Hawaii from the state of Washington where such aid is possible.

Help add Hawaii to the growing number of states where a person can receive appropriate relief from suffering in the dying process.

Edward Geller

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:50 PM
To: HLTtestimony
Cc: kapiolani.adams@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Emerald Adams	Individual	Support	No

Comments: Aloha, I support SB1129. I believe individuals should have the right to exercise freedom over their own well-being, including how to comfortably end one‘s own pain and suffering. Mahalo

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kobayashi2 - Jessi

From: georgelee2468@gmail.com
Sent: Tuesday, March 21, 2017 10:49 PM
To: HLTtestimony
Subject: Medical Aid in Dying

I support The Medical Aid in Dying Bill.
Rev. George Lee
2468 Lamaku Pl
Hon. HI, 96816 ,
Palolo.

Sent from miPad

kobayashi2 - Jessi

From: january H <januarywaimea@gmail.com>
Sent: Tuesday, March 21, 2017 11:51 PM
To: HLTtestimony
Subject: Medical Aid In Dying Act S.B. 1129

Dear House Health Committee,
I read the proposed Medical Aid In Dying Act S.B. No. 1129
I think the added amendments are good, and beneficial to all.
Please vote Yes, and pass it.
It will protect those who are
ready to die, and help it be done safely.
Not only the patient, but doctors, families, and
friends will benefit by having a well thought out
Act to oversee the safety of all.
If I were in that situation I would truly be thankful
that our lawmakers took time to make this a safe, serious
option.
Mahalo ~Thank you
Aloha~
January Herron-Whitehead

j a n u a r y

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:53 PM
To: HLTtestimony
Cc: jpetrie70sman@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
John Petrie	Individual	Oppose	No

Comments: Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members. I'm writing in OPPISITON to SB1129 SD2 "Relating to Health." Thank you for your consideration. Sincerely John Petrie 134 Kapahulu Ave. #601 (808) 294-3599

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:33 PM
To: HLTtestimony
Cc: Godisaloha@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Karen Padilla	Individual	Oppose	No

Comments:

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kobayashi2 - Jessi

From: karl jacobs <karljacobs@juno.com>
Sent: Tuesday, March 21, 2017 11:04 PM
To: HLTtestimony
Subject: Aid in dying

I'm a 77 year old who lives in Maui. I'm in good health, but I very much like the idea that when it comes my time I could be assisted by my doctor to ease my passage.

Karl Jacobs

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Rep. Sharon E. Har
Rep. Dee Morikawa
Rep. Marcus R. Oshiro
Rep. Chris Todd
Rep. Andria P.L. Tupola

NOTICE OF HEARING

DATE: Thursday, March 23, 2017
TIME: 8:30 AM
PLACE: Conference Room 329

STRONG OPPOSITION to: Senate Bill 1129 SD2

Dear Chairman Belatti and Committee Members,

Thank you for your service to the State of Hawaii and representing the common interests of the people.

I am writing to express my STRONG OPPOSITION to SB 1129, Dr. Assisted Suicide.

As a concerned citizen and small business owner who was born and raised in Hawaii, I'm deeply troubled by the message this bill is sending to our ohana. We know that life has its ups and downs and there are times when we feel like we can't cope, lose fight, too stressed and because we have no hope, we give up. Hopelessness differs on who you are talking to. It may be triggered a divorce, teenage breakup, economic crisis or as in this case, terminal illness.

Hawaii has one of the highest teen suicide rates in the nation and we have upcoming legislation (HB 844, HB 1452, SB 384) proposing to establish suicide prevention methods/guidelines, yet SB1129 encourages suicide. Do you see the contradiction? On one hand we want to prevent suicide and on the other we want to encourage it? In states where dr assisted suicide is legalized it is a known fact that suicides rose. (In Oregon where doctor assisted suicide is legal, suicides in the general public are now more than 40% higher than the national average.) Legalizing suicide for the terminally ill in Hawaii, could have the same unintended consequence of increasing suicides among the general public, which includes vulnerable populations such as teens, as well as people with psychiatric disabilities. A law to end ones life will validate that DEATH IS THE SOLUTION to hopelessness, yet we know it is NOT.

I'm also concerned regarding the availability of the "death drug" upon arrival to the home. Should it fall into the wrong hands, what is the recourse? The patient may change their mind and leave it in the medicine cabinet for a later date, in the meantime a curious youngster comes along or a greedy family member could disguise it as medicine and "Houston we have a problem".

Another issue, that is disconcerting is how this bill affects life insurance policies. Most don't cover a policy owner who commits suicide, yet, if its dr assisted suicide, the recorded reason for death is the actual illness NOT SUICIDE. How is that fair to our insurance companies and those who pay premiums?

Also, will there be a recourse for a doctor or pharmacist who refuses to prescribe the death drug?

I believe, we in Hawaii are a community with ALOHA. With compassion, we look after the terminally ill and our aging kupuna. We cherish our moments with them, to bring them pain relief and comfort thru palliative care till they meet a natural death. We offer HOPE. ENCOURAGEMENT and VALUE even when they don't see it. We are also hopeful regarding medical breakthroughs which may come before the determined date of death. And then again, miracles do happen today.

No matter what we face, good or bad, LIFE is precious and AloHa is Hawaii's LIFE GIVING message.

Sincerely,

Lois Young

808/753-3089

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:51 PM
To: HLTtestimony
Cc: lorainelani@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Loraine Cross	Individual	Oppose	No

Comments:

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TESTIMONY to House Committee on Health

Regarding: S.B. 1129 SD 2 Relating to Health

Thursday, March 23, 2017

8:30 AM -- Conference Room 329

Submitted in **OPPOSITION** by: Mary Smart, Mililani, HI 96789

Chair Au Belatti, Vice Chair Kobayashi, and Committee Members:

1. I Strongly OPPOSE SB 1129 SD2. The bill legalizes what is now classified as manslaughter. No individual, regardless of "good intentions" should participate or facilitate in the taking of human life. Suicide pills are not "medication". Medication helps you recover from an illness. Although section -18 of the bill states that mercy killing and active euthanasia is not authorized, that is exactly what is being legalized. Even though this state doesn't consider a person adult enough to imbibe alcohol until 21 years old, this same body thinks that someone 18 years old is adult enough to terminate their life -- even without family notification. Something is wrong with that concept. As we try to reduce teen suicides, this bill gives the green light to teenage "assisted" suicide.

2. This bill is promoted by the misguided notion that killing the patient can be for their own good. The elderly and handicapped will become targets from insurance companies and may be pressured by family members. Many elderly fear they will be a burden to their family when, in fact, their family will likely grow closer during those last months and years of life. I cared for my father who had Parkinson's disease for the last 12 years of his life. That experience was mutually beneficial. We developed a very close bond. Section -6 assures us that someone with depression causing impaired judgment would not be a valid candidate, however, only a person suffering from depression or deep fear would consider this deadly option. There is nothing humane or dignified about what is being proposed in SB 1129, SD2. This bill treats human beings no better than an animal being "put down."

3. A request for assisted suicide is a cry for help -- not a request to be pushed over the edge. Section -4 (3) (E) makes it clear there are satisfactory alternatives to suicide "including but not limited to comfort care, hospice care, and pain control." Those alternatives constitute a dignified and humane death which an overdose of pharmaceuticals does not. The fact that this mainland bill is being forced on the people of Hawaii is a travesty. People who want to end their lives have been doing so since the beginning of time. The state shouldn't involve medical and pharmaceutical professionals. They should be focused on extending life, not shortening it.

4. Assisted suicide does not necessarily result in a "peaceful, humane death as given as the purpose of authorizing this life-ending process. There have been many incidents of bad reactions and slow death. Section -4 (3) (C) of the bill advises that the patient has to

be advised about the possible negative effects. Those negative effects should be listed in the bill so that an informed decision can be made. The specific pills are not identified nor the specific side effects of these pills are not listed in the bill. There is no indication whether the FDA has approved these "medications" for the purpose being advocated in this bill. However, for those who have researched this proposal, there are reports of side effects that include vomiting the pills which results in the patient becoming very uncomfortable. The "witness" may even need to call for medical assistance. There is nothing dignified nor humane about this process for the patient nor the witness.

5. There are no safeguards that the pills will not be used by someone other than the person who requested them. Once the pills are in the hands of the "consumer", positive control is lost. This is dangerous to the community. Accidental or even intentional death of someone who never requested the prescription could happen. Paragraph 15 directs that unused pills be disposed of in the nearest qualified facility that properly disposes of controlled substances -- but in any case, by lawful means. Many family/friends left behind may not recognize the pills as lethal and dispose of them in the garbage.

6. In paragraph 14 it states "The department shall annually review a sample of records maintained pursuant to this chapter." Exactly what Department will do this review, what data will be collected and what percent of cases will be considered. There are so many restrictions on access to data, that there will be no safeguards to protect Hawaii residents. Furthermore, this bill authorizes the falsification of the reason for death on the death certificate. It would be difficult to impossible to research abuses under these provisions that fail to report the true cause of death (suicide by lethal dose).

7. Doctors make mistakes -- and just having a second opinion doesn't guarantee an accurate diagnosis. Even if the diagnosis is correct, the prognosis can be very wrong. Many people live well beyond expectations. Even some diseases that could be classified as terminal if they weren't treated appropriately, for example diabetes, are not debilitating and a long and happy life is possible with readily available medication. Yet, these patients who many be suffering from temporary depression would be eligible to commit suicide under the provisions of this bill. That provision affects a large number of our residents since diabetes is so prevalent in Hawaii.

8. If this bill passes, doctors who participate in this type of activity should have a medical specialty designation so that patients can identify the purveyors of death from those doctors/medical professionals who will work to preserve life and make the final months and years of life comfortable and with manageable pain relief. Having physicians willing to participate in the prescription of death, weakens doctor- patient trust that has been the foundation of our health care success.

9. Although Oregon was given as a positive example, many of us are aware that patients were offered the suicide pills as a less costly solution to their health care than the medications that would prolong their life. There is nothing humane nor dignified about that. Promoting death to cut health care costs is not acceptable for Hawaii. Because the

death is falsely reported as occurring from the underlying disease, honest research of abuses is difficult if not impossible.

10. Section -16 is an especially egregious violation of trust in regard to contacts since death by suicide in insurance policies is normally precluded as a covered event.

11. Hawaii is renowned for the love and care we have of our kupuna. However, with the promotion of suicide pills, our aging loved ones may feel the pressure of the "duty to die" so that they don't become a burden on their family and society. We will lose that respect for elders when a "standard of care" ignores the dignity of all humanity.

12. Other countries have gone down the slippery slope of voluntary suicide to now involuntary euthanasia. We do not want this international and mainland uncaring solution brought to Hawaii.

Vote NO on SB 1129 SD2.

kobayashi2 - Jessi

From: Nancy Kickertz <NancyKickertz@msn.com>
Sent: Tuesday, March 21, 2017 10:01 PM
To: HLTtestimony
Subject: SB1129

To the members of The House Health Committee:

I am writing to ask for your support of SB1129, also known as the Medical Aid in Dying Act. I believe passing this Bill is the right thing to do because it provides patients at the terminal stages of incurable and irreversible diseases a choice of how and when their lives will end. The key is "choice". There are many individuals whose religious, spiritual or ethical beliefs do not include ending their lives at a time of their choice. There are many others, myself included, who believe that a prolonged and frequently agonizing end to life due to an incurable and irreversible illness is a cruelty to both the dying person and those they love; and that the comfort of having the choice to make an end to one's suffering provides an enormous peace of mind.

I have had some experience with both family members and two very dear friends whose deaths were of the prolonged and agonized type I mention above. They did not particularly fear death, but they feared what came before: the loss of control and dignity, the agonizing pain, and the knowledge of the inevitability of continued loss and pain. As my fiercely independent mother was slowly spiraling toward death she begged me to help her end her life. Of course I could not, but could only sit helplessly by as the constant pain and her inability to control here body's functions left her humiliated and thoroughly diminished.

I have heard opponents of this Bill concerned about possible abuses by greedy family members or uncaring providers of care. However even the best palliative care cannot insure a peaceful end. I know this because I have been there with two friends in hospice, with great palliative care provided. However, a reading of the Bill provides assurance that there are more than ample safeguards against such abuses. I would submit to you that to deny a person meeting the multiple criteria laid out in those safeguards the right to make such a personal decision is a far greater abuse.

Opponents of the Bill also say that palliative care is the answer. I believe in palliative care, but it is no panacea. I have attended two friends who were well cared for in hospice settings with great palliative care who nonetheless wanted to choose to end their lives. That choice should have been theirs.

Please support the passage of SB1129. It is the right thing to do.

Respectfully,
Nancy S. Kickertz
1015 Aoloa Place #441
Kailua, Hawaii 96734

kobayashi2 - Jessi

From: Patrick Chee <patrick.c.chee@gmail.com>
Sent: Tuesday, March 21, 2017 9:50 PM
To: HLTtestimony
Subject: Death With Dignity SB1129_SD2

Dear House Committee on Health,

I urge you to support SB1129, the Death With Dignity bill.

This bill describes a compassionate policy that will allow terminally ill people to get the assistance they need, at the time that they need it, when they are capable of making such a choice.

Denying terminally ill people the right to get the help they n eed to die with dignity will bring undue suffering to those people and their families.

This bill strikes the right balance that makes sure people who have been given a terminal diagnosis the right to die under the circumstances of their own choice.

Thank you for the opportunity to testify in support of this important bill.

Mahalo,
Patrick Chee
Honolulu, HI 96822

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:32 PM
To: HLTtestimony
Cc: h96821@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Reginald Fung	Individual	Oppose	No

Comments: SB1129 SD2 Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members, I strongly oppose this bill- this is making it legal to commit suicide My name is Reginald Fung and I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health." Thank you for your consideration. Reg Fung 400 Keawe Street Honolulu, Hawaii 808-373-1787

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:14 PM
To: HLTtestimony
Cc: scott@aloha.net
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Scott Crawford	Individual	Support	No

Comments: I believe that when medical circumstances lead a person to choose to end their own life, as is their ultimate sovereign right, they should be able to do so in the most dignified, conscious and painless way with the support of their medical team. Please support Medical Aid in Dying.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:31 PM
To: HLTtestimony
Cc: inhocsig@lava.net
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Susan Duffy	Individual	Oppose	No

Comments: Strongly oppose SB1129 SD2. To sanction the taking of human life is to contradict a primary purpose of law in an ordered society. Any law that would allow assisted suicide would demean the lives of the most vulnerable in our society and expose them to exploitation by those who feel that that they are better off dead. Such a policy would corrupt the medical profession, whose ethical code calls upon physicians to serve their patients and not to do them harm. Those who are the most marginalized in our society…the poor, the frail, the elderly, racial minorities, the disabled and those who lack adequate health insurance would be among the first to feel the pressure to die. There is no aloha in suicide. Please do not support this bill.

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kobayashi2 - Jessi

From: thanh tran <doggy968@gmail.com>
Sent: Tuesday, March 21, 2017 10:18 PM
To: HLTtestimony
Subject: Senate Bill 1129 SD2

I support this bill for those who has terminal illness and there's nothing that their doctor can do about it.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 12:14 AM
To: HLTtestimony
Cc: tagustin@goodsill.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Travis Agustin	Individual	Oppose	No

Comments:

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:52 PM
To: HLTtestimony
Cc: wonw002@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
William Won, MD, FACS	Individual	Comments Only	No

Comments: Dying is such a personal matter that legislation to "aid" in doing so is such a ridiculous concept. If such a measure is passed, it will be open to fraud and all other sorts of shenanigans. As a physician who practiced for over 35 years, I never once encountered a patient who needed "medical aid in dying".

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:48 PM
To: HLTtestimony
Cc: aktcppi@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Adrian Tam	Individual	Support	No

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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Testimony from:

- Dr. Aida Wen, Geriatric Medicine
- Hearing:
    - Date: Thursday, March 23, 2017
    - Time: 8:30 am

- Regarding:
    - Measure number: SB 1129, SD2 (SSCR893)
    - Relating to Health: Establishes a medical aid in dying act that establishes a regulatory process under which an adult resident of the State with a medically confirmed terminal disease may obtain a prescription for medication to be self-administered to end the patient's life. (SD2)

To the Honorable Chair Belatti and members of the House Committee on Health:

As an Internal Medicine Physician, Board certified in Geriatric Medicine, Hospice and Palliative Medicine practicing in Hawaii, I would like to submit testimony expressing my concerns regarding the Medical Aid in Dying bill.

I have been in practice for 25 years, and I have seen firsthand the issues that my patients and families encounter as they face serious illness. The average age of my patients is about 89 years old. Not unexpectedly, many have chronic illnesses-- such as end-stage cardiac disease, end-stage kidney disease, end-stage lung disease, etc. In addition, at least half of my patients also have dementia at some stage.

I have walked many patients and families through the journey of dying. Along the way, I have met patients and families who have asked me to help them die. As I listen to their fears and concerns, I find that I am able to meet these needs, one way or another. I make it my mission to find resources and strategies to help these people find meaningful things to do with their limitations, (including level of cognition), provide sensory pleasure (loving touch, massage, music, aromatherapy, taste, etc), and teach caregivers how to create "moments of joy", even when their loved one no longer recognizes them. I try to find resources and create support for the patients and families. When we go "all out" and work with the entire interdisciplinary team, and pull in the family and friends, I see a miraculous transformation. Not only is the patient is at peace, the patient experiences times of joy and laughter, and the family feels supported and empowered, and the family is able to have rich interactions that they never would have dreamed of. The healthcare profession should be able to make the "last chapter" of their lives meaningful and peaceful. It is a lot of work, but by having advanced directive discussions, and a rallying of support from all members of the community, a "good death" can be planned for and achieved—and it does NOT have to include ending a person's life. I have seen this scenario played out time and time again, and that is what I would wish for all of my patients. From what I have seen in my 25 years of practice, I believe that "Physician Aid in Dying" is not necessary. If a person has a terminal illness (certified to be <6 months), that life will come to a close naturally. Writing for

lethal prescriptions is not necessary, and robs the patient and family of opportunities to grow in grace, to learn about service, and to learn about love and forgiveness…

Certainly, living with dying is scary, and living with dementia, is sometimes even harder. In my line of work, I find that the people who find this the hardest are the families and caregivers. Oftentimes, especially when a patient has dementia and has limited capacity, families struggle with making decisions for their loved ones, oftentimes "transferring" their own desires to be the desires of their loved ones (ex: "I wouldn't want to go through that", " I wouldn't want to be a burden". Furthermore, caregiving for persons with dementia can last even more than ten years. Caregiver stress and burnout is common, and many providers in our current healthcare system, financial, and social systems do not know how to provide the support that these caregivers need. So, wouldn't it be "easier" to "end the misery"? Therefore, I see this population as particularly vulnerable.

The proposition for "Aid in Dying" does not have safeguards. How will "doctor shopping" be managed? If the doctors who "Aid in Dying" are not trained in palliative medicine, nor have the skills and patience to draw out concerns from the patient and family, and do not know the community resources available to provide for the enhanced and intensive psychosocial and spiritual care needed, then this will become the "easy way out". Will there be a needs assessment that will inform how we need to support these people? Will this kind of data be collected? Will lethal prescriptions become "unaccounted for" and be accessed by un-intended persons such as children or other people with dementia, like the problem of opioid diversion? Will there be coercion? Dementia is a common risk factor for elder abuse by caregivers. All too often, I have seen these elders as a target for their money, whatever the strategy. Unfortunately, I have seen so-called "caregivers" convince a dementia patient to sign documents allowing them to become their surrogates. Indeed, if they can convince them to trust them, they could certainly get meds for them and be in a position to convince them to take them.

While Physician Aid in Dying may satisfy the few interested in "self-determination", this may place the 26,000 patients with dementia in Hawaii at risk. In Hawaii, we should spend our time and resources to empower our families to better care for our Kupuna.

This bill runs counter to the culture in Hawaii. It is not necessary. And it is not worth it.

Sincerely,
Aida Wen, MD
aidawen@hawaiiantel.net
808-295-0650

Jackie Mishler

Position Statements

Euthanasia, Assisted Suicide, and Aid in Dying

Date: April 24, 2013

Status: Revised, Combined Position Statement

Originated by: ANA Center for Ethics and Human Rights

Adopted by: ANA Board of Directors

Purpose: Historically, nurses have played a key role in caring for patients at end-of-life across healthcare settings. Nurses provide expert care throughout life's continuum and at end-of-life in managing the bio-psychosocial and spiritual needs of patients and families both independently and in collaboration with other members of the interprofessional healthcare team. While resources do exist to educate and support nurses in this role, there are limited resources to assist nurses in understanding and responding to patient and family questions related to euthanasia and assisted suicide.

The purpose of this position statement is to provide information that will describe the nurse's ethical obligations in responding to requests for euthanasia and assisted suicide, define these terms, support the application of palliative care nursing guidelines in clinical practice, and identify recommendations for nursing practice, education, administration, and research.

Statement of ANA Position: The American Nurses Association (ANA) prohibits nurses' participation in assisted suicide and euthanasia because these acts are in direct violation of *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001; herein referred to as *The Code*), the ethical traditions and goals of the profession, and its covenant with society. Nurses have an obligation to provide humane, comprehensive, and compassionate care that respects the rights of patients but upholds the standards of the profession in the presence of chronic, debilitating illness and at end-of-life.

History/previous position statements: ANA adopted position statements on Euthanasia and Assisted Suicide originated by the Task Force on the Nurse's Role in End-of-Life Decisions, Center for Ethics and Human Rights on December 8, 1994.

Supersedes: Position Statements: Assisted Suicide (12/08/94); Active Euthanasia (12/08/94).

Supportive Materials

ANA's Foundational Documents

Code of Ethics for Nurses with Interpretive Statements

Provision 1, Interpretive Statement 1.3 of *The Code* (2001) speaks to the nurse's commitment to the inherent:

> "… worth, dignity and rights of all human beings irrespective of the nature of the health problem. The worth of the person is not affected by death, disability, functional status, or proximity to death. This respect extends to all who require the services of the nurse for the promotion of health, the prevention of illness, the restoration of health, the alleviation of suffering, and the provision of supportive care to those who are dying" (p. 12).

In a succeeding paragraph, the statement goes on to say that:

> "… nursing care is directed toward meeting the comprehensive needs of patients and their families across the continuum of care. This is particularly vital in the care of patients and families at the end-of-life to prevent and relieve the cascade of symptoms and suffering that are commonly associated with dying…Nurses may not act with the sole intent of ending a patient's life even though such action may be motivated by compassion, respect for patient autonomy and quality of life considerations" (p. 12).

Nursing's Social Policy Statement: The Essence of the Profession

In the section entitled, "Knowledge Base for Nursing Practice" of this document, it states that "Nurses are concerned with human experiences and responses across the life span. Nurses partner with individuals, families, communities, and populations to address issues such as….physical, emotional, and spiritual comfort, discomfort, and pain…emotions related to the experience of birth, growth and development, health, illness, disease, and death….decision-making and the ability to make choices" (2010b, pp.13-14). In its discussion of the Code of Ethics for Nurses, the section entitled, "Standards of Professional Nursing Practice", *Social Policy Statement* clearly states that "although the Code of Ethics for Nurses is intended to be a living document for nurses, and health care is becoming more complex, the basic tenets found within this particular code of ethics remains unchanged" (2010b, p. 24).

Nursing: Scope and Standards of Practice, 2nd Edition

Standard 7, under the heading "Standards of Professional Performance," reiterates the moral obligation of the nurse to practice ethically and to provide care "in a manner that preserves and protects healthcare consumer autonomy, dignity, rights, values, and beliefs" and "assists healthcare consumers in self determination and informed decision-making" (2010a, p. 47).

Other Supporting Material

Palliative and hospice care provide individualized, comprehensive, holistic care to meet patient and family needs predicated on goals of care from the time of diagnosis, through death, and into the bereavement period. The following excerpt from this document emphasizes the role of palliative nursing care in the nurse's recognition and relief of symptoms within his or her professional boundaries and in a manner consistent with safe, competent, ethical nursing practice:

> "…Palliative care recognizes dying as part of the normal process of living and focuses on maintaining the quality of remaining life. Palliative care affirms life and neither hastens nor postpones death. Palliative care exists in the hope and belief that through appropriate care and the promotion of a caring community, sensitive to their needs, patients and families may be free to attain a degree of mental, emotional, and spiritual preparation for death that is satisfactory to them" (ANA & HPNA, 2007, p. ix–x).

World Health Organization on Palliative Care

The World Health Organization (WHO) defines palliative care as:

> "… an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (National Consensus Project for Quality Palliative Care, 2009, p. 8). Palliative care "affirms life and regards dying as a normal process" and "intends neither to hasten nor postpone death" (National Consensus Project for Quality Palliative Care, 2009, p. 8).

Terminology

Assisted suicide: Suicide is the act of taking one's own life. In assisted suicide, the means to end a patient's life is provided to the patient (i.e. medication or a weapon) with knowledge of the patient's intention. Unlike euthanasia, in assisted suicide, someone makes the means of death available, but does not act as the direct agent of death. Nurses have an opportunity to create environments where patients feel comfortable to express thoughts, feelings, conflict, and despair. The issues that surround a request for assisted suicide should be explored with the patient, and as appropriate with family and team members. It is crucial to listen to and acknowledge the patient's expressions of suffering, hopelessness, and sadness. Factors that contribute to such a request should be further assessed and a plan of care initiated to address the patient's physical and emotional needs. Discussion of suicidal thoughts does not increase the risk of suicide and may actually be therapeutic in decreasing the likelihood. The relationship and communication between the nurse and patient can diminish feelings of isolation and provide needed support.

Aid in dying: Aid in dying is an end-of-life care option in which mentally competent, terminally ill adults request their physician provide a prescription for medication that the patients can, if they choose, self-administer to bring about a peaceful death (Compassion & Choices, 2012).

Euthanasia: Euthanasia, often called "mercy killing", is the act of putting to death someone suffering from a painful and prolonged illness or injury. Euthanasia means that someone other than the patient commits an action with the intent to end the patient's life, for example injecting a patient with a lethal dose of medication. Patients may consent to euthanasia (voluntary), refuse euthanasia (involuntary), or be unable to consent to euthanasia (non-voluntary). In euthanasia someone not only makes the means of death available, but serves as the direct agent of death.

For the purpose of this position statement, the term *euthanasia* refers to those actions that are inconsistent with the *The Code* and are ethically unacceptable, whether the euthanasia is voluntary, involuntary, or non-voluntary. The nursing profession's opposition to nurse participation in euthanasia does not negate the obligation of the nurse to provide compassionate, ethically justified end-of-life care which includes the promotion of comfort and the alleviation of suffering, adequate pain control, and at times, foregoing life-sustaining treatments. Though there is a profound commitment both by the profession and the individual nurse to the patient's right to self-determination, limits to this commitment do exist. In order to preserve the moral mandates of the profession and the integrity of the individual nurse, nurses are not obligated to comply with all patient and family requests. The nurse should acknowledge to the patient and family the inability to follow a specific request and the rationale for it (2010c).

Hospice care: Hospice care is the care of patients and families at end-of-life during the last few weeks or months of life and, as such, builds on the palliative care model to minimize suffering by providing appropriate symptom management and emotional support. In a study conducted by Herman and Looney (2011), symptom distress was the variable that most significantly correlated with quality of life following by symptom frequency, severity, and depression. The higher the symptom distress (inclusive of depression), frequency, and severity, the lower the quality of life. As noted by Sherman and Cheon (2012):

> "In short, palliative care/hospice partnership creates a common sense allocation of health care resources as patients move across the illness trajectory and approach the end-of-life. With palliative and hospice care, the wishes and preferences of patients and families are respected, often with a desire to withdraw life-prolonging treatments and insure their comfort and dignity as death approaches." (p. 156)

Palliative sedation: The primary intent of palliative and hospice care is to relieve or minimize suffering through effective symptom management in order to enhance the patient's quality of life and support patients and families in the dying process. There are times, however, when the patient's symptoms may become intractable and refractory to treatment. Both the definition and terminology associated with palliative sedation have been widely debated. In its 2011 position statement entitled "Palliative Sedation", the Hospice and Palliative Nurses Association (HPNA) states that:

> "While there is no universally accepted definition, palliative sedation can be understood as the controlled and monitored use of non-opioid medications intended to lower the patient's level of consciousness to the extent necessary, for relief of awareness of refractory and unendurable symptoms. Previously, palliative sedation was termed terminal sedation; however, the term palliative sedation more accurately describes the intent and application to palliate the patient's experience of symptoms rather than to cause or hasten the patient's death" (p. 1).

Interdisciplinary assessment and collaboration is essential to determining the appropriateness of palliative sedation and assure effective communication between the patient, family, significant other, surrogate, and/or other healthcare providers. (HPNA, 2011, p. 2). As patient advocate, the nurse plays a pivotal role in maintaining the human dignity of persons by providing highly competent, compassionate nursing care that is ethically appropriate and consistent with acceptable standards of nursing practice. HPNA describes:

> "… the ethical justification that supports palliative sedation is based in precepts of dignity, respect for autonomy, beneficence, fidelity, nonmaleficence, and the principle of double effect, which evaluates an action based on intended outcome and the proportionality of benefit and harm" (p. 1).

Withholding, withdrawing, and refusal of treatment: The withholding or withdrawal of life-sustaining treatment (WWLST), such as mechanical ventilation, cardiopulmonary resuscitation, chemotherapy, dialysis, antibiotics, and artificially provided nutrition and hydration, is ethically acceptable. Studies indicate that most patients who die in a hospital, particularly in intensive care, do so following the withdrawing or the withholding of life-prolonging therapies (Ersek, 2005). WWLST is allowing the patient to die from their underlying medical condition and does not involve an action to end the patient's life.

Patients have the right to exercise their decisional authority relative to health care decisions, including foregoing life-sustaining treatments. The provision of medications with the intent to promote comfort and relieve suffering is not to be confused with the administration of medication with the intent to end the patient's life. In palliative sedation, medications are used to create varying degrees of unconsciousness for the relief of severe, refractory symptoms at end-of-life, when all other palliative interventions have failed. Some clinicians and ethicists consider this an alternative to assisted suicide, as the intention of the physician is not to cause death, but to relieve suffering (Quill, Lee, & Nunn, 2000). Some have argued that patients have a right to the autonomous choice of assisted suicide and that ending suffering quickly is an act of beneficence (Ersek, 2004, 2005).

Legislative and community initiatives: Fontana (2002) asserts that nurses caring for terminally-ill patients who are considering assisted suicide will increase as the aid-in-dying movement continues to achieve momentum. Three states have legalized assisted suicide, beginning with Oregon in 1997, followed by Washington in 2008, and Montana in 2009 (Lachman, 2010). The mission of the organization, Compassion & Choices, is to "improve care and expand choice at the end of life" (www.compassionandchoices.org). Compassion & Choices provides education, support, and advocacy to patients and families related to accessing excellent end-of-life care, promotes healthcare policy initiatives to expand the option of assisted suicide, and upholds an individual's right to seek assisted suicide to avoid intolerable suffering. Nurses will likely be increasingly exposed to requests from patients or families and encounter ethical dilemmas surrounding the legal option of assisted suicide. Nurses need to be aware of their own sense of suffering, discomfort, confusion, and inadequacy that could be caused by aid-in-dying. Nurses should seek the expertise and resources of others including nurse colleagues, other interprofessional healthcare team members, pastoral services, hospice specialists, and ethics consultants/committees when confronting the complexity of these issues. Acknowledgement of the struggle of those loved ones caring for the patient and the patient's vulnerability can connect nurses deeply with the experience of the patient and family.

Despite changes in a few states regarding the legalization of assisted suicide, the public, as well as professional nursing, remains uneasy. Seventy percent of the Ferrell et al (2002) sample of oncology nurses opposed legalization of assisted suicide. Carroll (2007) found a public divided, but an increasing acceptance toward support of both assisted suicide and euthanasia. Nursing needs to be prepared for political and public moral discourse on these issues and to understand how *The Code* responds to these questions. Nurses must examine assisted suicide and euthanasia not only from the perspective of the individual patient, but from the societal and professional community perspectives as well. Involvement in community dialogue and deliberation on these issues will allow nurses to recommend, uphold initiatives, and provide leadership in promoting optimal symptom management and end-of-life care.

The Oregon Nurses Association (ONA) has developed resources to guide nurses in their practice around patient or family requests for assistance in dying (ONA, 1997). Nurses can choose to be involved in providing care to a patient who has made the choice to end his/her life or may decline to

participate based on personal moral values and beliefs. In this latter case the nurse can "conscientiously object to being involved in delivering care. ONA states that the nurse is obliged to provide for the patient's safety, to avoid abandonment, and withdraw only when assured that alternative sources of care are available to the patient" (Task Force, 2008, p. 2).

If the nurse chooses to stay involved with the patient, the nurse may do all of the following:

- Explain the law as it currently exists.
- Discuss and explore patient options with regard to end-of-life decisions and provide resource information or link the patient and family to access the services or resources they are requesting.
- Explore reasons for the patient's request to end his or her life and make a determination as to whether the patient is depressed and, if so, whether the depression is influencing his or her decision, or whether the patient has made a rational decision based on personal values and beliefs (ONA, 1997, p. 2).

***Professional organization perspectives on participation*:** Both the American Medical Association and the ANA (2010b) state that clinician's participation in assisted suicide is incompatible with professional role integrity and violates the social contract the professions have with society. Physician-assisted suicide is essentially discordant with the physician's role as healer, would be problematic to control, and would pose grave societal risks. Instead of joining in assisted suicide, physicians must aggressively answer to the necessities of patients at the end of life (AMA, 1996). Both have vowed to honor the sanctity of life and their duty not to inflict harm (nonmaleficence). The American Psychological Association (2009) takes a position that neither endorses nor opposes assisted suicide at this time. The American Public Health Association (2008):

> "Supports allowing a mentally competent, terminally ill adult to obtain a prescription for medication that the person could self-administer to control the time, place, and manner of his or her impending death, where safeguards equivalent to those in the Oregon DDA [Death with Dignity Act] are in place. A "terminal condition" is defined in state statutes. Some states specify a life expectancy of 1 year or 6 months; other states refer to expectation of death within a "reasonable period of time". .

Acknowledging the prohibition against participation in assisted suicide does not necessarily lessen the distress and conflict a nurse may feel when confronted with a patient's request. Nurses may encounter agonizing clinical situations and experience the personal and professional tension and ambiguity surrounding these decisions. The reality that all forms of human suffering and pain cannot necessarily be removed except through death is not adequate justification for professional sanctioning of assisted suicide.

Nurses receiving requests for assistance in dying is not new. Many studies have documented such requests (Asch, 1996, 1997) Ferrell, Virani, Grant, Coyne, & Uman 2000; Ganzini, Harvath, Jackson, Goy, Miller, & Delorit, 2002; Matzo & Emanuel, 1997; Volker, 2003). The number of requests and the nurse's subsequent illegal action was initially startling to some, especially in the Asch (1996) study, where 17% of the critical care nurses received requests and 16% engaged in assisted suicide or euthanasia. The validity of the study was questioned because the definitions were vague. In Matzo and Emanuel (1997) only 1% of respondents stated that they provided or prescribed drugs they knew would be used for assisted suicide. Ferrell, et al. (2000) found 3% had assisted in helping patients obtain medication and 2% had administered a lethal injection at the patient's request.

The nurse may not administer the medication that will lead to the end of the patient's life. Also the nurse may not subject patients, families, or colleagues to judgmental comments about the patient's choice. If the nurse believes that assisted suicide is morally justified, but works in a jurisdiction where assisted suicide is illegal, then participating puts the nurse at risk for civil and criminal prosecution, loss of license, and imprisonment (Ersek, 2005). Relative to ANA's position, participation in assisted suicide would be in direct violation of *The Code*.

Several questions are still relevant to assess the patient's request for dying. All of the questions are directed to understanding the meaning of the request to the patient. For example, questions such as: What reason does the patient give for the request? Does the patient view suicide as the only option? What is the social, cultural, and religious context? These questions assist nurses in better understanding the meaning of these requests and help patients deal with the emotional suffering that may accompany this burden.

Recommendations

- Increase education for undergraduate, graduate, and doctorally-prepared nurses in developing effective communication skills in caring for patients with life threatening illnesses who request assisted suicide or euthanasia.

- Increase education for nurses in values clarification to promote nurses' understanding and clarify attitudes towards euthanasia and assisted suicide while at the same time supporting a patients' autonomous decision-making.

- Develop and/or coordinate efforts with other nursing organizations to help nurses reframe end-of-life care communication to avoid inflammatory language (i.e. "pull the plug") that undermines improvements in palliative care and to continue the dialogue regarding nursing's role when patients request assistance in dying.

- Collaborate with local nursing organizations in states where assisted suicide is legal to educate nurses regarding what professional obligations do and do not exist when nurses in those states are present at such requests.

- Increase ANA outreach to the media to assist the public in acquiring a better understanding of palliative care and hospice and dispel potential misunderstandings.

- Promote frank and open discussions within nursing at the highest levels of leadership in an effort to discourage secrecy and misunderstanding as to the realities of daily nursing practice for those nurses who work in practice settings where these issues are not unusual, given the population being served.

- Provide resources to help nurses manage their own distress and the distress of their patients when assisted suicide or euthanasia is requested.

- Encourage nurses to seek the expertise and resources of others including nurse colleagues, other interprofessional healthcare team members, pastoral services, hospice specialists, and ethics consultants/committees when confronting the complexity of these issues.

- Increase nursing's voice in the assisted suicide and euthanasia debates in practice and legislative arenas to articulate the reasons for ANA's opposition to nursing's participation, based upon its ethical position as reflected in *The Code.*

Summary

The American Nurses Association recognizes that assisted suicide and euthanasia continue to be debated. Despite philosophical and legal arguments in favor of assisted suicide, it is the position of the ANA as specified in *The Code* that nurses' participation in assisted suicide and euthanasia is strictly prohibited.

Nurses must acquire the competencies required to become experts in providing palliative care and manage the patient's symptoms compassionately and effectively in collaboration with other members of the interprofessional healthcare team. Nurses must remain informed and be cognizant of shifting moral landscapes, legislative activity, and ongoing debate related to assisted suicide and euthanasia. More education is needed to assist nurses in responding in an ethical and compassionate manner that is consistent with the provisions and interpretive statements outlined in *The Code* when patients present with such requests.

ANA acknowledges that there are nurses working in states where assisted suicide is legal. The ANA Center for Ethics and Human Rights is available to provide consultation to nurses who are confronted with these ethical dilemmas to assist them in upholding their professional responsibilities, despite the moral distress they may encounter when confronted with these situations.

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Jackie Mishler

1. The bill begins by corrupting language and proceeds with assertions that are either clearly false or found nowhere in the field of medicine. There is nothing in the field of medicine called “medical aid in dying.” It is a made-up term because the accurate description, “physician-assisted suicide,” was deemed poor marketing. Laws should be made using the real meanings of English words, not made up terms.

2. Paragraph 3 is a series of fictions. Not only is “medical aid in dying” not a term used in medical practice, “terminal illness” is not a medical diagnosis. And a key term of the bill is that it applies to an ill adult with six months or less to live when the accuracy of that estimate is denied by the proponent’s chief lobbyist and by multiple occurrences in states that have this law in place.

3. Paragraph 4 makes multiple false statements

- There have been multiple abuses of the Oregon law, including those noted in past testimony to Hawaii legislative committees at past hearing on similar bills. Oregon reports no abuses because their law does not provide for or allow reporting of abuses and, in fact, makes every effort to conceal possible abuses from those who might report them.
- If the intention of the law is to deny people who rely on the state for medical care the treatment for cancer for instance and instead supplying the drugs kits for physician-assisted suicide, then, yes, the law in Oregon is working as intended.
- And it is a false assertion that any PAS law has improved the care of the state’s terminally ill and dying. The PAS law in Oregon and other places may have satisfied a very small group of generally well-off proponents of PAS because they got what they want, it has resulted in the attrition of treatment options for those less well-off and has created a fear among elderly patients – again, reported in prior testimony to Hawaii legislative committees, of going to “suicide doctors.”

4. Paragraph 5 commends what the bill wishes to make legal for those who wish to take advantage of it. This is a tautology. The people who want this will be happy they get it. What the report does not address is what impact this bill has on those who don’t want it. This is not addressed and has not been addressed by any objective source in any state where PAS is in practice. Because of the deliberate opaqueness of the Oregon law, the negative impact on those who did not ask for PAS to be legal has been clear from anecdotal evidence, the only evidence that can be brought to light because of the cloak of government secrecy.

5. Paragraph 6 refers to safeguards, but this too is merely a convenient fiction. Safeguards require transparency for identification and a clear structure for enforcement. Neither of these is available in the bill. How does the bill prevent “doctor shopping,” allowing a willing patient or, as happened in Oregon, her caretaker daughter from going doctor to doctor, ignoring appropriate refusals, until finding a doctor willing to prescribe the lethal drugs, in spite of the patient never before being in the doctor’s care? How does the bill address the implicit coercion to die, rather than have your care cause a drain on a family’s finances? Those advocating this bill are well-off and this is not an issue for them. But the damage they leave in their wake is something they close their eyes to and which the bill makes no attempt to really address. To demonstrate the fantasy that the phrase “strict safeguards” represents, one only has to imagine an abuse of this law and try in vain to figure out how the abuse could even be identified under the terms of this bill, let alone brought to trial. There are simply no enforcement provisions and the record keeping is truncated and hidden. And contrary to the assumptions of the report, what may be the most serious repercussions on people who have

no desire for this bill is not that they won't be eligible for "medical aid in dying" based on age or disability, but that they won't be eligible for anything else because treatment is too expensive and they are not worth it. If you doubt this, long more deeply into the treatments Oregon used to cover for those who require state aid and what Oregon covers after 20 years of PAS.

6. The bill allows participation by advanced practice nurses, as noted in paragraph 7, which is a dramatic expansion of this bill over the practice of PAS in the states where it is currently legal. There is no evidence that the implications of this expansion have been examined with any thoroughness. The recommendation to delete this provision of the bill seems warranted.

7. In paragraph 8, what seems to purport to be a safeguard could just as easily be a cause for abuse of the law. What evidence as can be recovered from events in Oregon indicate that about 75% of lethal prescriptions in the first decade or so or Oregon's law were likely written by 4 or 5 physicians for patients who had not for the most part been previously under their care.

8. The law requires the medical examiner to falsify the death certificate. Any law which recommends falsification of records is inherently questionable. This requirement extends the fiction that this bill is based on and requires the cause of death to be an "underlying cause" which cannot be verified. Medicine is imperfect and misdiagnoses occur. When someone is depressed by what is actually a misdiagnosis and gets these lethal drugs as a result, then takes them and dies, there is no "underlying cause." Is the medical examiner supposed to then note that the underlying cause is a "mistake?" Is that now a cause of death to be put on an official death certificate? This is the kind of compelled corruption that has no place in law.

9. The "good faith" standard recurring in this bill and suggested amendments is the lowest possible standard in medicine and has no place in a situation where a death is involved.

10. The bill does not address the profound effect implementation of this bill can have on the relationship between Hawaii doctors and their patients.

11. There seems to be no consideration in the bill of the very likely effects of what can occur from lawsuits attacking the arbitrary terms of the bill. What does the bill propose to do when people sue under equal protection for the term to be extended from 6 months to a year? More alarming but no less likely, what about when there is suit under anti-discrimination that "terminally ill," not being a medical diagnosis anyway, be stricken from the law. Then the law provides no capability of preventing a depressed patient from demanding lethal medications under this law. If this seems farfetched, one need only look at what is occurring now in Belgium and the Netherlands, both of which predated Oregon in permitting PAS. Both countries also allow euthanasia. And if that seems farfetched, there is a bill in the Oregon legislature to expand the PAS law to permit euthanasia.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 8:39 PM
To: HLTtestimony
Cc: andrewkayes@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Andrew Kayes, M.D.	Individual	Oppose	No

Comments: Please read this carefully. I am a practicing doctor in Hawaii. I would hope, as a member of that group, that this testimony may carry a bit more weight. This may be the most important testimony I have written in a while. I am a licensed Hawaii Physician and adamantly opposed to Hawaii allowing physicians to prescribe medication to cause someone to die. It is inhumane and Hawaii should not take part in this. Hospice care should be available and people who are critically ill should be made as comfortable as they can by whatever means necessary. Any medication for comfort, even if it hastens death is reasonable. This is called the principle of the double effect. And that is OK. We can already do this as physicians. However, having a physician prescribe a drug specifically for the purpose of death is against the Hippocratic Oath, is wrong, and should not be supported by our state. Sometimes right is right and wrong is wrong. This is one of those cases. Please do not give in on this one. Please do feel welcome and free to contact me for any further discussion. Please contact me if you wish to talk to a doctor who opposes this and why. I had a grandmother die in hospice care, and I have had patients I have known go to hospice. I can talk to you about those circumstances if it would help you better understand why I support hospice and oppose physician assisted suicide. Hawaii already has a doctor shortage. If the legislature chooses to do this, I am not sure I should be practicing here. If this passes I am considering leaving the state or possibly running against and ousting my current representative or senator. If my elected representatives cannot see why this is fundamentally wrong, and choose to not listen to the doctors of the state, then the only positive thing I can do is run against them, win and oust them so something this wrong does not happen again. I will not forget, never ever. I have spoken to many other like minded doctors. If this passes, it will surely deter doctors of good conscience from coming to our state. Please stop this. Sincerely, Andrew Kayes,M.D. Medical Director Maui Diagnostic Imaging.

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kobayashi2 - Jessi

From: Bernard Mendonca <bmendonca4765@gmail.com>
Sent: Tuesday, March 21, 2017 9:30 PM
To: HLTtestimony
Subject: SB1129 SD1

I Bernard Mendonca I am totally against this bill vote no

Thursday March 23 , 2017 Conference Room 329 Time 830AM To Della Au Belatti And Health committee

I'm standing up against this bill for all the elderly and misfortunate that can't speak for themselves this will encourage more suicides Among the young for this is a Suicide Bill that should never pass

Bernard Mendonca

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 8:57 PM
To: HLTtestimony
Cc: b.backers@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Bobbisue Backers	Individual	Support	No

Comments: Aloha Chair Belatti, Co-Chairman Kobayashi and Honorable Committee Members: I support the Death with Dignity law for Hawaii. No one should be forced to suffer in pain at the end of life. This law would not force anyone in Hawaii to comply with the law, it simply offers a humane and compassionate option to the dying. Please do not allow those who oppose this bill based on their religious beliefs to take this humane option away from those who want to use it at the end of their lives. The proposed bill has enough safeguards built in to prevent abuse of the ill and dying. Mahalo. Bobbisue Backers 3731 Kanaina Ave #223 Honolulu, HI 96815 (808)732-1677

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kobayashi2 - Jessi

From: Carole Iacovelli <carole.iacovelli@gmail.com>
Sent: Tuesday, March 21, 2017 8:24 PM
To: HLTtestimony
Subject: Hawai'i Medical Aid in Dying Act (SB 1129)

I am writing in support of the Senate bill 1129. Compassionate end of life decisions can be done as demonstrated in Oregon. I respectfully request you support for this bill. Thank you, Carole iacovelli
1376 Kainui drive
Kailua, 96734

Sent from my iPad

kobayashi2 - Jessi

From: Caroline Kunitake <caroline.m.kunitake@gmail.com>
Sent: Tuesday, March 21, 2017 8:37 PM
To: HLTtestimony
Subject: Senate Bill 1129 SD2 (SB1129 SD2)

Aloha Health Committee,

I am writing to support the Death with Dignity Bill. I believe that terminally ill people in Hawaii need to have the option to die with dignity in order to control the end of their life. I believe it is compassionate to provide a terminally ill person the option to stop unnecessary pain and suffering for themselves and family members.

Twenty years ago, I was accepted to the UH Manoa's Bachelor of Science Nursing program. I decided not to finish the program because of a terminally ill breast cancer patient that I was assigned at the Queens Hospital oncology unit. My patient's body was so grossly deformed from the cancer tumors eating away at her chest. She had no nipples, no breasts, no skin that wasn't bleeding around the trunk of her body. The tumor nodules were growing out of her scalp, her arms, legs and feet. I needed to change the xeroform bandages wrapped around the trunk of her body. As I removed the bandages, the membranous tissues would break and bleed constantly. Although she was on a morphine drip and could press a button to have a bolus of morphine injected into her body as needed, she was obvious exhausted from physical and emotional pain caused by the cancer.

This patient's husband sat in a chair next to her hospital bed as I changed her dressing. He looked broken, forlorn and depressed. It was such a sad and hopeless situation. The cancer tumors grew into her lungs and there was so much fluid that needed to be drained from her internal cavity. At that moment, I questioned the healthcare system and the laws governing physician assisted suicide for the terminally ill. Other foreign countries ensured this option for their citizens. I couldn't understand or accept why the US did not protect practical and meaningful options at the very end of life. Despite the United States' wealth, medical technology and sophisticated healthcare system, a US citizen/resident would have less options for quality of life because of the limits of the law. I couldn't reconcile my end of life beliefs with the healthcare system and decided to leave nursing school immediately. I quit nursing school the next day. Although I felt like a failure for quitting nursing school, I knew that I couldn't continue due to my conscience. Looking back, I was so grateful to briefly care for this terminally ill breast cancer patient because she helped me realize that I disagreed with the law at that time.

Certain religious groups may view an unnatural death through physician assisted suicide as immoral. Yet it is tragically unfair to terminally ill patients and families who do not share these religious beliefs and cannot afford to fly to another state (OR, CA) to legally end their life. I believe that it is cruel to force the terminally ill to continue suffering when they no longer want to be alive and there is no hope for recovery.

Planned deaths can provide the opportunity for family, friends and loved ones to be there for the terminally ill so that they do not die alone. The terminally ill person also may take advantage of the time before their death to say their farewells before they are decrepit, weak and no longer in touch with reality.

Thank you for taking the time to review my testimony. I hope that this bill will be passed in the Senate and House to help those who desperately want the option for death with dignity here in Hawaii.

Mahalo,
Caroline Kunitake

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 8:26 PM
To: HLTtestimony
Cc: cocom0tion73@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Colleen Bui	Individual	Oppose	No

Comments: Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members, My name is Colleen Bui and I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health." Thank you for your consideration. Colleen Bui 740 Gulick Avenue Honolulu, Hawaii 96819 YOUR PHONE NU

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kobayashi2 - Jessi

From: Colleen Lawrence <aloharejuvenation@gmail.com>
Sent: Tuesday, March 21, 2017 9:16 PM
To: HLTtestimony
Subject: Death with dignity

Aloha house health committee,

I am in support of the Medical Aid in Dying Act. I was the caregiver for my mother who had a major stroke and smaller TIA's over the 4 months I cared for her in her home where she stated she wished to dye, not in an institution. Hospice and private nurses made home visits regularly. Family and friends felt mother was so blessed to be cared for in her home with me. The final day the whole family was there with her peaceful passing. She had requested no dramatic means to revive her. I will always cherish that moment and the months I was able to spend with her.

I have since helped Hospice clients rest into their deaths and ease the concerns of their families at this final time. Life is precious and so is the final moments of life as we dye. Please allow digni ty and peace for all beings at this time if it is their choosing.
Thank you for your time,
Colleen Lawrence
--
Colleen A, Lawrence
Aloha Rejuvenation Therapy, Llc.
P.O. Box 5078
Honokaa, Hawaii 96727
808-775-9130

kobayashi2 - Jessi

From: Dana DiNunzio <danadinunzio@hawaii.rr.com>
Sent: Tuesday, March 21, 2017 8:17 PM
To: HLTtestimony
Subject: Bill 1129 SD2 (SB1129 SD2)

Please pass the Death With Dignity bill.

Sincerely, Dana DiNunzio

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 8:33 PM
To: HLTtestimony
Cc: dbyun112@hotmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Doris Byun	Individual	Oppose	No

Comments: Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members, My name is Doris Byun and I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health." Thank you for your consideration. Doris Byun 888 Kapiolani Blvd #1612 206.229.3947

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Eunice Kong

To Whom It May Concern:

I am in support of SB1129, a law to assist terminally ill patients to pass with dignity.

I recently lost my mother on February 4th, 2017, to Terminal Esophageal Cancer. She was diagnosed in late September, 2016; Diagnosed at stage IV, chemotherapy treatment was not a good option. My mother and I both wanted her to live her remaining life with as much quality and peace, however, her cancer took the best out of her during her last month. She experienced much pain, despite sedative pain medications, and suffered a great deal. She was an ideal candidate for SB1129- not just for her peace and dignity, but for her loved ones as well.

I hope our leaders will consider the dying patient in need, and consider the patients' right to dying peacefully and with dignity.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:35 PM
To: HLTtestimony
Cc: jcrfarmer@aol.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
jason farmer	Individual	Oppose	No

Comments:

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 7:40 PM
To: HLTtestimony
Cc: johnkmorris2244@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
John K. Morris	Individual	Oppose	No

Comments:

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:28 PM
To: HLTtestimony
Cc: jfujioka@hawaiiantel.net
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
JULIA FUJIOKA	Individual	Support	No

Comments: I support SB1129 SD2, Medical Aid in Dying, because I strongly believe that one should be able to choose to and be able to die if terminally ill, in agony, and or in a condition of poor quality of life with no hope for improvement.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:47 PM
To: HLTtestimony
Cc: wkplus8@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
katie Cheshire	Individual	Oppose	No

Comments: Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members, My name is KATIE CHESHIRE and I'm writing in SINCERE OPPOSITION to SB1129 SD2 "Relating to Health." Thank you for your consideration. 92-1256 Pueonani St., Makakilo, HI 96707 312-3771 MAY GOD'S WILL REIGN, THE GIVER OF LIFE!!

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kobayashi2 - Jessi

From: Kay Caldwell <kcaldwel@hawaii.edu>
Sent: Tuesday, March 21, 2017 9:25 PM
To: HLTtestimony
Subject: Testimony for The Hawaii Medical Aid in Dying Act

On a personal level, I feel very strongly about The Hawaii Medical Aid in Dying Act. I don't see this as an assisted death act, but a death with dignity bill where when there is absolutely no hope in life continuing a person can choose how to die.

I personally began my battle with breast cancer ten years ago. At that time I went through six months of chemo and radiation treatments and was declare in the end to be in remission! However, at the same time I began helping a dear friend who was battling advanced colon cancer that had spread throughout his abdomen. His doctors gave him no hope of survival and they did all they could to make him as comfortable as they could. I hear people say better palliative care is the answer to these situations, but this man spent five months both at Queens and in Hospice care in such excruciating pain, I found it unbearable to watch. All they could do was hook him up to morphine IVs, give him pain patches, and do anything else they hoped would keep him comfortable. However, he lived in horrible misery and tears until the day he died.

For me, spending so much time watching this happen was something that was burned in my soul. Why did anyone have to go through this? He didn't want to end his life this way! It was then I realized when nothing more can be done, it is time to move on to the other side with peace and dignity!

This experience is now even more personal for me. A year and a half ago I was re diagnosed with breast cancer that has traveled to my lung. I have been told by my doctors that it is stage IV, terminal, and the best they can do is try and treat the tumors that are there. However, the cancer is not curable, and I will have to go through chemo treatments for the rest of my life. Luckily I am doing okay right now other than the very uncomfortable side effects from the treatments. Sadly, though, I know at any time my situation could change. That is when I go back to what my friend went through! I absolutely do not want to go through that kind if torture as I await what I know is inevitable - Death! I strongly feel I should have the choice to die with peace and dignity and that the legislators of Hawaii can be compassionate and make that happen for me and all others like me!

Kay Caldwell

Sent from my iPad

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:16 PM
To: HLTtestimony
Cc: kairobinson@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Kristi Robinson	Individual	Support	No

Comments: As a Registered Nurse with 20 years of experience, and as a private citizen who wants choice and autonomy for myself and my loved ones when faced with a terminal medical condition, I strongly support Medical Aid in Dying, SB 1129 SD 2. I have cared for many, many patients as they are facing the final months of their lives. Even if their physical discomfort is reasonably well- controlled (which it often isn't, even with hospice care and palliative measures), patients express a great deal of emotional distress at the lack of control and options they feel during those final months. More than anything, they don't want to linger for a long period in a bed-ridden state. - This has nothing to do with "not wanting to be a burden" on their family. - They simply feel quite strongly that they no longer need or want to stick around just for the sake of sticking around, once they are past whatever their personal threshold is of debilitation. On a personal level, having seen many times, up close and personal, what "dying" looks like, I absolutely want the option to take my exit as I see fit. The ability to CONTROL my destiny at that time is of utmost importance. I bristle at people who object to medical aid in dying due to their personal religious or other beliefs. They have no right whatsoever to impose their beliefs on others. They can die in as prolonged a manner as they want to if faced with a terminal condition. - But don't force that on me or others who feel as I do. Again, I want the ability to have some control over my final exit, and I strongly support SB 1129 SD 2.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 8:12 PM
To: HLTtestimony
Cc: laurayw@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Lauray Walsh	Individual	Support	No

Comments: Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members. My name is Lauray Walsh and I'm writing in support of SB1129 SD2 "Relating To Health." Thank you for hearing and passing SB1129, SD2. Lauray Walsh 77-6483 Walua Rd. Kailua Kona, HI 96740 laurayw@yahoo.com 815-366-8309

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 8:41 PM
To: HLTtestimony
Cc: meosheepdog@yahoo.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Myra Oshiro	Individual	Oppose	No

Comments:

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kobayashi2 - Jessi

From: Patti Lynn <pattilynnmaui@gmail.com>
Sent: Tuesday, March 21, 2017 9:11 PM
To: HLTtestimony
Subject: Support sb1129 dying with Compassion

I support this bill

Patti Lynn
Makawao Maui
Sent from my iPad

kobayashi2 - Jessi

From:	alohadavis@hawaiiantel.net
Sent:	Tuesday, March 21, 2017 9:19 PM
To:	HLTtestimony
Subject:	SB1129 SD2 "Relating to Health."

Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members,

My name is Rose Davis and I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health."
I personally do not think we have any more right to decide when we die than we were born. Thank God a higher power than us makes that decision.
Thank you for your consideration.

Rose Davis
1621 Ulupii Place
Kailua, HI 96734
(808) 223- 5304
alohadavis@hawaiiantel.net

Sent from Mail for Windows 10

kobayashi2 - Jessi

From: Roxanne Fox <roxyfox@pixi.com>
Sent: Tuesday, March 21, 2017 9:36 PM
To: HLTtestimony
Subject: SB1129 SD2 Death with Dignity Bill Testimony

Name: Roxanne Fox

-SB 1129, SD2
-March 23, 2017
-House of Representatives Committee on Health

My parents were members of what used to be called the Hemlock Society back in the eighties and were adamant about wanting to die on their own terms and not have their lives prolonged with special measures if they had terminal illnesses.

This was not possible for either of them as they died in a state where a death with dignity bill had not passed.

Each of my parents, despite all their planning and ensuring their wishes were known by family and caregivers, died not as they'd hoped - i.e. letting go on their own terms - they died after months of lying helpless in a hospital bed. And each was in pain that could only be lessened - not stopped by medication that they were assured would keep them comfortable.

It is a harrowing experience even to witness such pain in loved ones. I hope the House Panel will pass this bill.

Mahalo,
Roxanne

Testimony for SB1129 SD2 – House Committee on Health
March 23, 2017, 8:30am, Room 329

By Wilma Youtz
P.O. Box 10273
Honolulu, HI 96816-0273

Representatives Belatti, Kobayashi, Har, Morikawa, Oshiro, Todd, and Tupola:

Thank you for your patience in hearing the impassioned testimony from both sides on the issue of physician-assisted suicide. This issue is so emotionally charged, for who in this room has not been touched by the sorrow and pain of losing a loved one to an untimely, if not difficult and painful, death?

Hawaii is the "Aloha State." It is my deep concern that Hawaii not become a "Pro-Suicide State" for many reasons. Human life is precious, from keiki to kupuna. **Our laws should serve to protect the lives of the weak and defenseless, not enable the unnatural demise of them**. What safeguards would there be against coercion and elder abuse? How can doctors fulfill their oath to "do no harm" if they are called upon to prescribe and condone lethal medication?

There have been notable advances made by modern medicine in the area of pain control. Doctors can now treat pain in terminally ill patients with a number of options, including palliative sedation as a last resort. And yet studies done by the state of Oregon, the first state to legalize assisted suicide, report that patients choose assisted suicide primarily because of reasons related to disability -- loss of autonomy, being less able to engage in enjoyable activities, and loss of dignity -- not due to fear of inadequate pain management. Hospice Hawaii has helped countless individuals and their families cope with impending death with love, comfort, and dignity. **Instead of sanctioning an irrevocable and deliberate means to end life through physician-assisted suicide, support should be given to organizations and services that can assist the terminally ill in addressing the psychological, social, and physical pain that disability can bring**.

There is a chilling aftermath seen in states that have legalized assisted suicide: rising rates of teen suicides. How effective are suicide prevention programs in schools if the law permits assisted-suicide among adults? **SB1129 sends the wrong message to our youth**. Moreover, with rising health-care and medical costs, it can segue far too easily into euthanasia. Will doctors prescribe costly life-saving treatments if assisting in suicide is better for the "bottom line" of their practices and insurance companies and their patients' pocketbooks?

There are many reasons to oppose physician-assisted suicide. But **the most profound reason can be found when one simply contemplates what causes and enables the human heart to continue beating from day 22 within an embryo until natural death. God knows the end of each of our lives from the beginning. Who would not**

want another year, month, week, day, or minute with a now-departed loved one? Let us seek ways to ease their pain without promoting their premature and unnatural death.

I am a member of Concerned Women for America of Hawaii. **I respectfully ask the Committee to vote "No" on SB1129**. Thank you for you serious consideration.

kobayashi2 - Jessi

From: Space Options <design@spaceoptions.com>
Sent: Tuesday, March 21, 2017 8:04 PM
To: HLTtestimony
Subject: SB-1129.SD2 - Testimony -Against Aide to Die, Physician Assisted Suicide, Compassionate killing, Love by killing

If we ratify physician assisted suicide we may be helping a very few, elite, highly educated, individuals.

But we neglect many;

- Teen agers in particular are susceptible to suicidal thoughts. If it is legal we may be legitimizing and elevating suicide as an option for teenagers.
- Individuals with disabilities who may have only 6 months to live as sanctioned by a doctor, may be compelled to take the poison, but what if the doctor is wrong, or what if that individual changes their mind at the last minute will there be someone there ready to rescue them?
- The elderly who perceive that they are a burden will feel guilty and may be coerced thinking it's better for their family for them to be dead. That is not compassion. Look at it from the perspective of the most vulnerable to this bill. Not from the perspective of the few who are pushing this bill.
- Dying does not cause you to lose your dignity.
- When has drinking poison or taking a poison pill looked so dignified.
- I can just see the ad on TV. It seems to look dignified because the person is in the room alone with the poison.
- How dignifying will you look when you are found by someone?
- How does that person who found you know that you did it to yourself and it was not someone else? With that lethal poison in your house, what about your family and children?
- When I saw the PBS special of the fellow with Lou Gehrig's disease all I saw was a man with fear in his eyes and his wife repeatedly telling him he needed to go through with it because he agreed to do it. She was the caregiver. I kept hoping the camera crew or interviewer would see the fearful look in his eyes and say something to him. No one did they all stood aside like it was their duty there was no compassion.
- Why does this bill only provide one way to go with no way to return if you change your mind. Who will be in control of your life in the final moments if you change your mind, you or the doctor? What choice will you have then?
- Will there be witnesses there when you decide to take the pill? Someone who'll watch over you in case you change your mind with emergency medical assistance to stop the procedure and get you back? We all have changed our minds.
- Would you want your kids to grow up in a society the equates compassion as killing? Or have Love is given in a form of a poison help you die?
- Associating the word compassion or love to assisted suicide is 180 degrees from the truth.

- Compassion equals grace, grace equals charity, caring, through the good time and hard times. That equals is love.
- Does helping someone die really help them feel better or does it help you feel better?
- Nothing about physician assisted suicide is about compassion or love.
- Hawaii is known as a place where beauty and life flourishes.
- Where Grace and Charity flourishes and hearts open to help no matter what they need to face.
- The Hawaiian Way is to show Compassion and Grace in the face of despair, hopelessness, and fear, and shower those in crisis with warm aloha.
- Think of it, what are we saying here, come to Hawaii we will help you die? Will that be in our visitor ads too? There is no advantage no priority to justify having this law in Hawaii.
- Hawaii is not the place to come to have a physician hand out death.
- It is the place with opportunities to flourish and live life with all the aloha in it.

Jean Tessmer

THE SENATE
THE 29TH LEGISLATURE
REGULAR SESSION OF 2017

MARCH 22, 2017

HOUSE COMMITTEE ON HEALTH
REPRESENTATIVE DELLA AU BELATTI, CHAIR
REPRESENTATIVE BERT KOBAYASHI, VICE-CHAIR
MEMBERS OF THE COMMITTEE

RE: SB 1129 SD2 –TESTIMONY IN STRONG OPPOSITION

I am a registered nurse. I strongly oppose SB 1129, SD2. I have spent my entire profession career caring for people in all stages of life, from the tiny, premature infant fighting to grow strong enough to go home to their loving parents to the octogenarian during their last moments surrounded by loving family and friends. Each of their lives was a gift that they, their parents and families treasured.

"Death with Dignity" has nothing to do with dignity. It is an attempt to lend respect to a practice, suicide, which has always been consider both a tragic choice for the person involved.

Proponents talk about this legislation as being compassionate. Once again, it has nothing to do with compassion. It crosses the line between caring, which is real compassion, and killing, which is immoral and criminal.

As legislators and representatives of all of the people of Hawai`i please be cautious about legalizing killing in any form. Please remember that a host of profession, religious, abuse prevention and disability rights organizations, including those listed below, have rejected this pro-death and anti-life law because of the danger it presents in facilitating the abuse and killing of very vulnerable people in our community:

Hawaii's Partnership for Appropriate and Compassionate Care (HPACC)
Hawai`i Family Advocates
American Medical Association
American Nurses Association
American Association of People with Disabilities
Autistic Self Advocacy Network
Church of Jesus Christ of Latter-day Saints (Mormon Church)
Disability Rights Center
Disability Rights Education and Defense Fund
Episcopal Church
Focus on the Family
Jewish Churches in America
National Council on Disability
National Council on Independent Living
National Organization of Nurses with Disabilities
National Spinal Cord Injury Association
United State Conference of Catholic Bishops
World Association of Persons with Disabilities

In addition to my opposition to SB 1129, SD2 for the reasons stated above, I have additional concerns associated with specific wording in the proposed legislation.

1. Related to the definition of both the "attending provider" and the "consulting provider" found on Page 10 of the proposed bill. Both of these definitions include the "advanced practice registered nurse" (APRN) as a healthcare provider; the "consulting provider" definition includes the words "…prognosis regarding the patient's disease." In doing a review of the current Hawai`i Nurse Practice Act I was unable to find evidence that determining a patient's prognosis is within the APRN's scope of practice.

2. Related to method of documenting the patient's cause of death. It appears, from the wording in the proposed bill that the underlying terminal illness would be used as the patient's cause of death. Why would the immediate cause of death not be included? Providing complete information would facilitate the review of records of individuals who die as a result of "physician assisted suicide". Not including this information on the death certificate makes it impossible to assure patients, families and the public at large that safeguards written into the proposed legislation have, in fact, been maintained.

3. Access to medical records of patients electing to use "patient assisted suicide" also seems to be restricted to the Department of Health for an "annual review of a sample of records maintained…" This will make quality assurance and research on physician assisted suicide by independent groups difficult if not impossible.

Hawai`i is known for its "aloha " spirit and values it so much that is written into Hawai`i state law. (*Hawai`i Revised Statutes§5-7.5)* As you consider this legislation please consider the many and clearly delineated reasons for opposing this legislation and any others like it.

Thank you for allowing me to submit testimony on this very concerning legislation. My prayers are with you as consider this bill.

Aloha,

Susan M. Slavish, RN, BSN, CIC

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 6:44 PM
To: HLTtestimony
Cc: waterfromarock@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Addie Elliott	Individual	Comments Only	No

Comments: Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members, My name is Addie Elliott and I am writing in OPPOSITION to SB1129 SD2 "Relating to Health." Thank you for you hard work in keeping our citizens safe. Addie Elliott 1219 Rycroft St. Honolulu, HI 96814

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 7:16 PM
To: HLTtestimony
Cc: andrewapang@aol.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Andrew Kamoku	Individual	Oppose	No

Comments: Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members, My name is Andrew Kamoku and I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health." Thank you for your consideration. Andrew Kamoku 2019 Puna St Honolulu HI 96817 1(808)931-0296

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kobayashi2 - Jessi

From: AnnePierce <mauianne22@hawaii.rr.com>
Sent: Tuesday, March 21, 2017 6:57 PM
To: HLTtestimony
Subject: Please support aid in dying (SB 1129)

Hello. Please support SB 1129, Medical Aid in Dying. I have worked with many dying people and have seen some get to the point of such struggle and pain, only the gift of death could bring relief and dignity to their life. Please, let's honor those who need this assistance to end their life in peace.

Mahalo,
Anne Pierce
Haiku

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 6:53 PM
To: HLTtestimony
Cc: ariannafeinberg@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Arianna Feinberg	Individual	Support	No

Comments: As a Democrat I strongly support Medical Aid in Dying. Although we can prolong people's lives with our modern medicine, it's not always the best quality of life. Give people choice and compassion to do what they want at the end of their life.

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kobayashi2 - Jessi

From: Diane Ware <volcanogetaway@yahoo.com>
Sent: Tuesday, March 21, 2017 6:29 PM
To: HLTtestimony
Subject: SB1129 In Support

Dear Senators,
Please pass this bill, this session. I am 69 and feel I need to have this possibility as I age. If not I need to move somewhere it is possible, such as California, and I.
Thank you for your compassionate vote for this bill.

Diane Ware Volcano Hawaii 96785 808-967-8642

Diane Ware

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 6:35 PM
To: HLTtestimony
Cc: lguerrero4992@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Enrica Guerrero	Individual	Oppose	No

Comments: Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members, My name is Enrica Guerrero and I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health." Thank you for your consideration. Enrica Guerrero 95-1038 Keni Street Mililani, HI 96789 808-673-3457

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HOUSE OF REPRESENTATIVES
THE TWENTY-NINTH LEGISLATURE
REGULAR SESSION OF 2017

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

TESTIMONY SUPPORTING SB1129 SD2
FOR
Thursday, March 23, 2017
8:30 AM
Conference Room 329
Hawaii State Capitol

Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members,

My name is Jacqueline Wright and I'm writing in support of SB1129 SD2 "Relating To Health."

I'm 85 years old and may be needing this law in the future. I and many other residents of Hawaii will benefit in innumberable ways from its passage. I'm sure you are all aware of the overwhelming support of the people of Hawaii for this law, as well as the safeguards provided in the law. Death With Dignity allows the terminally ill to decide for themselves what's best for them and to regain control over their illness and the conditions of their death.

Similar laws are already in effect in Oregon, California, Colorado, Vermont and Washington State. The option to die a peaceful death at the time and place of their choosing provides the terminally ill with invaluable peace of mind at an extremely private time of their lives.

I believe your compassion, reason and common sense will prevail and you will pass SB1129, SD2.

Mahalo,

Jacqueline Wright
67-5165 Kamamalu Street 3A
Kamuela, HI 96743
808-885-4210

kobayashi2 - Jessi

From: Jan Gaffney <janotterskykoalani@gmail.com>
Sent: Tuesday, March 21, 2017 6:54 PM
To: HLTtestimony
Subject: Medical Aid in Dying Act

Our family of three adults over the age of 70 years lived in Oregon where this type of aid is available. We are all for this act to pass here in Hawaii. Many safeguards are in place to protect us "Kapuna".

We have seen many loved ones suffer greatly and not just elders. The choice should be with the patient that is suffering without the ability of Doctors to control their pain.

We want that choice if we are in such a situation.

Jan and Howard Gaffney and Shirlene Hanson

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 6:27 PM
To: HLTtestimony
Cc: karibenes@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Kari Benes	Individual	Oppose	No

Comments:

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Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members,

My name is Michael Beverford and I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health." Thank you for your consideration.

Michael Beverford
1216 Pua Lane
Honoluul, HI 96817
808-277-2263

Dear Chairman and Committee Members,

I ask you to please vote no on SB1129. The so-called "right to die" may soon become the "duty to die" as our senior, disabled and depressed family members are pressured or coerced into ending their lives. At a time when health insurance coverage is in flux for millions of Americans, discussions of legalizing doctor prescribed death seems especially dangerous. In a dollar-driven environment, it's too tempting for death to become a reasonable substitute to treatment and care when medical coverage is uncertain and medical costs continue to rise.

Every day patients demonstrate their faith in the medical profession by taking medications and agreeing to treatment on the advice of their physicians. Patients trust that the physicians' actions are in their best interest with the goal of protecting life. Physician-assisted suicide endangers this trust relationship by making physicians actors in a patient's death.

In one instance in the Netherlands, a doctor had the family members hold their elderly relative down while she injected the lethal drugs into the patient. She had them hold her down because the patient was flailing and screaming that she did not want to die. The doctor has been formally reprimanded because the patient was suffering from dementia and could not properly consent. The doctor should have been charged with murder. Please do not pass this bill that will lead down a dangerous slippery slope, from those wanting to die, to others killing off the elderly, disabled, and undesirables. Thank you.
Quentin Whitehurst

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 6:44 PM
To: HLTtestimony
Cc: rayrayjay@hotmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
rediate	Individual	Oppose	No

Comments:

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 7:16 PM
To: HLTtestimony
Cc: emorocker808@aol.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Salome Jones	Individual	Oppose	No

Comments: Life is precious, at every stage.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 7:15 PM
To: HLTtestimony
Cc: sgardner@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Sheryl P Gardner, M.D.	Individual	Support	No

Comments: I have been a Mililani resident the past 30 years and Mililani physician until my retirement 5 years ago. However it is as a previous Oregonian with continued Oregon ties that I have followed Oregon's Death With Dignity Act, now almost 20 years old. Oregonians remain strongly supportive of their law. It has not been abused. Concerns being raised in Hawaii were also raised in Oregon in the 1990's. After the law was implemented these dire scenarios did not happen. I strongly urge the Hawaii Legislature to pass SB 1129 to give Hawaii residents expanded end of life options.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 6:25 PM
To: HLTtestimony
Cc: onlyJESUS.wtr@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Walter Rickard	Individual	Oppose	No

Comments: Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members, My name is Walter Rickard, Jr and I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health." Thank you for your consideration. Walter Rickard, Jr. 46-153B Haiku Rd. Kaneohe, HI 96744 (808) 235-0718

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 4:17 PM
To: HLTtestimony
Cc: shayb316@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Achaia Wong	Individual	Support	No

Comments: If I should ever have a terminal disease or pain that is unbearable I want the option to choose if I live or die. I would like medical assistance to be an option available to me if I decide to end my life.

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kobayashi1- Oshiro

From: Adele Ching <smokyvally@aol.com>
Sent: Tuesday, March 21, 2017 8:38 AM
To: HLTtestimony
Subject: Supportive Testimony for SB 1129 SD 2

I strongly urge the 2017 Hawaii State Legislature to pass SB 1129 SD 2 to provide for medical aid in dying. Choosing to die is not a decision taken lightly or frivolously; but ultimately, human beings should have that choice as a legal right.

Sincerely,
Adele S. Ching
Member, Hawaii Democratic Party
Ululani Street, Kailua HI

Sent from my iPhone

Sent from my iPhone

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 8:18 AM
To: HLTtestimony
Cc: athurston@irmt.org
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Anne Thurston	Individual	Support	No

Comments: I support this bill strongly. It would make an enormous difference to the peace of mind of the terminally ill and their families if they were able to die at home. There are many safeguards in place, and the evidence of the process in Oregon gives us great confidence that the system will work well. Please pass this into law.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 5:40 PM
To: HLTtestimony
Cc: ariellekline@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
arielle	Individual	Oppose	No

Comments:

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 4:28 PM
To: HLTtestimony
Cc: surfzone@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Betty L. Bodlak	Individual	Comments Only	No

Comments: As a retired RN, as a person 82 years of age, and as someone who has dealt with end of life issues directly both personally and professionally I want to offer my support for this Bill. I read the details thoroughly and feel with the history from five other states over the past two decades there are assurances built in and thus it can provide for those who meet the very specific criteria the peace of mind only those in such situations can appreciate. Passing this Bill says that the State of Hawaii understands that there is a difference between extending life merely, and at all costs, and dying peacefully and with dignity and personal choice over the most personal of decisions. It is not for everyone, no question. But we are fortunate to have other states' experience to show us the benefits and safety of passing this Bill for those who will benefit from this option as they face their last days.' Most seriously, Betty L. Bodlak Haleiwa

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March 23, 2017

Representative Della Au Belatti, Chair
Representative Bertrand Kobayashi, Vice-Chair
State House Committee on Health
State Capitol
Honolulu, Hawaii 96813

Dear Chair Belatti, Vice Chair Kobayashi, & Committee Members:

Re: Support of SB 1129, SD 2

Please allow terminal ill patients and their family members to have the ability to voluntarily request and receive prescription medication for self-administration so they can die in a peaceful and dignified manner.

Family members already have the legal right to instruct medical personnel to remove life support whether or not the patient has signed consent on a Health Care Directive or PLOST. Passage of SB 1129 is another vehicle to for patients with the mental capacity to make life chooses before entering a critical state.

This has nothing to do with religion. Those patients and family members whose faith prohibits this course of humane action have the right not to exercise this option. However, their religious belief should not be imposed on others.

When it is my time, I want to have the option to go peacefully rather than go through the ravages of prolonged and painful death. It will spare our love ones the emotional ordeal and expense.

I urge your support on SB 1129, SD 2.

Sincerely,

Brian Tamamoto

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 8:30 AM
To: HLTtestimony
Cc: danny.melton@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Danny Melton	Individual	Oppose	No

Comments: Dear Rep. Della Au Belatti, Chair and Rep. Bertrand Kobayashi, Vice Chair I strongly oppose SB 1129 Medical Assisted Suicide. Having recently my best friend to ALS and my father to cancer, I witnessed to men who loved life, their families, and both who wanted to live as long as possible to be with their families. Despite their debilitating pain, they believed life was worth living especially since they were surrounded by family and those who care. Life is a gift. I believe this bill does not provide protections for the elderly and emotionally vulnerable individuals who have been diagnosed with potentially terminal diseases that a physician opines will end their lives in six months or less. There are many who with positive emotional support would not want to end their lives by their own hands artificially. Additionally people who are under significant emotional stress can be subject to coercion. Especially the elderly. With positive emotional and palliative care--those who are at the end of life's journey can live out their lives with the dignity God intended for all humans. Please do not allow this bill to move forward. Mahalo for your service to our Hawaii and its people. Respectfully, Danny Melton Colonel, U.S. Marine Corps (ret) Waipahu, Hawaii

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kobayashi2 - Jessi

From: Ellen Dumonceau <ellen.dumonceau@gmail.com>
Sent: Tuesday, March 21, 2017 4:34 PM
To: HLTtestimony
Subject: HR1129

This is aa letter in support of legislation that allows terminally ill people the option of medical aid in dying. as a 74 year old woman it is critically important to me to have my autonomy respected in making choices regarding my health care.
like most people i want my death to be a peaceful one at home with the people and animals i love nearby.

i see both life and death as fundamentally sacred and this option is one way to honor death, not as an enemy to be overcome at all costs, but as part of the natural cycle of life that no longer needs to be feared because one may be forced to endure unbearable pain and suffering.

thank you,
Ellen Dumonceau
45-657 Halekou Pl.
Kaneohe, HI.96744
tel. 523-0783

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 4:39 PM
To: HLTtestimony
Cc: fmnhawaii@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Francis Nakamoto	Individual	Support	Yes

Comments: Comments: Chair Belatti, Vice Chair Kobayashi and members of the House Health Commerce Committee, I speak in support of SB 1129. For over a year before my 96-year old mother passed away of heart failure, she constantly talked to her children to let her die. She was in constant pain after she suffered a spinal injury which left her bed ridden. Just years before, she enjoyed life, was able to walk with assistance, and even take an occasional trip to Las Vegas. Several months before she died, she was diagnosed with colon cancer. During the last month of life, she pleaded with us to let her go. By then, massive bed sores caused by lack of blood pressure and immobility racked her with pain with every movement on top of her severe back pain. Yet, her family could do nothing for her. As an attorney, I knew fulfilling her last wish was impossible and illegal. Hawaii had no medical aid in dying law. Current law would allow her doctor to provide only palliative care. Anything more would put her doctor at risk of criminal prosecution, just to grant her last wish. You have the power to change that for people, like my mother, who only wish to die with dignity and end their excruciating suffering. It is no one else's business to force my mother or anyone else like her to endure all the suffering she bore once she decided it was past time to end her miserable existence. SB 1129 will finally allow people, like my mother, in the last days of their livee, to die as they wish once their prognosis is terminal. It provides adequate safeguards to assure that a dying person truly wants to die when they so choose to and on their own terms. It is not suicide. They are already dying. No one else but the dying can make that decision. Their last moments will be calm, peaceful and dignified, allowing them to avoid the unbearable pain and suffering which are often related to death today. It has been 15 years since this State seriously considered giving dying persons the right to die with dignity. Thousands of our citizens have been denied that basic right since then, including my mother. Let's not deprive thousands more, including persons like myself who are getting older and prone to having serious health issues, the right to dignity and peace in their last days. Please pass SB 1129. Thank you.

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kobayashi2 - Jessi

From: semlib1@gmail.com on behalf of Jack Bilmes <bilmes@hawaii.edu>
Sent: Tuesday, March 21, 2017 4:06 PM
To: HLTtestimony
Subject: SB 1129

Dear Committee members:

I am writing to request that you pass SB 1129. Put simply, why should some of us have the right to tell others that they must die in prolonged agony? To my knowledge, there is no evidence of abuses in states that allow medical aid in dying. Surely, appropriate regulation is all that is required.

To me, this is the most important decision that you will be called upon to make.

Thank you for considering my opinion,
Jacob Bilmes
1212 Punahou St. #1008
Honolulu, HI 96826

Testimony Presented Before the House Committee on Health

March 23, 2017, 8:30 AM

SB 1129 SD2 – RELATING TO PHYSICIAN ASSISTED SUICIDE

Chair Belatti, Vice Chair Kobayshi, and Members of the Committee:

Thank you for this opportunity to testify in the **strongest opposition** of SB 1129 (and all the similar proposals) which would permit physicians to authorized deadly amounts of medications to terminally-ill patients for the specific purpose of assisting their commission of suicide.

While this may be seen by some as well intended, it is **simply outrageous** in so many ways. It appears to be totally in opposition of the physicians' basic Hippocratic Oath. For millennia, a physician's function has been to defend, protect, and assist life: "**First, do no harm**".

Physicians cannot be allowed to act as **surrogate executioners**, by providing intentional access to the tools of death, for the very purpose of death. It's not a "maybe"; it's "bang, your dead".

It is **not** at all the same as providing genuine palliatives, for the purpose of relieving or minimizing pain during the final stages, which might lead to a slight acceleration of death.

Shall we next pass a law that says, "If a physician certifies that a patient in terminal, then someone off the street, without any liability, can sell a gun and ammunition to the patient for the specific purpose of aiding the patient to commit suicide"? Where else could this then take us?

It's a bit messier, perhaps, yet a shot to the temple will instantaneously render the patient unconscious, and unable to experience pain. Technical death -- the heart stopping -- follows very shortly thereafter. That might start a whole industry for suicide kit providers.

To begin with, and no matter what some other States may have done, this is simply **not right**. Beyond that, it opens a door to a very slippery slope that threatens to undercut the value of human life itself.

This Bill is a **really bad idea**, in and of **itself**, it is **fraught with unintended consequences**, and it is **fundamentally immoral**.

There are very few, if any, families that have not had to endure the pain of watching loved ones pass away over time due to disease, major injuries, and so forth. While not yet perfect, we have good tools to manage the patient's pain, and those should be used for that purpose only.

Mahalo for your consideration,

James R. Kennedy, PhD
jimkennedy@hawaii.rr.com
808 937-5387

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 8:09 AM
To: HLTtestimony
Cc: talljoann@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
joann tall	Individual	Support	No

Comments: This is so critical to the individual rights of each person. I have watched both of my parents suffer needlessly because they were not allowed to choose how they dealt with their end of life issues. This bill will allow each person their personal choice and that is the American way.

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Testimony of John M. Knox to
HOUSE COMMITTEE ON HEALTH
In Support of S.B. 1129
March 23, 2017, State Capitol Conference Room 329

Chair Belatti, Vice Chair Kobayashi, and Members of the House Health Committee, my name is John Knox, and I strongly support Senate Bill 1129.

I mentioned my support for this bill to a physician friend of mine (whose own practice does not involve care for the terminally ill). The doctor shrugged. "We don't need to get all legal about that," was the response. "It's handled all the time on an informal, unspoken basis. You know – just leave the bottle of morphine out for the patient."

This is a friend of mine, a good person. I didn't want to pick a fight, but I thought, "Wow, does everyone get that opportunity, or just some people? If it's someday offered to me, but in an unspoken way, will I in my pain even understand the opportunity? It may be common for this doctor and certain other ones, but if I actually asked – and in a state of agony didn't know how to be subtle about it – how would I know if my own life's-end doctor would also shrug and leave that bottle out for me, or instead put me under watch? Would I know if it had the right amount for me, or just make me feel worse?"

We should all have the right to end our suffering peacefully and legally, without having the sense we're breaking the law and traumatizing our family by some unexpected and grisly form of suicide. And those doctors who do wish to assist should have that right, too – in a forthright and legal fashion. Thank you for your attention.

John M. Knox, 808-342-3749, johnmknox808@gmail.com
41-858 Laumilo St., Waimānalo HI 96795

kobayashi1- Oshiro

From: Island Man <islander119@hotmail.com>
Sent: Tuesday, March 21, 2017 9:30 AM
To: HLTtestimony
Subject: SB1129 SD2

HOUSE OF REPRESENTATIVES
THE TWENTY-NINTH LEGISLATURE
REGULAR SESSION OF 2017

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

TESTIMONY SUPPORTING SB1129 SD2
FOR
Thursday, March 23, 2017
8:30 AM
Conference Room 329
Hawaii State Capitol

Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members.

SB1129 SD2

Thank you for hearing and passing SB1129, SD2.

The latest Hawaii poll (Fall of 2016) revealed that "eight out of 10 Hawaii voters (80%) agreed that a mentally capable adult who is dying of a terminal disease that cannot be cured should have the legal option to request prescription medicine from their doctor, and use that medication to end their suffering in their final stages of dying." A majority of Catholics (82%), and I am apart of that majority and those associated with the Christian Fellowship (83%) said terminally ill adults definitely or probably should have this legal option.

Joseph Basque
568 Kalanikoa St.
Hilo, HI 96720
961-4631

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 5:24 PM
To: HLTtestimony
Cc: ppchawaii@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Judith A Mick	Individual	Support	No

Comments: It is not just that people who are dying should have the right to choose how they die , it's that the rest of us who are not suffering do not have the right to deny them that choice. Please pass SB1129. Mahalo. Judy Mick, Kailua

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March 21, 2017

TO: Honorable Chair Belatti and Members of House Committee on Health

RE: SB 1129 Relating to Health
Support for hearing on March 23

I am a private citizen with a strong interest in the rights of individuals in our democracy and today's world to make their own informed decisions when such decisions do not harm others.

I support SB 1129 SD2 to establish a death with dignity act under which a terminally ill adult resident may obtain a prescription for medication to end the patient's life. Should the time come when I am terminally ill, I expect to be able to make a personal decision about whether and when to end my life and not be forced by others and by law to endure meaningless pain and suffering. I say this as a private citizen who is enabled to make other decisions about my own health and well-being, so should also be able to do so about my own death.

This is not a philosophical issue for me, as I am in my 70s and will die within the foreseeable future, one way or another. I support this bill and the death with dignity act it will establish as a person who has been treated successfully for cancer. While I survived one episode through chemotherapy and major surgery, I have lived a rich and full life. If there is a reoccurrence, I am fully aware that my chances of survival would be remote. We will all die eventually, and my personal choice is to die with dignity—not have my family and loved ones see and try vainly to support me to no avail. It is wrong to force terminally ill patients to tolerate pain and suffering that serves no purpose other than stripping away one's final shreds of dignity through a slow and miserable death. Just as I would not force another person to end his or her life, I believe that it is no one else's right to force me to live when terminally ill.

Thank you for your consideration.

Sincerely,

Luanna H. Meyer, Ph.D.
Professor Emerita, Education

kobayashi2 - Jessi

From: Lynn Allen <maui.acudoc@gmail.com>
Sent: Tuesday, March 21, 2017 4:01 PM
To: HLTtestimony
Subject: SB1129

Thank you for hearing this important bill.

I am in complete support of SB1129.
We afford this dignity to our animals; we should surely allow it for ourselves as well.

Lynn Allen
Kihei, HI
96753

Sent from my iPad

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:57 AM
To: HLTtestimony
Cc: carrmaria@hotmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Maria Pena	Individual	Support	No

Comments: Dear Committee members, I would like to express my strong support for SB 1129 establishing medical aid in dying for the state of Hawaii. I was first introduced to the issue of Death with Dignity when I learned about the story of Brittany Maynard, a young newly wed diagnosed with a terminal illness in her late 20's. I was extremely touched by her story and that of others who receive the horrific news of imminent death due to an terminal illness. I believe government should assist those that are underrepresented and in need of our assistance most and these principles apply definitively to the Medical Aid in Dying issue. Patients diagnosed with a terminal illness should have the opportunity to choose what is best for them with respect to their bodies. Why should anyone get to decide what is in the best interest of a terminally ill patient due to skewed perception and/or misguided religious principles? Death with Dignity at its core is about the right to choose. We should leave the decision for medical aid in dying, which no one takes lightly and is undeniably agonizing, to the patient who is affected by the diagnosis. We must respect the wishes of patients who are at the end of their life and suffering. I would want nothing less for myself or my family. Thank you for the opportunity to share my thoughts on Medical Aid in Dying. Mahalo, Maria Peña

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 4:32 PM
To: HLTtestimony
Cc: bob-marion@hawaiiantel.net
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Marion McHenry	Individual	Support	No

Comments: I feel that this is a very important bill. This bill has been carefully crafted following the bills from other states. We need to have support in our state for those who are suffering with painful, terminal illness. I strongly support this bill.

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kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:58 AM
To: HLTtestimony
Cc: lukesarvis@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Luke Sarvis	Individual	Support	No

Comments:

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 6:15 PM
To: HLTtestimony
Cc: Nathanlodico7@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Nathan Lodico	Individual	Oppose	No

Comments: Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members, My name is Nathan John Lodico and I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health." Thank you for your consideration. Nathan Lodico 1402 Piikoi Street 805-302-4823

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kobayashi1- Oshiro

From:	chingston@hawaii.rr.com
Sent:	Tuesday, March 21, 2017 9:50 AM
To:	HLTtestimony
Subject:	*****SPAM***** Supportive Testimony for SB 1129 SD 2

I am not terminally ill. I have had direct experience with dying family and friends who said the following: "I'm too tired to go on", "I feel so helpless and powerless", "I just want to die, but I keep waking up" , and the comment that lingers with me, "I don't want to sleep into death, I want to be alert and smile."

I want the autonomy and freedom of choice for how, when and where I die. Currently, I need to fly off island, leaving behind friends and family (big one), establish short-term residency, cause my own death, and have my remains flown home for burial. This does not seem anxiety-free, and this is not how I want my end of life to play out.

Please add Hawaii to the list of states who have this law. There is no slippery-slope as evidenced by the outcomes from Oregon's law.

Thank you,
Pandy Ching

kobayashi1- Oshiro

From: Nelson Higa <nelhiga5@yahoo.com>
Sent: Tuesday, March 21, 2017 9:59 AM
To: HLTtestimony
Subject: Supportive Testimony for SB 1129 SD 2

Dear Legislative Leaders,

I supportive SB 1129 SD 2, which establishes a regulatory process under which an adult resident of the State with a medically confirmed terminal disease may obtain a prescription for medication to be self-administered to end the patient's life.

I believe if I was stricken with a terminal, painful illness with only a number of months to live, I would like to choose when to end my life. I want that choice.

Thank you for considering my testimony.

Nelson.

Nelson Higa
3009 Ala Makahala Place #708
Honolulu, Hawaii 96818

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 4:47 PM
To: HLTtestimony
Cc: shannonkona@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Shannon Rudolph	Individual	Support	No

Comments: STRONGLY SUPPORT!

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kobayashi2 - Jessi

From: Susan Parks <scparks@alumni.usc.edu>
Sent: Tuesday, March 21, 2017 5:43 PM
To: HLTtestimony
Subject: Support of Medical Aid in Dying

My father-in-law passed away in the 1980's and until then I would have opposed this legislation. But let me tell you what happened to change my mind.

Paul J. Parks had cancer and had stopped chemotherapy. His was in his late 70's age-wise. He was tall (6 ft 4 in) and a robust man who in his younger days was a lumber jack. He served in the US Army, WWII, and later was a lifetime professional musician.

As stomach cancer took its toll, he was ended up skin and bone, slightly below 99 pounds, but he lived month after month, beyond expectations, his heart kept beating. I read to him most nights. I was an elementary principal at the time and there were some nights I had to work. I stopped going to choir rehearsal on Thursday nights and church on Sundays to help him and his wife Sylvia, who lived another 20 years.

Each night when he tired I would close the book and he would say his prayers, asking God to take him, to spare him such great pain, discomfort, indignity and to spare his dear wife Sylvia. He did NOT want to wake up the next morning. One night he was in such pain, and taking the maximum medication allowed, that he cried and angrily said, "We treat dogs and horses better than I am being treated. None of my dogs ever suffered such pain for so long". That was the moment. Why could we not have eased his tremendous pain? Why could he not have chosen to say enough is enough? It was dreadful for him and to watch him suffer so. Family could have gathered at his request and been there, all of us, at his passing.

Fast forward to July 2015. My husband was being treated for a different cancer at Queen's Cancer Center, Punchbowl He had successful chemo but then the cancer roared back and my husband of 48 years, Gary L. Parks, decided to do no more chemo. He accepted hospice and made decisions regarding his care. Although he never complained until his final dialysis session, which he stopped part way through because sitting in the chair, his six foot frame down to the 150's did not have enough fat to cushion that chair, we talked and he, who NEVER missed a dialysis session (he treated it as his job in retirement), decided that if he was in too much pain, he would simply stop going to dialysis. He knew that it would just take a couple of weeks max and he would go gently into that night. He did not want to even come close to the same fate as his father. We did not reach that point--I say we because his cancer certainly was a family affair, just as his father's was.

With Hospice's help and supervision, he finally slept deeply and simply did not wake up. His final words, ironically, were to tell us to be sure to wake him in plenty of time to get ready for dialysis. We could not waken him, his organis were failing, his respiration slowly, and after four days of sleep, he gently passed in the night. How much better that was for all of us. His three adult children came from the mainland to be part of the hospice conversation and they knew the dialysis "back door" if needed. They understood and were at peace with his decision, which as it turns out, he did not need to trigger and we were all there.

This is clearly a difficult decision to put into law, but it is clear that in this day and age we should do that and do that carefully. As I learned from my father-in-law and then my husband, we should treat our dear family, the people we love, as kindly as our pets.

My dear husband of 48 years, Gary Leigh Parks, rests at the National Cemetery of the Pacific in the company of other veterans and their loved ones.

Sincerely,

Susan Parks

--

Dr. Susan C. Parks
626-786-5172 cell
808-888-2630 home

Kapolei, Hawaii

kobayashi1- Oshiro

From: Marcia Berkowitz <mberkowitz@vocationoptions.com>
Sent: Tuesday, March 21, 2017 10:17 AM
To: HLTtestimony
Subject: SB1129 SD2 TESTIMONY

To

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Rep. Sharon E. Har
Rep. Dee Morikawa
Rep. Marcus R. Oshiro
Rep. Chris Todd
Rep. Andria P.L. Tupola

NOTICE OF HEARING

DATE: Thursday, March 23, 2017
TIME: 8:30 AM

Testimony of Marcia Berkowitz:

I am adamantly opposed to this bill as it will allow for "physician shopping". It does not account for depressed individuals seeking out physicians who will administer prescriptions for end of life. Where is the Aloha spirit for these individuals?
In addition:

.

A tremendous amount of misinformation is being broadcast about this bill. Some examples:

- Advocates for this law claim the majority of Hawaii citizens are in favor. There is no objective evidence of this. A mainland group called Compassion & Choices, formerly the Hemlock Society, committed $250,000 to pass the law this year. This is all money coming from a mainland organization whose reason for being is to promote legalizing assisted suicide.

- Proponents claim the bill has safeguards. This is false on its face. There is no mechanism for accountability in the bill. There is no transparency in record keeping. There is no requirement for a patient to be evaluated for possible depression or coercion. Once the lethal medications are issued, there is no system for making sure they are either used or returned. A simple test for a safeguard: If a provision in the law is not followed, what is the consequence? There are no consequences for failure to comply with the already limited provisions in the bill, therefore there are no safeguards.

- Advocates claim there have been no problems with the Oregon law. This is false. Oregon doctors have testified at the Hawaii Legislature in prior years about failures and corruption in the

Oregon law. But since in Oregon there are no safeguards, no consequences to non-compliance, no tracking of medications, no open records, no independent audit, and records are not kept but destroyed, there is no way to present uniform accepted data for peer review. But there are abundant anecdotal records of abuses of patients as a result of PAS in Oregon. These failures and abuses fall disproportionately on the poor, the elderly, and those of limited competence and capability – exactly the people who should be protected.

Thank you,

Marcia Berkowitz, Certified Rehabilitation Counselor, Licensed Mental Health Counselor
P.O. Box 2
Kahului, Hi 96733
808-298-4142

kobayashi1- Oshiro

From: Randall Steverson <rsteverson@gmail.com>
Sent: Tuesday, March 21, 2017 11:00 AM
To: HLTtestimony
Subject: Support Medical Aid in Dying Act

I strongly support the Hawaii Medical Aid in Dying Act (SB 1129).

I have known loved ones who suffered greatly while dying. My paternal grandmother lay in her hospital bed and asked God why he was causing her such suffering. She would have been grateful for relief from such agony. My maternal grandfather had a serious stroke that left him completely paralyzed and barely able to speak. He said he only wanted to die, but had to linger on for six months.

I believe we should not have to endure such pain and suffering. Medical aid in dying is a compassionate choice.

Please vote to send the Medical Aid in Dying Act for a full vote of the House.

Thank you.

Randy Steverson

kobayashi1- Oshiro

From: richardcgoodman@juno.com
Sent: Tuesday, March 21, 2017 10:38 AM
To: HLTtestimony
Subject: Supportive testimony for SB 1129 SD2

Last year my sister June Parker in Seattle was diagnosed with stomach cancer. She grew weaker day by day and was in pain. She opted for Death with Dignity and with her four children at her bedside, she died peacefully in November. It was a great blessing for her and her family.
Richard Goodman

kobayashi1- Oshiro

From: Alfred Resch <resch.lan-hnl@hotmail.com>
Sent: Tuesday, March 21, 2017 11:00 AM
To: HLTtestimony
Subject: SUPPORT MEDICL AID IN DYING

Greetings,

I totally support the medical aid in dying legislation.

H.A. Resch
1692 Laukahi Street
Honolulu, HI 96821

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 7:59 AM
To: HLTtestimony
Cc: suzy.okino@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Suzy Okino	Individual	Support	No

Comments:

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kobayashi2 - Jessi

From: Tom Tizard <tizard8@hawaii.rr.com>
Sent: Tuesday, March 21, 2017 5:09 PM
To: HLTtestimony
Subject: SB1129

HON. REP.'S:

BY NOW YOU HAVE HEARD MANY VOLUMES OF POSITIONS SUPPORTING, AND OPPOSING THE DEATH WITH DIGNITY BILLS. FROM MY 80-YEAR-OLD PERSPECTIVE, I RELY ON IT'S BASIS IN THE VERY SUCCESSFUL OREGON LAW. OVER THE YEARS, THERE HAS BEEN NO ABUSE OF THE LAW THERE, A VERY LOW RATE OF USAGE, AND THE EFFECT ON THE LOCAL MEDICAL COMMUNITY OF INCREASING PALLIATIVE CARE!

A WIN-WIN ALL AROUND. AND I SAY TO THOSE WHO OPPOSE IT'S PASSAGE, "IF YOU DON'T WANT IT, DON'T USE IT!"

LASTLY, REGARDING THE OPPONENTS, I HOPE THAT ALL OF OUR LEGISLATORS ARE ALERT TO THE MISUSE BY "NON-PROFITS" & CHURCH-AFFILIATED GROUPS OF THEIR 501c3 STATUS ("NO ATTEMPTS TO INFLUENCE PENDING LEGISLATION PERMITTED"), AND READY TO TAKE ACTION TO CALL OUT SUCH ACTION, AND TO REPORT IT TO THE IRS!

IMUA! AND MAHALO,

THOMAS TIZARD
KAILUA

Dear Chairperson and committee members,

I urge you to vote no on SB1129. This assisted suicide bill opens the door to abuse of the elderly or infirm. Once a lethal prescription is written, an abusive caregiver or relative who stands to inherit from the patient can pick it up and give it to the patient in food or drink. Since no witness is required at the time of death, who would know if the patient consented?

If assisted suicide is made legal, it quickly becomes just another form of treatment. It will always be the cheapest option, especially in a cost-conscious healthcare environment. Barbara Wagner, an Oregon resident, was denied coverage for her cancer treatment but received a letter from the Oregon Health Plan stating the plan would cover assisted suicide. Another Oregon resident, Randy Stroup, received an identical letter, telling him that the Oregon Health Plan would cover the cost of his assisted suicide, but would not pay for medical treatment for his prostate cancer.

Those living with disabilities or who are in vulnerable healthcare circumstances have justifiable concerns should assisted suicide become an option. Financial pressure, peer pressure, and even pressure from uncaring family members can be placed on these individuals to take the suicide option. In fact, nothing in the Oregon or Washington style laws can protect from explicit or implicit family pressures to commit suicide, or personal fears of "being a burden." There is NO requirement that a doctor evaluate family pressures the patient may be under, nor compel the doctor to encourage a patient to even notify their family.

Oregon's data on assisted suicide is flawed, incomplete, and tells us very little. The state does not investigate cases of abuse, and has admitted, "We cannot determine whether physician assisted suicide is being practiced outside the framework of the Death with Dignity Act." The state has also acknowledged destroying the underlying data after each annual report. Again, I urge you to vote no on this bill.

Thank you for your consideration. Tracey Clay-Whitehurst

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 6:20 PM
To: HLTtestimony
Cc: wayne_ching@hotmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Wayne Ching	Individual	Oppose	No

Comments: I oppose this bill because as written, measures to prevent ABUSE are vague and totally INADEQUATE to prevent unjustified and untimely KILLING of our elderly in the name of compassion. It also assumes the medical profession is an exact science. which it is not. Or free of subjective and personal biases, which it is not.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 6:18 PM
To: HLTtestimony
Cc: wjmetzger@hotmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
william metzger	Individual	Support	No

Comments: I testify in support of this Death with Dignity bill, SB1129 SD2. I am 80 and I want the choice to self-administer medications if I am terrible pain at the end of life. Thank you. William Metzger 3120 Beaumont Woods Place Honolulu, Hi 96822 988-6220

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kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 8:40 AM
To: HLTtestimony
Cc: cableguy1@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
William Joseph Collins	Individual	Support	No

Comments: I heartily support this bill. It is barbaric that we still allow our terminally ill citizens to starve to death or die in pain when a better solution is available. We do this for our pets - why not our loved ones?

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Cover Sheet re:
Fax: 1-800-535-3859

Testimony
Regarding SB 1129 SD 2
"Medical Aid in Dying"
House Committee on Health Hearing
March 23, 2017

In opposition to SB1129 SD 2

A. Stephen Woo, Jr., M.D.

193 Halai Street
Hilo, HI 96720

One page and Cover sheet

Members of the House Committee on Health:

Aloha:

I strongly object to SB 1129 SD2, paragraph 17 which states:

"Actions taken in accordance with this chapter shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide under the law. "

Merriam-Webster defines suicide as the "**killing of oneself intentionally."**

The prime function of the death certificate is to certify both the **cause of death** such as cancer, stabbing and so on, and the **manner of death,** of which there are only **five admissible** responses: **natural, accident, suicide, homicide and undetermined.**

Paragraph 17's attempt to re-define the meaning of the word "suicide," proclaiming **what it is not, but not saying what it is,** poses a huge problem.

As a pathologist in Hilo I tried to complete death certificates as accurately as possible, not only as a moral and professional obligation but also to benefit the deceased and society. It is the final chapter of the patient's life, with medical and legal consequences.

Without a valid death certificate there is no burial, no transfer of benefits nor of property to the family, and most importantly, **no closure.**

Paragraph 17 forbids classifying the death a suicide. To designate it one of remaining four choices, namely *natural, accident, homicide, or undetermined* is to lie.

However, if that item on the certificate is left blank, the certificate is invalid, of no benefit to anyone. Our people deserve better.

Truth is the foundation of Hawaii's culture and of all society.

Though this bill may be acceptable elsewhere, it cannot stand in Hawaii where we proclaim

"The life of the land is perpetuated in righteousness."

Please reject this bill.

Mahalo.

A. Stephen Woo, Jr. M.D. 3/21/17

Amy Tanaka

A few years ago I was diagnosed with Non Hodgkins lymphoma and underwent a grueling regiment of chemotherapy. Initially, it was recommended that I undergo 6 sessions of chemo; however, because I was so weakened by the treatment with a 35 lb weight loss and a dangerously low white cell count, in addition to having suffered congestive heart failure due to the chemo, my physician mercifully terminated treatments after 5 sessions. I truly believe that I would not have survived my 6th session. Although I am currently in remission, I am acutely aware that my cancer may recur because the disease had spread to my lymph nodes and, as in many recurrences, will probably come back with a vengeance. Should that occur, the only condition under which I would undergo additional chemotherapy is with a firm assurance of a complete cure, which I would imagine would be far- fetched. I would never undergo any further treatment merely to prolong my life; after my bout with chemo, there is no question in my mind that I would chose quality over quantity of life.

How comforting to know that, should I suffer a recurrence and the diagnosis is terminal, that I would have the option of ending my life on my terms and not subject my loved ones to the agonizing and indelible image of watching me suffer in the final stages of my condition. Unfortunately, I have been present when two of my close friends were in their final throes of cancer, and that image is forever engrained in my thoughts. I have often heard people remark with envy when they learn that someone had died in their sleep. What a comfort to the friends and family left behind to be able to state that their loved ones died peacefully and on their own terms.

I respect people who express opposition to this bill. However, they do not have the right to force their beliefs on others. They retain the right to live with their beliefs as should I have the right to end my life with some semblence of dignity. The qualifying steps towards having the option to terminate life in instances of an incurable and fatal condition undercut the chances of abuse. It is absurd to argue that people, especially the aged and easily influenced ones, will be coerced into agreeing to end their lives. What would the threat be? They have already been medically certified with a terminal condition. The statistics bear out that there has been no abuse of this right - the numbers that actually go through with their right to death with dignity are incredibly miniscule compared to the actual number of terminal patients. What is of utmost importance is the right to choose. Medical professions who oppose this measure argue that it is their duty to provide life sustaining care. By not supporting this bill,

they are merely prolonging suffering. Is it not their duty to provide comfort and to abide by their patient's wishes? Hospice will argue that they try to keep the patient as comfortable as possible, but who really can verify, other than the patient himself, what he or she is experiencing in the final throes of life, usually when the patient is unable to respond.

I had my 19 year old animal euthanized because of debilitating illnesses and marveled at the peaceful transition as she went to permanent sleep. The immense loss was bearable because it was unquestionably without pain or discomfort. We humans should also be entitled to this choice.

We all know that the vast majority of your constituents support this bill. You were elected to serve the majority, and I hope you will follow through on your campaign promises to respect the wishes of the electorate.

kobayashi2 - Jessi

From: Ann Egleston <manukolea1@gmail.com>
Sent: Tuesday, March 21, 2017 1:38 PM
To: HLTtestimony
Subject: SB 1129

For many years, both as a volunteer and an employee, I spent time with folks through the last days, weeks and months of their life. To die without dignity is inhumane.....please give us a choice.....support SB 1129.

Thank you for taking the time to hear my thoughts,
Ann Egleston

--
Take care of your thoughts when you're alone and
take care of your words when you're with people.

kobayashi2 - Jessi

From: Brian Goodyear <bsgoodyear@aol.com>
Sent: Tuesday, March 21, 2017 1:53 PM
To: HLTtestimony
Subject: Medical Aid in Dying (SB 1129)

Aloha Representatives,

I am writing to respectfully request that you support the passage of the Hawaii Medical Aid in Dying bill (SB 1129). In support of this request I would like to reiterate the written testimony that I previously submitted to the Senate, which has voted by a margin of 22 to 3 to support passage of the bill:

I am a clinical psychologist in private practice and a 46 year resident of the State of Hawaii. I would like to express my support for SB1129 as both a health care professional and an individual. I believe that this legislation would help to empower terminally ill patients who are facing the possibility of intolerable pain and suffering in the dying process by providing a wider range of options and a greater degree of personal control over end of life decisions. I would not only like my patients who might be dealing with terminal illness to have this option available to them, but I would also like to have this option available to me in the event that I should ever develop a terminal illness. In that case, I really don't know whether or not I would choose to use medication prescribed as an aid in dying, but I do know that I would like to have the choice. To those who would not want to consider that option for themselves, I would say that I very much respect your choice. Please, however, allow me and my patients the opportunity to make the choice for ourselves. A vote in support of this bill is, I believe, a vote for such freedom of choice. I would respectfully ask members of the Senate to cast your votes in favor of the passage of this bill.

I would also like to respond to some of the views expressed by certain opponents of this bill. First, although palliative care is very valuable in end of life care, extreme pain and suffering cannot always be relieved by traditional palliative care methods, as some opponents of medical aid in dying would have us believe. Second, the idea that mentally competent adults will be unduly pressured into making the decision to end their lives is, I believe, a red herring. A basic principle of our legal system is that mentally competent adults are ultimately free to make choices for themselves regarding their own lives and are responsible for those choices. Again, please allow us to have that choice and responsibility over our own lives.

Mahalo for your consideration of this important issue.

Brian Goodyear, Ph.D.
2924 Alphonse Place
Honolulu, HI 96816
(808) 285-9393

kobayashi2 - Jessi

From: Carol <emailcvk@aol.com>
Sent: Tuesday, March 21, 2017 12:42 PM
To: HLTtestimony
Subject: Medical Aid In Dying

Medical Aid in Dying is a bill that deserves to be passed for the following reasons:

1 - It is the wish of the patient. We are complying with THEIR wishes - they are not being coerced by the state or the medical field or anyone.

2 - Currently they are being coerced - we are denying people the right to choose for themselves.

3 - To anyone voting on this bill who believes they have no right - for whatever reason - to enact a law that allows a person to voluntarily end his life - I must ask what right have you to legislate that he or she must live in this state of constant pain?

4 - We know some people may believe this contradicts their religious or other beliefs; however none of us has the right to impose our beliefs on others. It is well understood that a patient and/or family who finds this practice unacceptable - for whatever reason - will opt to continue life until a natural death occurs.

4 - This is a law that will ALLOW not mandate aid to die.

5 - Note the key word 'medical'. What is being offered is the latest in medical technology. People are not being left to their own devices. We are allowing them to die with dignity and supervision and in the presence of their families if they so wish and the right to exercise their own free will.

Anyone who has seen a loved one die in pain after prolonged suffering must understand we have to give people the right to end this if they so choose.

Thank you.

Carol Kozlovich

kobayashi2 - Jessi

From: Charles Miller <millerc003@gmail.com>
Sent: Tuesday, March 21, 2017 2:21 PM
To: HLTtestimony
Subject: SB 1129

Dear Rep. Della Au Belatti, Chair and Rep. Bertrand Kobayashi, Vice Chair and all other members of the Committee on Health:

I am an oncology nurse specialist in Honolulu and am writing to urge you to support Hawaii's Medical Aid in Dying bill - SB 1129 - which just passed the Senate. I have been taking care of cancer patients for over 30 years and have seen too many patients forced to experience unbearable and unnecessary suffering at their end of life. While Hospice and Palliative Care are excellent options for many dying patients, they do not meet the needs of all. From personal experience I have seen the anxiety, pain and suffering experienced by cancer patients and their families and they approach their end of life. Many of these patients have asked me personally to help them end their suffering and I was powerless to answer their entreaties. I have come to believe that doctors in Hawaii should have the right to provide medication to dying patients when they ask for this option. This ethical and legal right is already approved in 6 other states and over 80% of Hawaii voters support aid in dying as do the majority of physicians. Governor Cayatano's Blue Ribbon Health Panel recommended passing medical aid in dying almost 20 years ago. I strongly believe now is the time to give Hawaii's people this choice. Please support SB 1129 and give the people of Hawaii an option that they have been seeking and deserve.

Thank you for the opportunity to testify in support of this most important legislation.

Mahalo nui Loa

Stephanie A Marshall, RN, MSN, FAAN
762 Kaulana Place
Honolulu, HI 96821

smarshal@hawaii.edu
808-561-6015

kobayashi2 - Jessi

From: Thejewelwithin <thejewelwithin@hawaiiantel.net>
Sent: Tuesday, March 21, 2017 3:28 PM
To: HLTtestimony
Subject: Please vote Yes on SB 1129

Please vote yes in SB 1129…passing from this life by choice, with some semblance of dignity and ease of pain, should not be a crime when the only alternative is a miserable existence.

Sent from my iPad
daniel rokovitz
96778

kobayashi2 - Jessi

From:	mailinglist@capitol.hawaii.gov
Sent:	Tuesday, March 21, 2017 3:47 PM
To:	HLTtestimony
Cc:	dl.davalos@yahoo.com
Subject:	Submitted testimony for SB1129 on Mar 23, 2017 08:30AM
Attachments:	HOUSE LTR FINAL - MARCH 21.tmd

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Daryl-Lynn Davalos	Individual	Oppose	No

Comments:

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kobayashi2 - Jessi

From: Dawn Eshelman <eshelmand001@gmail.com>
Sent: Tuesday, March 21, 2017 2:28 PM
To: HLTtestimony
Subject: Medical Aid in Dying

To whom it may concern:

I watched my mother slowly die over a period of 3 1/2 years from ALS (Lou Gehrigs).

She first lost her voice, then the use of her arms and hands, then the use of her legs and feet. She ended up totally paralyzed, and only able to blink her eyes.

The next step was to have a stomach tube put in, because she couldn't swallow. After that, i t was time to go on a respirator, because she couldn't breathe.

She decided not to go on a respirator, and ended up dying from suffocation (or drowning in her own saliva).

I know after witnessing her decline and death, that I would not want to go out t hat way, and that I would want to have control over how and when I chose to die. "Death with Dignity".

Sincerely,

Dawn Eshelman

Denise Anderson
49 Akilolo St
Honolulu, HI 96821
RE: Testimony in SUPPORT of SB 1129 SD2
Hearing scheduled for 8:30am, Thursday March 23, 2017

Aloha House Health Committee,

I am writing in SUPPORT of SB1129's Medical Aid in Dying bill. I believe that personal autonomy is our highest value as a society, and such a bill allows for greater personal autonomy for those already suffering from terminal illness.

I recently experienced my mother's passing: she had terminal pancreatic cancer. While she fought hard with chemotherapy, there finally came a time when it became harder to live than to die. She said she was very uncomfortable and wished she could go quickly. And yet she and her family and doctor could do nothing to help her. It was several weeks of Hospice care before she finally passed, and I'm not at all sure that she didn't suffer during that time. I think every human has the right not to suffer. So I am in favor of this bill.

Mahalo,

Denise Anderson

kobayashi1- Oshiro

From: Jana Hayden <janahayden1@gmail.com>
Sent: Tuesday, March 21, 2017 11:03 AM
To: HLTtestimony
Subject: In support of Medical Aid in Dying

To the Committee:

I urge you to pass the Medical Aid in Dying Bill. Working within healthcare systems to normalize medical aid in dying will ensure fewer people suffering at the end of their life. It should be every person's right to make their own decision regarding how much pain and suffering they are willing to endure. It will not lead to more people dying, but it will save them from suffering needlessly.

Thank you for your consideration.

Jana Hayden

kobayashi2 - Jessi

From:	jolourosof@hawaiiantel.net
Sent:	Tuesday, March 21, 2017 12:16 PM
To:	HLTtestimony
Subject:	SB 1129

Please O please consider and pass out the Medical Aid in Dying Bill. Aside from silly arguments about killing off the elders, which is murder -- already in our laws --why would any thinking person wish to deny a lucid person's right to end the pain and humiliation that accompany a terminal malady?

My wife rejected surgery and chemotherapy, wishing not be sicker before passing. Her hospice experience was great in a way, but also terrible when her nurses and aides had to perform humiliating procedures, as when morphine produced its quite often side effects.

The key point is choice, either to live on no matter what the consequences or to opt out peacefully. Who rationally could claim that government or religion could deny that option?

Again, esteemed representatives, please vote for SB 1129. I am Louis Rosof 304 4 Kalakaua Avenue in Honolulu and I and my daughter and son-in-law, Penny and Troy Snell, who live with me, urge you to do what the great majority of our state's citizens want done -- to enact a death with dignity bill.

Thank you so much.

kobayashi1- Oshiro

From: Jonathan McRoberts <jonathanmcroberts4@gmail.com>
Sent: Tuesday, March 21, 2017 11:20 AM
To: HLTtestimony
Subject: Medical Aid in dying Act

Aloha,

I strongly support the Medical Aid in dying Act. I am 68 years old and very much want to control my right to die as I choose. I already have a do not resuscitate clause in my trust. Being allowed to cut my life short if the future looked bleak and a lot of pain was involved, is extremely important to me. I am more interested in my quality of life than suffering through to the last possible moment.

Please give Hawaii citizens control over their final days.

Jonathan McRoberts
2214 Liliuokalani St.
Kilauea, HI 96754

652-6863

kobayashi2 - Jessi

From: Kathleen McMillen <IrishWoman@hawaii.rr.com>
Sent: Tuesday, March 21, 2017 3:53 PM
To: HLTtestimony
Subject: Bill 1129 SD2 (SB1129 SD2)

Please pass the subject bill. We need to give relief to those who suffer greatly in the dying process. It is the only humane thing to do. It is a matter of personal choice. It is not the State's job to decide such personal decisions for me.

Kathleen McMillen
&5-5768 Makelina Pl
Kailua Kona, HI 96740
808-326-4633 no texts

kobayashi2 - Jessi

From: Katie Romanchuk <ohialani@gmail.com>
Sent: Tuesday, March 21, 2017 3:14 PM
To: HLTtestimony
Subject: Right to die

Allow people the dignity to chose when to die. Some people are suffering excessively and only they know what it feels like, we cannot speak for them. Please allow this choice.
Katie Romanchuk Maui. HI

Sent from my iPhone

kobayashi2 - Jessi

From: Libby Tao <libbytao@hawaii.rr.com>
Sent: Tuesday, March 21, 2017 11:40 AM
To: HLTtestimony
Subject: Bill 1129 SD2 (SB1129 SD2)

Aloha Representatives,

I am urging you to vote YES for *Death With Dignity*. It is exactly as it states, death with dignity. The benefits far outweigh the concerns expressed about passing this bill. It is the only right thing to do. There is no saving grace, compassion or rightness in making people suffer far beyond what they should be, connected to tubes and the most powerful pain killers. For people faced with a long, painful, horrendous existence and dying process this is heaven-sent. A loving, easy departure. As our House Representative you are in a better position than I to have the statistics of the numbers of people in this position who will be so relieved that there is a way out, and this also be a relief to their families standing by and watching them suffer.

If we can offer this merciful and peaceful death to our loving animal companions, what in the world are we thinking in denying this to our human families? Let's make a vote for all of that and let death be a peaceful departure, an honorable and dignified departure, as we already aspire in living life.

Mahalo for your consideration and subsequent vote in favor.

With Loving Aloha
Rev Libby

Rev Libby Tao Kelson-Fulcher, D.D.
Weddings A La Heart
weddingsalaheart@hawaii.rr.com
www.weddingsalaheart.com
http://www.facebook.com/pages/Weddings-A-La-Heart/104191676289933
https://www.weddingwire.com/vendors/ratings

Author of the Forthcoming Book:
Opening Your Treasured Door To Love...A Romantic Resource For One-of-a-Kind Soul Ceremonies and Heartfelt Vows

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(808) 938-8565 Cell
(808) 327-3445 Fax

A. I WOULD LIKE TO TALK ABOUT 'DEATH WITH DIGNITY."
B. MY NAME IS MALCOLM SLAKTER. I AM A RETIRED PROFESSOR LIVING WITH MY WIFE IN MAKIKI FOR THE PAST 26 YEARS. I AM 87 YEARS OLD WITH A HISTORY OF TOO FREQUENTLY BEING IN AND OUT OF HOSPITALS AND ER'S FOR THE PAST 18 YEARS. ONLY THE UNPLEASANT MEMORIES KEEP ME FROM GOING INTO DETAILS.
C. HOWEVER, AT SEVERAL TIMES IN A HOSPITAL I HAVE BEEN SUFFICIENTLY MISERABLE WITH PAIN AND DISCOMFORT IT WAS ONLY THE BELIEF THAT I WOULD GET BETTER, AND OF COURSE MY WIFE'S SUPPORT, THAT CARRIED ME THROUGH. BUT I CAME TO REALIZE THAT IN CIRCUMSTANCES WHERE THERE WOULD BE NO HOPE OF GETTING BETTER, DEATH WOULD BE A FRIEND!
D. IN SEPTEMBER 2013, I WAS DIAGNOSED WITH STAGE 4 LUNG CANCER. SINCE I HAD NEVER SMOKED, IT TURNED OUT THAT THE MUTATION GIVING ME THE CANCER HAD A TARGETED DRUG TARCEVA. UNFORTUNATELY, ABOUT 6 MONTHS AGO MY PROSTATE CANCER, DISCOVERED AND TREATED IN 2003, METASTASIZED TO MY SPINE, AND A CT SCAN THE END OF NOVEMBER SUGGESTED THAT MY CANCER HAD PRODUCED A NEW MUTATION. A JANUARY BLOOD BIOPSY CONFIRMED A NEW MUTATION AND I AM NOW ON A DIFFERENT TARGETED DRUG WITH POSSIBLE LETHAL SIDE EFFECTS. SO MY ONCOLOGIST WILL BE USING BLOOD TESTS AND EKG'S FOR A MONTH TO SEE IF THE DRUG IS SAFE FOR ME TO TAKE. THEN THE QUESTION IS WILL I BE ONE OF THE 59% THAT THE DRUG WORKS FOR?
E. ALL OF THIS IS TO SUGGEST THAT I AM REACHING THE POINT WHERE 'GETTING BETTER' IS NOT A VIABLE OPTION—I CAN ONLY HOPE FOR STABLE! MY WIFE AND I HAVE BEEN MEETING MONTHLY WITH A PAIN/PALLIATIVE CARE PHYSICIAN FOR OVER 3 YEARS, AND HAVE WORKED WITH HIM TO FILL OUT ALL THE APPROPRIATE DOCUMENTS AT THE COMPASSION AND CHOICE WEBSITE. IN ADDITION MY WIFE AND I HAVE MADE INITIAL CONTACT WITH A HOSPICE AGENCY.

F. IN CONCLUSION, I AM HOPING I WILL NEVER HAVE NEED OF THE PASSAGE OF A DEATH WITH DIGNITY BILL BUT IT WOULD BE A HUGE COMFORT TO HAVE IT, JUST IN CASE. LIKE ALL OTHERS IN MY POSITION, **WE HAVE NO INTEREST IN IMPOSING THIS OPTION ON OTHER PEOPLE. WE ONLY ASK THAT OTHER PEOPLE NOT IMPOSE THEIR BELIEFS ON US,**

G. **SO,PLEASE BACK THE DEATH WITH DIGNITY BILL WHEN IT IS UP FOR A VOTE.**
THANK YOU! (FEEL FREE TO CONTACT ME FOR ANY REASON: 528-4409.)
SINCERELY,
MALCOLM J. SLAKTER, PHD
PROFESSOR EMERITUS
UNIVERSITY AT BUFALO

House Health Committee
RE: SB 1129
3/23/17
8:30 a.m.

Chair Belatti and members of the Committee:

I am Marcia Linville, testifying in support of SB 1129 SD2. This bill is as the title suggests a matter of dignity. Anyone who has watched a husband die of cancer, will recognize the worth of this bill. I, myself, plan to make use of it, if circumstances warrant it. It is more than just a matter of dignity, it is a matter of personal privacy and possession. NO ONE HAS ANY RIGHT TO MY LIFE BUT ME. I do not see how anyone's religious beliefs, which are not mine, should give anyone any control over my life, or my pain. It is a matter of dignity. I therefor request your support of SB 1129.

Thank you,
Marcia Linville
536-4466

kobayashi2 - Jessi

From: Mare Grace <maregrace9@yahoo.com>
Sent: Tuesday, March 21, 2017 3:01 PM
To: HLTtestimony
Subject: SB 1129

To our esteemed legislators.
I am writing to request that you do everything in your power to see that this bill is passed. I am 83 years old and have suffered from chronic pain for over 20 years. Each year it becomes more difficult to function. I have had a good life and feel deeply grateful to have been blessed with the good fortune to live in beloved Hawaii. However, I know it will soon be time for this old body to have served its purpose and my deepest desire is to be able to die peacefully and gracefully. Having worked as a hospice volunteer I know firsthand that intense pain is often not possible to overcome without taking away one's ability to relate to life and to loved ones.
I feel that if this bill were law, whatever time remains for me can be faced with joy and equanimity. I may never need to use this option but just knowing it was available would bring great peace to my remaining years.
Thank you for your thoughtful consideration.
Mare Grace
Kamuela, Hawaii

Sent from my iPad

kobayashi2 - Jessi

From: Marie Anne <manne899@gmail.com>
Sent: Tuesday, March 21, 2017 11:29 AM
To: HLTtestimony
Subject: DEATH WITH DIGNITY

HOUSE OF REPRESENTATIVES
THE TWENTY-NINTH LEGISLATURE
REGULAR SESSION OF 2017

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair

Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members.

My name is MARIE ANNE and I'm writing in support of SB1129 SD2 "Relating To Health."

Thank you for hearing and passing SB1129, SD2.
MARIE ANNE
45-638 Halekou Place
Kaneohe HI 96744
808-728-4842

I am a retired DOE teacher and currently a substitute elementary teacher on the Windward side of Oahu; community volunteer with my therapy dog in Hospices, Nursing Homes and Hospitals; and member of the First Unitarian Church of Honolulu.

» Death with dignity laws improve palliative and hospice care. Over 90% of Oregonians requesting life-ending medications are in hospice, twice the US average.
Daily I see first hand how long people can suffer through dying and so I believe in this bill.

» Using the law will be voluntary for both patients and physicians. Only the patient can make the request for medication. The patient can rescind the request at any time.
» This law would allow a person the freedom to die at a time and place of their choosing. Nationally, only 20% of people die at home while 90% of people using Death With Dignity die at home
» Death With Dignity allows the terminally ill to decide for themselves what's best for them and to regain control over their illness and the conditions of their death.
» The option to die a peaceful death at the time and place of their choosing provides the terminally ill with invaluable peace of mind at an extremely private time of their lives.
» If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having qualifications specified by the department of human services by rule.
Not having a caring family I want to make my own decisions.

»SB1129 SD1 is modeled on the historic Oregon statute and includes all of the proven safeguards to protect patients from misuse. The Oregon law has been in effect since 1997 without a single incident of misuse.

Having lived in Oregon from 1977 to 1994 whe n this issues was being discussed before it was passed I was also a proponent at that time.

» The inclusion of Advance Practice Registered Nurses (APRNs) as "providers" is very important due to Hawaii's geographical makeup and the lack of physicians in the many remote and rural areas of our state.
» The latest Hawaii poll (Fall of 2016) revealed that "eight out of 10 Hawaii voters (80%) agreed that a mentally capable adult who is dying of a terminal disease that cannot be cured should have the legal option to request prescription medicine from their doctor, and use that medication to end their suffering in their final stages of dying." A majority of Catholics (82%) and those associated with the Christian Fellowship (83%) said terminally ill adults definitely or probably should have this legal option.
» Some of the many safeguards in SB1129 SD1 include:
1) Confirmation by two physicians of the patient's diagnosis, prognosis, mental competence, and voluntariness of the request. NOTE: "voluntariness" is a legal and philosophical concept referring to a choice being made of a person's free will, as opposed to being made as the result of coercion or duress].
2) Multiple requests by the patient: an oral request followed by a valid written request for medication which must be witnessed by at least two individuals in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request. One of the witnesses shall be a person who is not: A relative of the patient by blood, marriage, or adoption; A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.
3) The patient's attending physician at the time the request is signed shall not be a witness.
All of the many “safeguards” put in place for Hawai’i should make this an easy decision for lawmakers. Please consider yourself and your loved ones. We are all going to die - how do you want yourself or your loved ones to be able to die with dignity?

Marie Anne
manne899@gmail.com

Be the change that you wish
to see in the world.

kobayashi2 - Jessi

From: Martha Martin <mauimartha@gmail.com>
Sent: Tuesday, March 21, 2017 11:28 AM
To: HLTtestimony
Subject: HI Medical Aid in Dying

Please enact a Medical Aid in Dying act.
The human body wears out differently; some die peacefully and others die in agony. Medicine cannot cure every disorder. Medicine cannot even give relief from all pain.
Please pass a law to allow terminally ill people the right to choose medical aid in dying.
Those who oppose this are free to choose not use it.
Those who are not terminally ill will not be given this choice.

Please enact a Medical Aid in Dying act.

Martha E. Martin
POB 790300
29 Hana Hwy
Paia, HI 96779

Sent from my iPad

kobayashi2 - Jessi

From: Martin Black <MBlack@staradvertiser.com>
Sent: Tuesday, March 21, 2017 11:24 AM
To: HLTtestimony
Subject: The Hawai'i Medical Aid in Dying Act (SB 1129)

As a 60 year old resident of the State of Hawaii I strongly support this measure. It should be an option for those who meet the criteria in the bill. Please allow people in such difficult circumstances to have this option.

Sincerely,

Marty Black
Kailua, HI
808-864-7334

Mary M. Uyeda, APRN

To the House of Representatives – Committee on Heath – March 23, 2017

I support SB 1129, as a patient's right to choose in their own unique situation, at the end of life.

During my 30 years of bedside nursing in Intensive Care, I have personally witnessed a wide range of deaths from perfectly peaceful to prolonged agony, often dependent on the physician and nurses in charge of their care.

Most of us would choose to have a confidential understanding with our own primary physician. But this luxury no longer exists unless you are wealthy. In addition, many physicians are uncomfortable with terminal sedation. In these days of high-tech medicine, we are often just a number occupying the bed subject to the accountability of those in charge of us. Often a Living Will is overlooked or outdated, and, while it does preserve the option of no treatment, it does not address a comfortable death. By the way, "no treatment" does not translate to no care.

As a nurse, it became my mission to ensure that a terminal patient and their family had the best setup, with outcomes. It was not always an easy exit since some confused patients or families had unresolved issues. Also when a ventilator was being removed (this is called ex-tubation) the terminal sedation orders were often liberal, providing for larger-than-usual doses of a combination of pain and tranquilizer medications. This would make a new nurse feel liable, especially if the patient started gurgling or seizing.

As a nurse, I felt vulnerable for doing the right thing, easing the patient's efforts as death approached. When it is my turn to exit this world, I hope that a brave physician and nurse might do the same for me.

I am one of the 8 of 10 Hawai‘i State residents who want this option. I believe that I have earned the right to die with dignity in my own bed at home with loved ones, like my parents did. The Oregon law has built-in safeguards which prevailed over the last 20 years and Hawaii is far behind.

I support SB 1129, which has been long overdue during my 30 year career as a nurse.

kobayashi2 - Jessi

From: Mary Manju <springmanju@earthlink.net>
Sent: Tuesday, March 21, 2017 2:38 PM
To: HLTtestimony
Subject: aloha

I do support. People need choices in hard times.

Maxine KL Anderson
1703 S. Beretania st, Apt. C
Honolulu, HI 96826
RE: Testimony in SUPPORT of SB 1129 SD2

Hearing scheduled for 8:30am, Thursday March 23, 2017

Aloha House Health Committee,

I am writing in SUPPORT of SB1129's Medical Aid in Dying bill. I believe that personal autonomy is among our highest values as a society, and such a bill allows for greater personal autonomy for those already suffering from terminal illness.

Recently, in December of 2015, I participated in my family's end-of-life care for my grandmother, Joyce Quimby. She had been diagnosed with pancreatic cancer in 2012 and given only a few months to live. She surpassed all of our and the doctors' expectations, beat the cancer back twice, but it ultimately took her life. In her final days, when she was responsive but too weak to get out of bed, she explicitly asked my mother and auntie's to end it—she was ready, and she wanted to go be with my grandfather who had been waiting for her for the last 20 years. She lost consciousness shortly thereafter, but held on for 3-4 days while we provided palliative care. Our hospice provider was kind enough to provide a self-administered morphine system after the first day or two in which we were able to dose her regularly to ensure she was not in pain.

Ultimately, those 3-4 days in which she was unresponsive were unnecessary and torturous for both her and our entire family. She was still responding to external stimuli and her three daughters had to stand by, powerless to alleviate her suffering. If this bill had been law at the time, we could have eased her passing at a time and place of her choosing rather than subjecting her to various pokes, prods, and other invasive measures utilized in those final days. In addition, my mother has been diagnosed with Multiple Sclerosis and while she is currently still entirely healthy, she has expressed to me on multiple occasions that she wants to control how and when she passes from this world. I am terrified of the idea that she will not have control over her own life and body when the time comes.

Mahalo nui for your time and consideration,

Maxine Anderson

March 21, 2017

Representative Della Au Belatti, Chair
Representative Bertrand Kobayashi, Vice Chair
And Members of the Committee on Health
House of Representatives
415 South Beretania Street, Room 329
Honolulu, HI 96813

Re: Testimony in support of SB 1129 SD2, Hawaii's Medical Aid in Dying Act

Aloha Chair Belatti, Vice Chair Kobayashi and Committee Members,

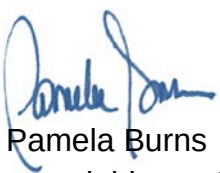
Thank you for the opportunity to provide my strong support for SB 1129 SD2, Hawaii's proposed medical aid in dying legislation.

Medical aid in dying is a safe and trusted medical practice for which a terminally ill, mentally capable person who has a prognosis of six months or less to live, has the option to request from his/her doctor a prescription for medication which he or she can choose to self- administer through ingestion to peacefully shorten an unbearable dying process.

The people of Hawaii, together with their families and their doctors, should have the option to make the end-of-life decisions that are right for them in the final stages of a terminal illness so they can put an end to their dying process painlessly and peacefully. SB 1129 SD2 would give those who are dying this important option to provide them relief from extreme pain.

I wholeheartedly support SB 1129 SD2 and hope that you will pass this bill. Passing this legislation is the most compassionate action to take as it would support the rights of terminally ill individuals and allow them to have the full range of care options to make end-of-life decisions that most align with their values for a peaceful death.

Thank you for your consideration.



Pamela Burns
pamelabburns@gmail.com

kobayashi2 - Jessi

From: Punahele Travel <vtravel@hawaiiantel.net>
Sent: Tuesday, March 21, 2017 11:27 AM
To: HLTtestimony
Subject: SB1129, SD2, March 23, 2017 Testimony

Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members!

My name is Victoria Kibler and I am writing to you on behalf of SB 1129 SD2. Having my own family members go through painful and excruciating illnesses and then death. I am asking for you to support SB 1129 SD2 and bring it to LIFE for us in Hawaii. I have watched my mother suffer for years, my grandfather reach out to me and ask me why he was being made to suffer and my brother ask me to help him make the pain stop. I think it's time for us as human beings to be able to take control of our suffering. No one really knows the pain that our loved ones are going through but I can only hope that you would not want your family members to go through what I have witnessed with my own.

I truly hope that the choices of SB 1129 SD2 will be available for myself and my family as we were not able to support our loved ones when they needed it.

This is not about politics or religion. This is about Quality, Humanity and Dignity of ones' Life.

With warm aloha,

Victoria Kibler
Kailua Kona, Hawaii

kobayashi2 - Jessi

From: R Caplett <caplettr001@hawaii.rr.com>
Sent: Tuesday, March 21, 2017 12:30 PM
To: HLTtestimony
Subject: I support the Medical Aid in Dying Act

Dear Members of the House Health Committee

After watching three family members die horrible deaths during prolonged Intensive Care Unit (ICU) stays, I don't ever want to witness another one. The experience was too horrible to ever be shown on television. For that reason, I suspect many in the general public have no idea that modern medicine can keep a human body alive to the point of torture. Two of my family had liver failure, followed by kidney failures. By the time they finally died, they looked like science fiction mummies. They were as good as dead days before their hearts stopped beating for the last time. At one point a physician told us he couldn't administer additional pain medicine because it would kill her.

Few rational people want to die, but when options are reduced to miracles, we should have the option of choosing how we die.

Sincerely

Richard Caplett
3075 Ala Poha Pl Apt 1812
Honolulu, HI 96818-1689

kobayashi2 - Jessi

From: RICHARD BIBEAU <rbibeau8@msn.com>
Sent: Tuesday, March 21, 2017 11:38 AM
To: HLTtestimony
Subject: SB1129

I support passage of this bill. Regardless of any personal or religious opinion, no one should interfere with a person's right to end their lives with dignity.

Richard Bibeau
Resident, Honolulu

kobayashi2 - Jessi

From: Robbin Reed <robbinr@hawaii.rr.com>
Sent: Tuesday, March 21, 2017 11:34 AM
To: HLTtestimony
Subject: Compassion & Choices

To Whom It May Concern,

I wish to again express my support for this legislation. For those who do not support it, they can ignore it, but for those of us who have watched someone we love SUFFER & Linger & heard them express their wish to be done, it would be so wonderful to know there are options. Please view this as allowing someone to have a choice as to how they go out. None of us will avoid dying, but for someone you love to have the choice to be able to discontinue suffering, is a reasonable, loving option.

Mahalo for your consideration,

Robbin Reed

kobayashi2 - Jessi

From: rowes001@hawaii.rr.com
Sent: Tuesday, March 21, 2017 11:24 AM
To: HLTtestimony
Subject: Testimony SB1129

Aloha Members of the Committee

I am writing in support the Death with Dignity Act, SB 1129, Hawaii's proposed medical aid in dying legislation.

As I have followed these hearings, and others over the years, I have heard much about how life is a gift from God. So indeed, it may be. But if it is, so is free choice.

As I was raised, perhaps the most important factor in a human life is free choice. It is through our choices that we form our life and character. It is only by those choices that we are able live life in God's example. If our lives are gifts from God, so must be our capacity to choose.

The proposed legislation is about individual choice, the choice to complete the artistry of an individual human life, to bring it to its inevitable end in a manner that fulfills our individual characters as we have crafted them through those choices. Such a choice, as the law will allow, will certainly not be for everyone. Given the Oregon model, which provides the design for this law, it will be a choice of a relative few.

As I was raised and educated, individual freedom of choice is one of those inalienable rights around which our unique form of government has been established to protect. Full and free individual choice is requisite to any pursuit of happiness. Is it not the responsibility of legislatures to protect the choice of those few that we make our society a free society that accommodates and even celebrates difference?

Our social institutions are based on the premise that citizens are rational, independent and free, possessed of autonomy and aware of their own self-interest. I do not understand why we abandon this premise when adults approach their inevitable death. All human beings deserve the respect to live their lives in dignity, as they choose. Why do we so coldly deny this and disregard the value of individual choice when life approaches its end?

Please vote in favor of SB 1129.

Mahalo
Sharon Rowe
citizen

kobayashi2 - Jessi

From: Susan Weldon <makakilogirl74@gmail.com>
Sent: Tuesday, March 21, 2017 11:21 AM
To: HLTtestimony
Subject: Supportive Testimony for SB 1129 SD 2

I am writing to submit testimony in favor of SB 1129 SD 2. As a career health care worker, as well as someone who has lost 3 immediate family members to cancer, I strongly support passage of SB 1129 SD 2 to allow the dying patient to have some choice about how and when they die.

Thank you for your consideration,

Susan Rinaldi Weldon
3763 Anuhea St.
Honolulu, HI 96816

kobayashi2 - Jessi

From: Geri Texeira <geritex@hotmail.com>
Sent: Tuesday, March 21, 2017 3:13 AM
To: HLTtestimony

There isn't enough people in the medical field on this island as it is. Why would anyone want to work against their beliefs. If they were ok with abortion they probably would be working there already. It is a shame that they invest in learning and may be put out of a job. I know what will happen because my main Hospital had the same law forced on them. St.Jonhs was the hospital of choice for 3/4 of the area. The law passed and St Johns sold to Mercy. Many excellent Doctors and Nurses moved to states that did not have that law forcing abortion down the throats of Christians or penalty was enforced or they were forced to resign. Now they are getting Doctors and Nurses that get hired and leave rapidly. Now they are stuck in a system that is declining. I was from the Springfield area in Missouri and people are driving to St Louis and Kansas City for skilled and knowledgeable services. A lot just go to Mayo Clinic's even farther away. If you pass this bill the people of Hawaii will suffer as the peopl e in Missouri has. Where are they to go? Now we have to go to Oahu because that is the only place that has decent services. You are focusing on the wrong health services. Besides, how are you going to replace the people that you are going to force to leave. You barely have enough to run a skeleton crew now. I moved here and had three heart Doctors in the first year. They all moved to higher paying jobs on the mainland. The Instead of doing this bill....you could upgrade your hospitals and equipment! I could not believe there was not a computer in the hospital here. And when they got one they didn't know how to operate it. The equipment in World War II is still being used today. Hawaii needs to think of its future. What is wrong i f someone explains pro life and abortion to a scared pregnant young girl? The family can decide to guide their child. Abortion has a lot of repercussions that affect them after the abortion. Who will address that issue? Who is going to pick up the pieces of the shattered lives abortion causes for the mothers, fathers, grandparents, and the practicing physicians and nurses. As far as I can see your law is as useful as opening Pandora's box on many people with no way of closing the box!

An Hawaiian widow , Geri Texeira. Kula, Maui

Live, laugh, love, and pray. Count your blessings.....

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 7:02 AM
To: HLTtestimony
Cc: aavery@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Alexandra Avery	Individual	Support	No

Comments: Aloha Senate Committee on Health members: Mahalo for hearing this important bill of which I stand in support. This bill will affect a small number of persons who at the last stage of their life, choose to receive and self administer medical aid in dying. Even so, it is a humane option for some who are unable to find palliative comfort through traditional means of morphine. Over the years that it has been practiced in other states, there have been no reported abuses of this option. Please make it possible to expand end-of-life options in Hawai‘i. Kama‘aina overwhelmingly support making medical aid in dying available for those with a terminal illness who are suffering at the end of life. Mahalo, Alexandra Avery

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 9:24 AM
To: HLTtestimony
Cc: ccuaresma@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Beatrice Ramos Razon	Individual	Support	No

Comments:

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kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 7:10 AM
To: HLTtestimony
Cc: charihawaii@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
MARIA R L SOLOMON	Individual	Support	No

Comments: I am in total support of SB1129 SD2 Medical Aid in Dying. By not giving me this right you are taking away my freedom of choice. I have worked hard all my life putting into the system and deserve to die with dignity and not be held to a standard of others w ho due to their believes are taking away mine. I am a young 71 and if this law doesn't pass in Hawaii, I will go to a state that will give me my rights.

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kobayashi2 - Jessi

From: Amy G Self <amygself@hawaii.rr.com>
Sent: Wednesday, March 22, 2017 8:08 AM
To: HLTtestimony
Subject: SB 1129

I strongly support SB1129. There is absolutely no reason why someone should be forced to experience all of the pain and suffering from diseases for which there are no cures until death finally occurs. Anyone who has been through this process with a family member or a friend at Hospice understands what this entails.

My father suffered a severe stroke at age 91 that left him paralyzed from his throat all the way down the right side of his body. He had a health care directive to not be kept alive by artificial means, which included such things as feeding tubes. I know that my father knew what was going to occur because he pulled the IV out of his arm in the emergency room. Because of the damage to his brain from the stroke, he would not have been able to respond to therapy. Therefore, my father was sentenced to death by starvation, which resulted in a twelve-day stay at Hospice while his otherwise healthy organs finally shut down. I was with him every day as he looked at me with tears in his eyes. Although he could not speak to me, I knew he was asking me to help him end his suffering. You see, my father had been my hero all of my life. He had always been there for me no matter what, but I found myself in a horrible position of not being able to help him in his final days (almost 2 weeks). I even begged the Hospice doctor to give him an overdose of morphine to help him go, but she said she couldn't because it was against the law. As an attorney, I knew that, but in my heart, all I could think about was helping my father die with the dignity I knew he would have wanted. I ended up telling the doctor that it was a horrible law because we treat our pets better than we treat our humans. In the end, I was beside my father when he drew his last breath and I cannot express the immense relief I felt for my father at that point. My father was a WW II veteran and he deserved better than that, in my opinion.

I have read some of the testimony submitted by the religious groups and I mean no disrespect, but why would SB1129 even affect their beliefs. If you choose to suffer through every stage of a disease until death, that's your choice. This bill will not take that opportunity away from you. However, please do not take away the option of dying with dignity away from the rest of us. Please rely on your own intelligence and pass SB1129.

Mahalo for taking the time to read my testimony.

Sincerely,

Amy G. Self, Esq.

Sent from my iPad

re: SB1129, SD1 Medical Assistance in Dying March 23rd, Thursday, 8:30 a.m. Room 329

Aloha Chair Bellati, Vice Chair Kobayashi and committee members.

I am a senior citizen and a resident of House District 19 (your district, Rep. Kobayashi) and Senate District 9. I am a member of AARP, Kokua Council, the Hawaii Alliance of Retired Americans and the Legislative Committee of PABEA.

I'm testifying in strong support of SB1129, SD1 which would establish a medical aid in dying act. It should be the right of any competent adult, who has been diagnosed with a terminal illness, to have the full range of options available to him/her and to make end-of-life decisions, including obtaining a prescription from his/her doctor. Whether or not such a prescription is filled, much less the medication actually taken, is not the issue. Having that option available often gives peace of mind and relief from worry.

Only adult residents of Hawaii who are mentally competent and have a terminal illness that will lead to death in six months or less will qualify. Patients must be capable of taking the medication themselves without assistance. This is voluntarily for both patients and physicians. Only the patient can make a request for medication and the request can be withdrawn at any time. Five states have enacted such legislation and twenty other states are considering this measure. There has not been a single incident of coercion.

Please support SB1129, SD1 to expand end-of-life options in Hawaii.

Thank you for the opportunity to testify. Barbara J. Service

kobayashi2 - Jessi

From: BONNIE BLACKLIDGE <bonnieblacklidge@me.com>
Sent: Wednesday, March 22, 2017 7:55 AM
To: HLTtestimony
Subject: Medical Aid in Dying

I am writing this testimony in favor of the Medical Aid in Dying Bill, SB1129. I am in favor of this bill because I watched both my mother and father die a horrible, long, lingering, death. They would have both been in favor of euthanasia, they begged for it. My brothers and sisters are in favor of euthanasia too. We realize that heredity may mean we will die as they did, and none of us want that. So please pass this bill. I need it. We need it. You may need it too.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 8:28 AM
To: HLTtestimony
Cc: britteross@hotmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Brittany Ross	Individual	Support	No

Comments: I strongly support giving individuals facing the end of their life the opportunity to choose a death with dignity. This bill safeguards loved ones and medical professionals who support those making this very difficult choice. In states where this legislation has passed, very few people select this as an end of life option and there are no documented cases of abuse.

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I am here to support the Death with Dignity Act, SB 1129, Hawaii's proposed medical aid in dying legislation.

I watched my husband and best friend die long and painful deaths although they both had great hospice and palliative care, it was not enough.

My husband begged me to help him find a way to end his agony and I had to stand by helplessly.

Currently in Hawai'i, terminally ill individuals have limited options if their suffering becomes unbearable at the end of life. Options include: declining treatment or avoiding unwanted medical treatment, hospice and palliative care, or VSED (voluntarily stopping eating and drinking). However, physicians do not always offer these options to their patients and, more importantly, these options may not result in a peaceful death. Many Hawaii residents do not qualify for some these options.

Please make it possible to expand end-of-life options in Hawai'i

Catherine Mc Donald

@yakmac@msn.com

TESTIMONY IN STRONG SUPPORT OF SB 1129, SD2 (SSCR 893)
House Committee on Health
March 23, 2017, 8:30 a.m., Conference Room 329

To: Chair Della Au Belatti and Vice Chair Bertrand Kobayashi
Members of House Health Committee

From: Charlene Cuaresma, Private Citizen

Subject: Establishes a death with dignity act under which a terminally ill adult resident may obtain a prescription for medication to end the patient's life.

My name is Charlene Cuaresma. I am testifying as a private citizen. I am a registered voter in District 50, Kailua. My training is in public health education. I have worked for nearly forty years to prevent disease through education, research, advocacy and service. I served as medical affairs director for the American Cancer Society, overseeing programs for the early detection of cancer, as well as the children‘s cancer camps, and patient services. I worked on a team of diabetes educators at Queens Medical Center for over a decade. I also had the privilege to serve as a volunteer for organ donor education in the Filipino community.

I strongly support this bill as a result of being with people in my family and in the community through their end of life stage, and witnessing not only their pain and suffering from terminal cancer, amputations, stroke, heart disease, and more, but also the pain and suffering of their loved ones present and far away. It has taught me that many were not aware of pain management or how to request it. Many still, were not even aware of other options such as medical aid to facilitate death with dignity. In the spirit of Supreme Court Justice Ruth Bader Ginsberg, this bill is ultimately about a reasonable person‘s right to choose, and the agency over one’s body, consistent with the provisions of this bill. I value the precept of separation of church and state. Regardless of what may influence a person‘s choice on how to deal with their end of life stage, the option of medical aid in dying should be offered.

Thank you for hearing this bill and for the opportunity to submit testimony to encourage this bill‘s passage.

Sincerely,

Charlene Cuaresma

Dawn N. O'Brien
360 Portlock Rd.
Honolulu, HI 96825

March 22, 2017

RE: OPPOSITION to SB1129

Aloha State Legislators,

I stand in opposition to this bill euphemistically called "Death with Dignity" but is far from it. As a member of the media, I've seen many such bills in other countries that lead to an abuse of the power to give life or to give death. Even by members of the health profession i.e. nurses who terminate an elderly patient for no vital reason. And get away with it. Or those who determine a baby can be terminated for having a less-than-desirable condition.

Pass this and the question becomes: "What is less than desirable"? And, most importantly, "Who gets to be that judge?" No human is worthy of being that judge.

Finally, our state motto, "The life of the land is perpetuated in righteousness" speaks of LIFE & PERPETUATION. This bill is for DEATH & DESTRUCTION. That is not the Aloha State or the heart of her people.

Mahalo & Godspeed,

Dawn O'Brien
Hawaii Resident & Voter, Media personality
360 Portlock Road, HNL 96825

March 22, 2017

Re: SB1129

To Whom it May Concern:

Please kill this dangerous bill. I have previously written to state my opposition to a bill that would readily kill members of our society. This bill if passed will be abused. There will be rationalizations for killing not only the terminally ill but also those seen as unfit by society: e.g. the mentally ill who may not be able to make decisions on their own.

Sincerely yours,

Esther C. Gefroh

Honolulu, HI

TO: Representative Della Au Bellati , Chair
Representative Bertrand Kobayashi, Vice Chair
Committee on Health

HEARING: Thursday, March 23, 2017
8:30 am
Conference Room 329

FROM: Esther McDaniel
Resource Caregiver (aka Foster Parent/Foster Care Provider)

RE: SB 1129 – Relating to Health

Thank you for the opportunity to submit testimony in OPPOSITION to SB 1129 SD 2.

I oppose public policy that advances the legalization of physician assisted suicide.

My position is grounded in truly living ALOHA - respect for the sacredness of human life and cherishing the breath of life. It is also grounded in the value of caring for persons who are most vulnerable while being able to trust the medical professionals also involved in the care.

Physician assisted suicide cultivates a culture of death rather than a culture of life and nurturing those in their most needy time.

Proponents of the legalization of physician assisted suicide refer to it as a private choice, a personal matter of self-determination to be accepted by the rest of society. However, physician assisted suicide is not simply a personal matter of self-determination. It is in fact a social act, involving others beyond the patient and requiring government oversight.

Endorsing physician assisted suicide as public policy will adversely affect and endanger vulnerable populations including those with mental health problems, chronic disease, physically or intellectually challenged; the young; and the frail elderly. My particular areas of concern are children and youth-those who have special needs or are medically fragile and in the foster care system and unable to advocate for themselves. We already have situations of children and youth who are able to verbalize their trauma and neglect and yet they are not always heard.

I belong to a community of foster and adoptive parents and many of us have cared for (and some have adopted) children who have been deemed terminally ill or expected to die from injuries or given a prognosis of a short life span due to their medical conditions. We have encountered people who question us for bringing these children into our families. Their viewpoint is that we are extending their suffering. Although I have experienced the death of a child who was abused, I also know children who are reaching their greatest potential within their disabilities. Some have competed in Special Olympics, attend public school and personally have been a blessing in my life without even being able to say a word. Despite

safeguards, will there come a time when children and youth and their caregivers fall within the definition of suffering? Who will then guard and protect those lives? I think it is necessary to look into how safeguards have been circumvented in states like Oregon and in countries like the Netherlands.

I am also concerned about suicide among teens and young adults. Although this bill states it is for adults, passing this bill still sends a message to our young people. As parents and adults, we have the most influence in our children's lives. We are already struggling with suicide in our state.

The American Association of Suicidology lists exposure to a friend, family member or celebrity's suicide as a risk factor for committing suicide. Why would we want to increase the number of suicides in our state and expose our teens and young people to even more of it?

Physician assisted suicide also erodes trust between patients and health care providers. It is incompatible with the ethical traditions and goals of health professionals and their oath to serve society well.

I support public policy that will improve and expand access to and implementation/delivery of high quality palliative and end of life care services. Palliative care anticipates the physical, psycho-social and spiritual needs of persons living with advanced serious illness and addresses their suffering.

Culturally, we value, among other things, ha (breath of life), ohana (our family) and kupuna (our elders). Physician assisted suicide stands against these important values and sends the message that we live in a culture of death, not life. Palliative care expresses ALOHA to our kupuna, our keiki, our ohana. It sends the message that their lives have value, importance, even when they are ill, advanced in age, or unable to speak for themselves.

Please vote against any advancement of physician assisted suicide and commit to working towards high quality palliative and end of life care.

If you have any questions please contact me at (808) 694-0000.

Mahalo!

Respectfully Submitted by Esther McDaniel

DATE: Tuesday, March 21, 2017

FROM: Genara Buza-Campos
Wife, Mother, Grandmother
Kapolei Resident

TO: House Health Committee
Rep. Dell Au Belatti, Rep. Bert Kobayashi, Rep. Dee Morikawa,
Rep. Chris Todd, Rep. Sharon Har, Rep. Marcus Oshiro, and
Rep. Andria Tupola

SUBJECT: Please Oppose SB 1129 SD2.

NOTICE OF HEARING
Date: Thursday, March 23, 2017
Time: 8:30am
Place: Conference Room 329

Aloha "love and peace" to our Hawaii legislators!

I oppose SB1129 SD2 establishes a medical aid in dying act that establishes a regulatory process under which an adult resident of the State with a medically confirmed terminal disease may obtain a prescription for medication to be self-administered to end the patient's life. (SD2)

This is propagandizing euthanasia. Euthanasia mercy killing is suicide. Allowing suicide medication to the suffering from an incurable or agonizing ailment administered by oneself is suicide. Suicide is the direct killing of oneself on one's own authority. Euthanasia is illegal in every state.

When both my mother-in-law heart disease (Kauai) and mother ovarian cancer (Seattle, WA) were dying in their hospital beds and no longer had any hope or promise for recovery, I gave them personal care in the comforts of home rather than dying in the hospital. I'm thankful they weren't mentally ill, but they did have impaired judgement, they couldn't make rational or autonomous decisions to end their lives, and they didn't want control over the timing of their deaths. I am at peace that no one lawfully took their lives, nor did our mothers give it up

the easy way out. I am at peace that they died naturally, reaching their goal of existence and achieving their highest good. You should have seen their end-of-life demeanor, high spirits, less burdened, worthy of their own person, smiles.

So, when the state makes it lawful to assist in death by prescription medication and as intended as a means to an end, is it for death's sake or for another means to something else? Could it be for economic reasons? Is there a financial incentive behind it? Who seeks to profit from this act?

What are the long term positive effects for good does it do for the volunteer patient and their families? What are the long term negative effects on the family? What are the effects on the physician and staff? What satisfaction or gratitude can come from a selfish act? Statistics show that most suicides are assisted by physicians versus self-administered. Isn't medical science intelligent and used to develop remedies that nature provides to preserve life? Instead, they wreck or destroy life that is entrusted to their care. Is this a good act, or a bad act?

According to a 2013 article on physicians aid-in-dying Ethics Magazine, "persons eligible must be competent in their decision and they want control over timing and death". Is the patient given a choice to act or not to act. To what degree is the person responsible for his own act? How do you determine that the person himself made his own choice? Can this person be given a chance for refusal?

I oppose this act which promotes the dangers of pleasure and attractiveness of the object that the patient may be encouraged to commit him/her self to it. This act encourages a person to forfeit his right to life. This act gives a person full mastership over his own life and goes against his own nature of a rational and free being. This act is wrong because it does not allow man to choose morally good acts. This act tries to dictate and contradict his purpose for existing.

Please vote NO on SB 1129 SD1, or continue your opposition to SB 1129 SD1.

Thank you sincerely,

Genara Buza-Campos

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 7:45 AM
To: HLTtestimony
Cc: gr84@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
g.m.clutter	Individual	Comments Only	No

Comments: i strongly oppose the passage of this bill

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kobayashi2 - Jessi

From: kkunitake@hawaii.rr.com
Sent: Wednesday, March 22, 2017 7:57 AM
To: HLTtestimony
Subject: Senate bill 1129SD2

Gentlemen: I strongly support senate bill 1129 SD2 because I feel that I should have a choice to die with dignity if I so chose.
Sincerely,
Janet K. Kunitake

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 7:39 AM
To: HLTtestimony
Cc: janetmgrace@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Janet Grace	Individual	Oppose	No

Comments: Dear Members on the Committee on Health: Thank you for the opportunity to submit testimony in STRONG OPPOSITION to SB1129 SD2. I have been caring for Hawaii's seniors and developmentally disabled populations for over 20 years. It's an immense privilege to say the least. I was also a ventilator caregiver on the beloved late Peggy Chun's, Peg's Legs Volunteer Team. Although I am clearly not a doctor, I've also had the honor of working with the best palliative care and hospice teams locally. Hawaii's healthcare professionals are some of the very best when it comes to ensuring our loved ones have access to high quality care. Healthcare I do know involves injury, illness and disease. Assisted suicide is none of these. Assisted suicide is a tragic commentary and will set a chilling precedent on how Hawaii values our most vulnerable populations. Hastening death is ludicrous, when many with terminal diagnosis actually thrive far beyond the DEADline that they were given by their doctor. Doctor's as brilliant as they are do make mistakes. They are human. Why are we risking losing those we love most because one man and his billionaire off-shore lobbyist think this is something the vast public wants. It's not true. When educated on the facts of this issue, many learn that the prescription involves taking 100 Seconal pills - that - in fact may not even kill them. Doctor is relieved of all responsibility. This is absurd. I cared for a 104 oldest living West Point graduate. He took his last breath (as did many other people) in my arms...He was sharp and lucid, but his body was dying under the heaviness of chronic disease such as COPD. Of course it was not easy, but with skilled hospice professionals keeping him comfortable and alleviating pain with proper medications he took his last breath with true dignity. Not alone in his room trying to ingest a bunch of narcotic powder. Imagine the horror in that. I could share literally hundreds upon hundreds of stories involving death and dying. Not a single one of them, no matter how we may believe our loved one is in excruciating pain, would have even suggested assistance to hasten "their" death. We know as well, Assisted Suicide is a slippery slope not just with elder abuse, pills laying around for young ones or addicts to find, but it is the ultimate gateway to euthanasia. How can you law makers have a clear conscience that family members and those with monetary opportunity would not encourage assisted suicide. How can you also, knowing statistically that Hawaii has one of if not the highest teen suicide rate in the nation. This is what is wrong with paradise. You are eroding the very unique gift of aloha and the special way Hawaii's families care for each other and even strangers. We can do MUCH BETTER than this. Let's continue improving upon the palliative and hospice care in place and allow those with terminal illness to die naturally with love and respect. Wow, just amazing we are even considering such a devaluing of life law. I urge you again to vote NO on this horrific bill. Mahalo, JM Grace

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 9:15 AM
To: HLTtestimony
Cc: mjrosehill@hotmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Jeanette L. Rosehill	Individual	Oppose	No

Comments:

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Date:	March 21, 2017
Testifier's name:	Joy Yadao R.N.
Committee:	House Committee on Health
Date and time of the hearing:	Thursday, March 23, 2017 8:30 am
Measure number:	SB 1129 SD 2

Aloha Chair Au Belatti, Vice Chair Kobayashi, and other House Health Committee Members:

My name is Joy Yadao and I strongly oppose SB1129. As a registered nurse with over 25years of experience, primarily in end of life care, this bill goes against everything I have worked for to improve access to quality care at the most precious time in ones life.

It is imperative that you understand the true dangers of this bill for the people of Hawaii. As the former Executive Director of the largest hospice and palliative care program in the state, I can say with absolute certainty that this bill, if passed will put innocent lives at risk. Our people deserve better care!

Accurate, up-to-date information is critical to have an informed discussion about physician-assisted suicide. The 2016 Oregon Death with Dignity Act annual report and data summary, published by the Public Health Division of the Oregon Health Authority and made available online to the public last month provide a telling assessment of the state of physician-assisted suicide in Oregon.

The data offers an unvarnished view of assisted suicide that is very different from what we have been led to believe about having adequate safeguards in place. Our fear is that SB 1129 SD 2, which is modeled after Oregon's law, will have the same loopholes and lax standards, if such a law is adopted by our state. Ultimately, our patients and their families will have the most to lose.

Top End-of-Life Concerns
During this legislative session, we have heard proponents of assisted suicide repeatedly claim alleviating physical pain and suffering is the primary reason for advocating their position. However, Oregon's 2016 data tell a different story. The data shows the top three end-of-life concerns among those who received prescriptions for lethal drugs: 1) they are less able to engage in activities to make life enjoyable (89.5%), 2) they feel a loss of patient autonomy (89.5%), and 3) they feel a loss of dignity (65.4%). None of these reasons relate to physical pain and suffering. In fact, by contrast, only about a third or 35.3% cited inadequate control of pain or concern as their primary end-of-life concern. [Source: Oregon Death with Dignity Act, Data Summary 2016, Patient Characteristics, page 6]

Mental Health Assessments

Although the primary end-of-life concerns relate to emotional and psychosocial health, only five patients in Oregon were referred for psychological or psychiatric evaluation in 2016. [Source: Oregon Death with Dignity Act, Data Summary 2016, DWDA Process, page 7] This is very small number based on the 204 patients who received prescriptions in 2016 and any other patients who received prescriptions prior to 2016. The surprising low referral rate for psychological or psychiatric evaluation may be due to the fact that physicians are not trained to assess mental health and may not know when such a referral is critically important.

Lack of Oversight

In 2016, 204 people received prescriptions for lethal drugs under the provisions of the Oregon Death with Dignity Act. Of those, 114 chose to terminate their lives, and 44 did not ingest the lethal drugs but died of other causes. The fact that the ingestion status of the remaining 54 patients is unknown raises a red flag for concerned physicians and other healthcare providers. Of these 54 patients, 10 have died but the Oregon report shows their ingestion status is unknown, and there is currently no data for the remaining 44 patients. [Source: Oregon Death with Dignity Act, Data Summary 2016, Participation Summary and Trends, page 5]

There is a lack of oversight because Oregon law does not require a provider to be present when the lethal drugs are ingested or at the time of death. According to the Death with Dignity Act 2016 data summary report, of the 133 deaths that occurred from ingesting lethal drugs in 2016, it is not known if a healthcare provider was present at the time of ingestion for the vast majority -- 100 patients. Five incidents were reported that there was no provider present at all. Of the 133 total deaths, there were only 14 incidents when the prescribing physician was present and 14 incidents when a healthcare provider other than the prescribing physician was present. [Source: Oregon Death with Dignity Act, Table 1, Characteristics and end-of-life care of 1,127 DWDA patients who have died from ingesting a lethal dose of medication as of January 23, 2016, by year, Oregon, 1998–2016, page 10]

Attempts to Strengthen Oversight

After 20 years of having the Death with Dignity Act, Oregon strives to have more stringent oversight and reporting. In an attempt to standardize reporting and data collection, a procedural revision was introduced in 2010. Rather than accept all information from all sources, the new procedure accepts information about the time of death and circumstances surrounding death only when a physician or another health care provider is present at the time of death.

Interestingly, for the 27 patients who terminated their lives in 2016, either the prescribing physician or another healthcare provider was present at the time of death. This leaves details about the other deaths subject to question since no reliable data is available. [Source: Oregon Death with Dignity Act, Data Summary 2016, DWDA Process, page 7]

Peaceful Deaths?

Proponents of assisted suicide claim patients can have a peaceful death through lethal drugs. Oregon's Death with Dignity Act data shows the contrary. Based on data available from only 25 Death with Dignity Act deaths during 2016, the time from ingestion until death ranged from seven minutes to nine hours. For two patients, the length of time between ingestion and death was unknown. The notion of a fast, peaceful death is largely rhetoric and is not based on facts. It is interesting to note that between 1998 and 2015, six patients regained consciousness after ingesting the prescribed lethal drugs, and these patients were not counted as a Death with Dignity Act deaths. [Source: Oregon Death with Dignity Act, Data Summary 2016, DWDA Process, page 7]

I thank you for this opportunity to testify before you and implore you to vote no on SB1129.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 9:00 AM
To: HLTtestimony
Cc: juliaelizabethallen@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Julia Allen	Individual	Oppose	Yes

Comments: Birth and death are public matters. By passing SB1129, we would create a pretense of privacy which undermines the public good. It diminishes us because we are each a part of mankind. Neither birth nor death is dignified. It is a fatal conceit to believe otherwise.

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 8:17 AM
To: HLTtestimony
Cc: karen_haddock@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Karen Haddock	Individual	Oppose	No

Comments: Please oppose this bill. No individual should have the authority to determine when and ill patienet is ready to die . No one has the right to rule over the life or death of the dying. Mercy for the dying is to give compassionate care, assistance with handling depression and allowing for a comfortable extension of life. Oppose to SN1129SD2

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Kat Brady
kat.caphi@gmail.com

COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Bert Kobayashi, Vice Chair
Thursday, March 23, 2017
8:30 a.m.
Room 329

STRONG SUPPORT FOR SB 1129 SD1 – COMPASSIONATE CHOICE

Aloha Chair Belatti, Vice Chair Kobayashi and Members of the Committee!

I am testifying in my own behalf this morning in strong support of this bill that allows a person of sound mind in the last stages of a terminal illness to exercise their personal autonomy and die peacefully.

This legislation builds on the 19 years of experience in Oregon, the first state that allowed people to use this safe and compassionate practice to end their suffering.

When my Mom was diagnosed with colon cancer, she asked me to be her health care proxy if she ever became unable to make her own decisions. We talked extensively about the treatments available and the reality of her diagnosis.

She lived for 7 more months and I was her 24/7 caregiver. It was the greatest gift she gave me. The time we spent together was amazing, revealing, and something I cherish every day. She shared things with me that I knew were important, but didn‘t understand until many years later.

Her doctor recommended chemotherapy and she went through three chemotherapy sessions, which left her sick and miserable for several days after the sessions. One morning, after the third treatment, she told me that she was done with chemo. She said she had a good life and was ready to die.

I called her doctor and told her that my Mom decided to end the chemo sessions. The doctor, with all the best intentions, tried to convince me that she wanted to try something a little different next time and asked that my Mom consider trying it. This was a difficult call for me because I understood that, as a scientist, the doctor was trying to find something that worked. It was a painfully long conversation as her doctor was explaining how this time the chemo could stop the growth of her cancer.

I knew my Mom was in stage 4 nearing the end of her life. I had read many books on cancer since I had a cancerous tumor in 1985 and spent a lot of time in medical libraries trying to determine my best course of action.

I finally had to tell the doctor that I appreciated her scientific curiosity, however, my Mom had decided that she was done with chemo. After more pleading by her doctor, I finally told her that I respected her zeal in trying to help, but that my Mom was done and that was not negotiable.

This all happened in the first 2 months of her diagnosis and her condition was deteriorating rapidly. She was losing weight and I could see her life force draining.

My Mom was a religious person, who only said the word "damn" once. One morning she woke up, she said "Oh s—t, I'm still here." I was stunned and said, "Mom, you said s—t!" We both laughed and then she told me of the dream she had just had.

She was in a big white room and there was a man in a white robe sitting at a white table. What did it mean, she asked? I told her that I thought it was a classic death dream. She said that she hoped it would come soon. We prayed together that it would.

It didn't. She lived for 7 months after her diagnosis. People told me how lucky we were that she went fast. I can tell you that that was the longest 7 months of my life and I will never forget the pain and suffering she endured.

What I learned from this is that it is really hard to die. No one is born with an expiration date. My Mom rallied 4 times when doctors expected her to die. It was the most painful thing to watch the person who gave me life and who was such a kind and generous person suffer.

I attended the Compassionate Choice panel discussion on February 23rd and respectfully disagree with Dr. Nakatsuka and Joy Yadao. NOT ALL PAIN CAN BE MANAGED.

I truly believe that is she had the means to end her suffering, that would have relieved the incredible stress she felt, that was in addition to the unbearable pain she suffered. I don't know if she would have taken that path, but I do know that it would have decreased her distress.

My Mom lived in excruciating pain and died weighing 45 pounds…with no dignity.

We closed her casket so her friends would remember Betty Brady as the vibrant and loving community activist she was her whole life.

SB 1129 SD1 affirms the right of mentally capable, terminally ill adults to determine their own medical treatment options as they near the end of life. Compassionate medical people should not be confronted with criminal liability for respecting the rights and autonomy of their patients.

I urge the committee to pass this bill so that people of sound mind with terminal diseases can choose to end their suffering and plan a graceful transition to the next life. This right to die is NOT suicide, it is respect for the right of a terminally ill and mentally capable person to not have to endure unbearable pain and suffering.

Some of the last words she spoke to me were, **"No one should have to go through this."**

Mahalo for allowing me to share the story of my amazing Mom.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 8:30 AM
To: HLTtestimony
Cc: kayaina808@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Kay Aina	Individual	Oppose	No

Comments: This bill 1) Opens the door to abuse of the elderly or infirm. Once a lethal prescription is written, an abusive caregiver or relative who stands to inherit from the patient can pick it up and give it to the patient in food or drink. Since no witness is required at the time of death, who would know if the patient consented? 2) Cheapens life. If assisted suicide is made legal, it quickly becomes just another form of treatment. It will always be the cheapest option, especially in a cost-conscious healthcare environment. Two Oregon residents, Barbara Wagner and Randy Stroup, were each denied coverage for their cancer treatments but received letters from the Oregon Health Plan stating the plan would cover their assisted suicides. Do we really want this for Hawaii? 3) Can turn treatable depression deadly. Most cases of depression among the terminally ill can be successfully treated. Yet, lethal prescription requests from terminally ill individuals are often based on fear and depression. Primary care physicians are not generally expert in diagnosing or treating depression, and nothing in the Oregon or Washington assisted suicide laws compels doctors to refer patients for evaluation by a licensed psychologist or psychiatrist to screen for depression or mental illness. Since this bill is patterned on the Oregon law, Hawaii also would have no protections for its depressed citizens. Do not pass this bill. Thank you.

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kobayashi2 - Jessi

From: Lana Oura <lana.oura@gmail.com>
Sent: Wednesday, March 22, 2017 8:46 AM
To: HLTtestimony
Subject: Testimony in support of SB 1129

I strongly urge you to support
SB 1129 allowing medical aid in dying as an end of life option for the citizens of Hawaii. Safeguards are in place and for anyone who is opposed, other end of life options are available to them. It's would be another option available to people already dying that wish to end their pain and suffering, retain their dignity, and transition into death in a more humane and peaceful way.

Mahalo!
Dennis Oura
43 Pohina St., 1601, Wailuku, Hi

Sent from my iPhone

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 8:43 AM
To: HLTtestimony
Cc: lindzbaby@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
lindsey	Individual	Oppose	No

Comments: Please vote no

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 8:24 AM
To: HLTtestimony
Cc: mhoapili@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Marcus Hoapili	Individual	Support	No

Comments: I believe that adults should have the choice to end their lives with dignity. This option should be a decision between themselves and their doctor.

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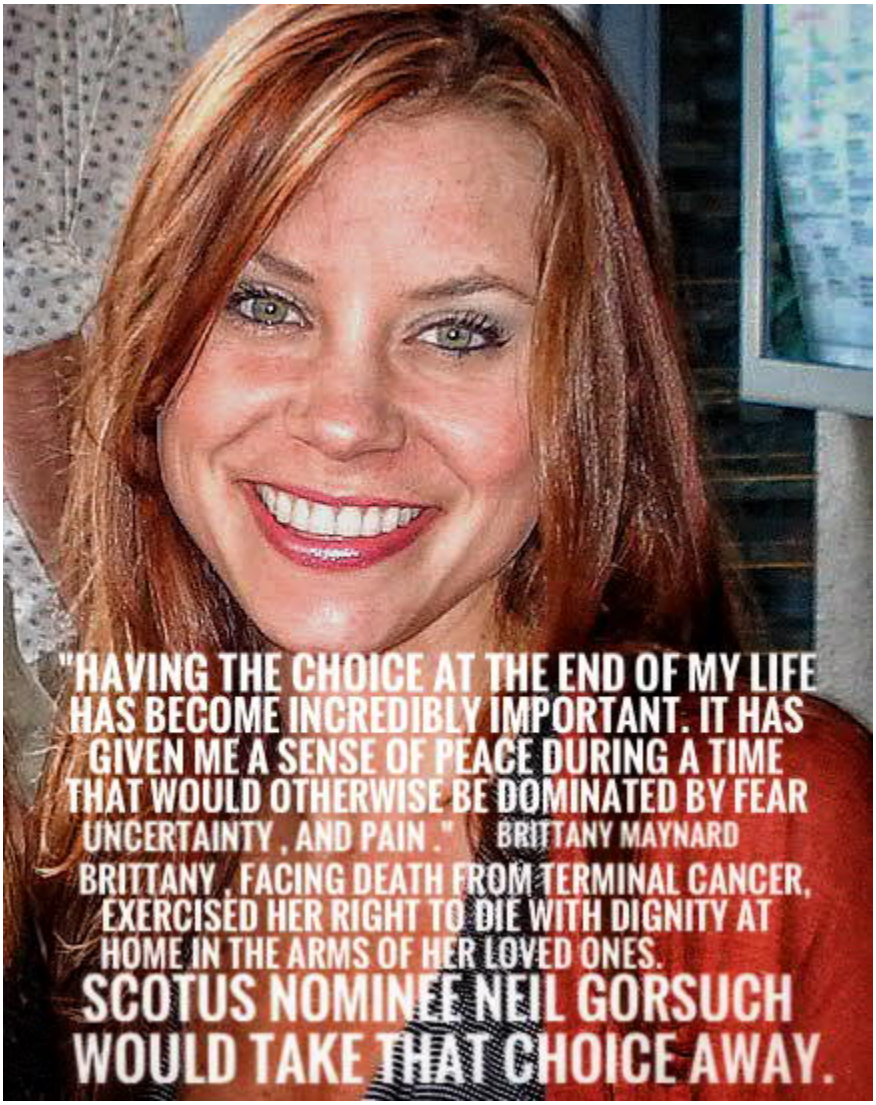
kobayashi2 - Jessi

From: Mark Ross <ross.mark69@yahoo.com>
Sent: Wednesday, March 22, 2017 9:15 AM
To: HLTtestimony
Subject: An important choice should be available to all .



Sent from my $137 preowned 'Deep State' iPhone

kobayashi2 - Jessi

From: Mary Sears <msears@uhalumni.org>
Sent: Wednesday, March 22, 2017 8:12 AM
To: HLTtestimony
Subject: Death with dignity

I strongly support Bill 1129 SD2 which supports physician assisted suicide. Please make this happen. Terminally ill patients should have this option available to them here in Hawaii.

Mary Sears
msears@uhalumni.org
(808) 373-6369
343 Hobron Lane, #3503
Honolulu, HI 96815

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 8:16 AM
To: HLTtestimony
Cc: mikepalcic@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Mike Palcic	Individual	Oppose	Yes

Comments: This bill takes us down the wrong path. It contravenes society's basic interest in preserving life and preventing the intentional taking of life. It massively bureaucratizes this taking with multiple approvals and waiting periods. It legitimizes the involvement of others, including the medical profession, in this taking. It makes a terminally ill person believe this “should” be done. It tries to soften the argument by telling us that taking one's own life is not suicide. It seems as much or more designed to alleviate the "suffering" of family, friends and heirs. It gets the job done and it's not dignified. This path is fraught with danger and will justify in a distressed person's mind the taking of one's own life for other reasons: depression, financial ruin, divorce or any of life's failures. Self- murder is against the law for good reasons and those reasons outweigh the establishment of a new patient "right" to choose suicide.

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kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 7:23 AM
To: HLTtestimony
Cc: neil.vonhof@gmail.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Neil Vonhof	Individual	Support	No

Comments:

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kobayashi2 - Jessi

From: Pamela Canton <z13thstar@gmail.com>
Sent: Wednesday, March 22, 2017 9:39 AM
To: HLTtestimony
Subject: Fwd: medical aid in dying

-------- Original Message --------
Subject: Fwd: medical aid in dying
From: Pamela Canton <z13thstar@gmail.com>
Sent: Wednesday, March 22, 2017, 9:36 AM
To: z13thstar@gmail.com
CC:

-------- Original Message --------
Subject: Fwd: medical aid in dying
From: Pamela Canton <z13thstar@gmail.com>
Sent: Wednesday, March 22, 2017, 9:32 AM
To: HTLtestimony@capitol.hawaii.gov
CC:

-------- Original Message --------
Subject: Fwd: medical aid in dying
From: Pamela Canton <z13thstar@gmail.com>
Sent: Monday, February 27, 2017, 9:27 AM
To: JDLtestimony@capitol.hawaii.gov
CC:

-------- Original Message --------
Subject: Fwd: medical aid in dying
From: Pamela Canton <z13thstar@gmail.com>
Sent: Monday, February 27, 2017, 9:23 AM
To: z13thstar@gmail.com
CC:

-------- Original Message --------
Subject: medical aid in dying
From: Pamela Canton <z13thstar@gmail.com>
Sent: Monday, February 13, 2017, 11:02 AM
To: CPHtestimony@capitol.hawaii.gov
CC:

25 years ago on Valentine's day my mother passed away after suffering the heinous effects of ALS, amyotrophic lateral sclerosis, watching her loose control over her bodily functions while her mind remained fully aware was almost more than I could bear. She couldn't communicate, she couldn't eat, she couldn't walk, she couldn't do anything that the rest of us take for granted.She watched the grandfather clock tick and waited for a miracle that never happened. Not everyone can have the amazing mind of Stephen Hawkins, and I think even, with his wonderful mind, living with ALS must wear on him as it did on my mother. Personally, I wouldn't be able to do it and the fear of this or something similar has made me plan for whatever the future might hold for me and how I might escape if I needed to. Please support the bill for medical aid in dying and I will give up my escape route because I have many fears that my plan might backfire and I would be in a worse situation. If I need to do this for a fatal tragic illness with no hope of recovery I would want to be successful. I have survived cancer and so far I personally have not had to be faced with this decision, please allow me to succeed if I needed to. Please support this bill. Please because if I ever need to, I will and by not passing this bill you put myself and others in a hard situation, we welcome the safeguards that this legislation would bring. aloha and peace to you.

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 7:44 AM
To: HLTtestimony
Cc: serenas.v3@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Serena Shimabukuro	Individual	Oppose	No

Comments: I oppose the proposed bill. There is no guarantee for the length of time a person has to live, and a person should not engage a medical professional in prematurely ending one's life. An individual's own termination of life is called suicide. A physician's participation in the ending of a patient's life is called homicide. This practice should not be allowed. Please join me in opposing this poorly conceived proposal to end human life.

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kobayashi2 - Jessi

From: Sharon Beach <sharon@beachfamily.net>
Sent: Wednesday, March 22, 2017 8:27 AM
To: HLTtestimony
Subject: Supportive Testimony for SB 1129 SD 2

I am in support of SB 1129 SD 2. Dignity in dying should be a fundamental human right guaranteed by our state. Forcing a terminally ill person to suffer is inhumane and uncivilized.

Sharon Beach, Maui

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 7:41 AM
To: HLTtestimony
Cc: ssimao1@hotmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Shirley Simao	Individual	Oppose	No

Comments: I oppose, please vote no!

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 7:51 AM
To: HLTtestimony
Cc: srfung@hotmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Sophie Fung	Individual	Oppose	No

Comments: I strongly oppose this bill! Not only does it violate the sanctity of life but it opens a Pandora box. It's a very slippery and steep slope in which our Kupuna and Ohana have no voice or recourse. I humbly plead with you to oppose the passing of SB 1129 SD2.

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kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 7:40 AM
To: HLTtestimony
Cc: staceykuhn@live.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Stacey E Kuhn	Individual	Oppose	No

Comments: I strongly oppose this measure.

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Steve Sibert @ stevebsibert@gmail.com

I am here to support the Death with Dignity Act, SB 1129, Hawaii's proposed medical aid in dying legislation.

Currently in Hawai'i, terminally ill individuals have limited options if their suffering becomes unbearable at the end of life. Options include: declining treatment or avoiding unwanted medical treatment, hospice and palliative care, or VSED (voluntarily stopping eating and drinking). However, physicians do not always offer these options to their patients and, more importantly, these options may not result in a peaceful death. Many Hawaii residents do not qualify for some these options.

The people of Hawai'i should have the option, together with their 'ohana and their doctors, to make the end-of-life decisions that are right for them in the final stages of a terminal illness -- including the option to request a prescription from their doctor to end their dying process painlessly and peacefully. SB 1129 would give those who are dying this important option.

Please make it possible to expand end-of-life options in Hawai'i

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 9:51 AM
To: HLTtestimony
Cc: suerainbowskies@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

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

Comments: I am dealing with metastatic breast to bone cancer. I urge you to support SB 1129 to provide me and others like me with the knowledge that if my suffering becomes too intense I have another option, medical aid in dying, that I can consider to hasten my death. I'm not sure I would take the medication but knowing it is available is a tremendous relief. Mahalo for your kind consideration. Sincerely, Susan Faith Rubin

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I am here to support the Death with Dignity Act, SB 1129, Hawaii's proposed medical aid in dying legislation.

My parents, both veterans that served this country for over 30 years were both diagnosed as terminally ill, with very different endings.

My terminally ill father suffered an agonizing, painful death even with hospice and palliative care, as the family watched and could not help him. We had failed him.

My mother after enduring this event and then being diagnosed terminally also ,did not want to put herself through this or have her family feel her suffering, found a way the be able to end her life with medical aid in dying.

No family should have to move to another state or have to resort to VSED (voluntarily stop eating and drinking), a long and painfully process to be relieved of such agony.

Many people do not qualify for Hospice and Palliative care if they are diagnosed as terminally ill;

They may be under 65 (Medicare)
Make too much money for (Medicaid) but not enough to afford medical insurance

Will they have to suffer the pain and agony if diagnosed as terminally ill?

As a Catholic this is very hard for me to do, but I promised my mother I would do everything possible so no other family would have to endure this.

In Hawaii we can't move or travel to make this choice for ourselves or have our Ohana with us if we have to relocate.

The people of Hawai'i should have the option, together with their 'ohana and their doctors, to make the end-of-life decisions that are right for them in the final stages of a terminal illness -- including the option to request a prescription from their doctor to end their dying process painlessly and peacefully. SB 1129 would give those who are dying this important option.

As a veteran myself (USMC), I ask you to please pass this bill.

Susan Lynch @ susanlynch808@gmail.com

kobayashi2 - Jessi

From: Susan Olson <susankukana124@gmail.com>
Sent: Wednesday, March 22, 2017 8:10 AM
To: HLTtestimony
Subject: Medical Aid in Dying

I am writing to ask you to please pass the Medical Aid in Dying Act (Senate Bill 1129) out of Committee to allow the full vote of the House of Representatives. The Senate has already approved this bill, 22-3.

All human beings should have the right to choose how they want to die without the interference of any government or religious institution. When a person is terminally ill, controlling pain is simply not enough. Sometimes, the process of dying drags on interminably, causing anguish for the dying person as well as the family and loved ones. If a patient's condition is terminal, then they should have the right to have a physician prescribe life-ending medication which could be taken to hasten their own death at the time of their own choosing. In states that have Death with Dignity laws, most people who obtain these medications do not actually use them but having the choice gives them peace of mind and personal dignity.

I watched my own mother unnecessarily die a long, slow death by starvation. She had multiple medical conditions that were terminal She chose to refuse tube-feeding and other aggressive measures to keep her body going. Instead, she signed up for Hospice and chose to stop eating and in the end, also stopped hydration. But her body took an entire month to shut down. She and our family endured a horrible ending as she grew weaker and weaker, lost control of bodily functions and felt mentally anguished to be leaving in such a horrifying way. She simply wanted it to be over and to have the dignity with which she had lived her life. This was denied to her because there was no state law to give her Medical Aid in Dying.

It should be noted that the states in which Medical Aid in Dying laws have been passed, have not experienced abuses of their laws. There are multiple safeguards to prevent abuse including second opinions, psychiatric assessments, counseling, waiting periods, etc. No physician is actually assisting the patient to die, in fact this is unlawful. It is the patient's CHOICE whether or not to take the life-ending medication and the patient must be able to get the medicine in their own mouth and to swallow it without assistance.

The majority of Hawaiian residents are in support of a Medical Aid in Dying law, In 2004, a similar bill was narrowly defeated largely due to an in-pouring of funds from out-of-state opponents using scare tactics. This was not fair and these opponent claims have proved to be erroneous. Please let the state of Hawaii have another chance to create a fair and safeguarded law by passing it out of your Committee.

Sincerely,

Susan Olson
75-6081 Alii Dr. #F102
Kailua-Kona, HI 96740

March 22, 2017

To: Representative Della Au Belatti
Representative Bertrand Kobayashi

From: Susan Oppie RN BSN
816 Birch St #305
Honolulu, HI 96814

Re: **SB1129- Establishment of a medical aid in dying act**

Written testimony in **support** of this bill

I have been a registered nurse for more than eighteen years. Eight and a half years I served as a hospice nurse and another four-plus years I worked on various floors in hospitals. During these years of direct patient care I saw death occur dozens of times and I learned what I hold to be true to this day- *there are worse things than death.* I have seen women and men in unbearable pain in their final months, weeks, days and hours. Even with the best hospice and palliative care available nothing could control these individuals' extreme discomfort. I have witnessed the visible panic in the faces of individuals who were not able to breathe due to cancer, Amyotrophic Lateral Sclerosis (ALS, aka Lou Gehrig's disease), Chronic Obstructive Pulmonary Disease (COPD), and other conditions affecting their lungs. I have visited those experiencing frightening hallucinations caused by pain medications. And I have attempted (without success) to help patients who had uncontrollable hiccups, not hiccups that lasted for minutes or hours but those that lasted continuously for days and weeks. This may sound like a minor discomfort to some but please believe me there is nothing minor about constant spasms preventing restful sleep or the ability to eat or drink. Additionally, I have listened to countless family members of the dying who shared their anguish and feelings of helplessness in making their loved ones more comfortable. These are just some examples of what I consider to be unnecessary suffering.

Four of my eight and a half years in hospice were served in Portland, Oregon and southern Washington. During this time I met several individuals who went through the process of obtaining the medications that could ultimately bring their lives to an end as allowed by the Death with Dignity acts in each of those states. Even though none of these individuals with whom I spoke wanted to get to the point where they felt it was time to use the medications, they expressed great relief that they had the option to do so. I was never in attendance when a life was ended in this manner but heard many reports that it was a very peaceful end. I believe that if there is a means by which people can be in control of how their

lives end and not be forced to needlessly suffer it should be made available and protected by law. I wholeheartedly support the passing of SB1129 because I know what having such an option means to those who are dealing with a terminal illness especially one that is known to potentially have a very unpleasant progression to the final moment of life.

Thank you for the opportunity to submit testimony.

kobayashi2 - Jessi

From: Susan Scofield <sscofield435@gmail.com>
Sent: Wednesday, March 22, 2017 7:55 AM
To: HLTtestimony
Subject: Supportive Testimony for SB 1129 SD 2

I support SB 1129 SD 2. If you ever experienced a love one suffering through the end of his/her life, having other options available just makes the dying process more humane.

Thank you for considering passage of this bill.

Susan Scofield
2752 Kamelani Loop
Pukalani, HI 96768
--
Sent from Gmail Mobile

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 9:09 AM
To: HLTtestimony
Cc: Terez.amato@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Terez Amato Lindsey	Individual	Support	No

Comments: Self determination is a cornerstone in life.Those who are terminally ills hold have the right to die with dignity if that is their choice. Thank you. Terez Lindsey

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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kobayashi2 - Jessi

From: Joycelyn <hazwell@gmail.com>
Sent: Wednesday, March 22, 2017 6:53 AM
To: HLTtestimony
Subject: Sb 1129

Please support SB 1129

Dr. Thomas Min advocated for a law as SB 1129 for many, many years. He testified every year at the Hawaii State Legislature until he no longer could. Dr. MIn died in 1998.

Some of you in the State Legislature may still remember him: **Dr. Thomas S. Min** was a private physician for the late Dr. Syngman Rhee, former president of the Republic of Korea.

Dr. MIn was my brother's father-in-law. Through my brother and his family, i knew Dr. MIn to be a very kind gentleman, doctor, father, father-in-law, and grandfather to my nephew and nieces. He was generous and loved his family immensely. I believe that he must have loved everyone and understood so well the value of human life and quality of human life and existence.

Dr. Min's dedication took him to the State Legislature, testifying as a physician/citizen for compassionate end of life laws for Hawaii citizens. He understood the importance and impact that compassionate end of life options would have for patients and their survivors. He was a doctor and saw first hand and probably suffered first- hand along with his patients and their families for the lack of compassionate end of life options. I recall him testifying frequently at the Legislature for such laws, year after year after year with no success. Yet, he endeavored.

Dr. Min worked hard to try to get compassionate end of life laws passed. He wanted to see this happen in his lifetime. He saw the need for it. But previous State Legislatures failed to pass any such laws to help terminally ill patients to quietly and peacefully end their pain and suffering. We still do not have compassionate end of life laws in Hawaii.

Dr. Min was a man ahead of his times because he knew and experienced first hand the need for such laws.

Please support SB 1129.

Sincerely,
Joycelyn iyo

Sent from my iPad

kobayashi2 - Jessi

From: Joycelyn <hazwell@gmail.com>
Sent: Wednesday, March 22, 2017 6:52 AM
To: HLTtestimony
Subject: Sb 1129

I am writing to support SB 1129.

This is the story of Margaret, my mother-in-law. She was ill for quite a while with cancer attacking her body. She suffered so much pain and eventually died of lung cancer that spread throughout her body. She did not have choices to end her life in a more graceful, peaceful, compassionate way. Her loved ones also suffered and could only watch her suffer until her death. Near the end she told her children that she wished and wanted a pill to end her pain, suffering, and life. There was no such option, she had to endure her pain and died suffering.

Almost all folk, all over the world, would only want our mothers and fathers to have peaceful senior years with the least discomforts as possible. Yet, so many people with terminal illnesses have end of lives that are overcome with pain, trauma, and suffering. And their loved ones and friends all suffer along with their beloved.

Please support SB 1129. It is a very important bill that many would be overjoyed to see it become law in Hawaii. A law that would alleviate the pain, suffering, trauma that patients and their survivors have to endure in terminal illnesses. Although it provides a choice to end life, it also offers hope and relief to the terminally ill individual as well their survivors for a "way out" . . . "opting out" of enduring pain, trauma, and suffering to the very end and rest of their life.

We will all die. Providing compassionate options is very humane and a kindness that we can offer to our fellow human beings. Pass this bill. It will give them an option. Those affected by a terminal illnesses will be the ones to decide if they will end their life. Give them the option. It is their decision. They are the ones suffering...not the rest of us or the State of Hawaii.

Sincerely,
Joycelyn iyo and Husband

Sent from my iPad

kobayashi2 - Jessi

From: Joycelyn <hazwell@gmail.com>
Sent: Wednesday, March 22, 2017 6:50 AM
To: HLTtestimony
Subject: Medical aid in dying. SB 1129

Please support this important bill.

Years ago my Aunty Kay committed suicide by drinking ammonia while a patient in the hospital in Honolulu. She could no longer bear to see her husband struggle with the anguish of her suffering and the financial toll it was taking on their family's finances. She was successful and chose to end her life in a most excruciating way.

I remember her although I was only in elementary school. Now I am a Senior Citizen.

My Aunty Kay had only kindness in her heart. She was a petite, soft spoken, Japanese woman, always well presented, who can only be described as very dignified and a gentlewoman. Her choice was to end her and her family's suffering in the only way she could as she was not ambulatory at all. She probably saw the container of cleaning ammonia and saw her chance to end her life and drank it.

She deserved a kinder, more compassionate, and humane way to end her life. Drinking ammonia to end your life is a violent way to die...full of suffering, pain, and trauma...also trauma for the hospital staff, her husband and extended family and friends. She did it because she saw no hope and the hopelessness it was causing all her family and loved ones.

I will send under separate email more stories of people i know. Each if them deserve to be heard individually and their story known in support of sb 1129 and IN SUPPORT of MORE HUMANE CHOICES for People now and in the future.

SB 1129 is an Important bill for Everyone.

Sincerely,
Joycelyn Iyo

Sent from my iPad

kobayashi1- Oshiro

From: Joycelyn <hazwell@gmail.com>
Sent: Wednesday, March 22, 2017 7:01 AM
To: HLTtestimony
Subject: Support SB 1129

Our story

We, our family and extended ohana, strongly support SB 1129.

My spouse has been diagnosed with cancer.

Although my roots are here on the Big Island, we have decided to uproot our little family, say goodbye to mother, father, sisters, brothers, nieces, nephews, friends, neighbors, and business associates. We are closing our thriving business which has an international clientele and selling our house. My spouse and adult child already have their one way tickets to the mainland. We have already settled on a house on the mainland. I will be joining them later next year when i can retire from the State. I am a government employee. I will be retiring before reaching full retirement age to take care of my spouse.

Why? Two reasons. We need to get my spouse to a place where there is better medical care whereas here there is only one oncologist in East Hawaii. Main reason, though, we are all moving to a State that has death with dignity laws where a person who has a terminal illness can opt for compassionate dignified death instead of having to endure the pain, suffering, and trauma that goes with cancer.

Sincerely yours,

Please support SB 1129

Sent from my iPad

SB 1129 TESTIMONY

HOUSE COMMITTEE ON HEALTH

HEARING DATE: 3/23/17 TIME: 8:30 A.M.

Please vote in support of SB 1129 (legislation allowing terminally ill, mentally capable adults the legal right to medication they can use to achieve a peaceful death.) I have witnessed firsthand the adverse effect of the individual, their loved ones, and their care givers, when you prolong the dying persons suffering. Imagine your loved one asking why they must continue to endure such pain and suffering and why in this day and age they are not allowed a more humane and peaceful death.

I understand that some people think the solution to dying on your own terms is to refuse food and water and rely on pain management medications that sedate you. Those medications do help control pain but the downside is that while your body is shutting down (and it can be a long wait) you wither away to just a sack of flesh and bones, and in many cases, due to the medications, you are no longer aware of your surroundings. Where is the dignity, humanity, and peace in that scenario? Please ask yourself, is that the kind of end of life experience YOU want for yourself and loved ones?

Yes, the opposition is well organized and funded, but please do not be pressured into thinking they are the voice of the majority.

All of our past governors that are still living (George Ariyoshi, John Waihee, Benjamin Cayetano, and Neil Abercrombie, have spoken out in support of Medical Aid in Dying. On top of that, recent polls show over 70 percent of adults residing in Hawaii support Medical Aid in Dying legislation. If Hawaii's Constitution permitted laws to be enacted via ballot initiative, we would already have this option.

Respectfully submitted,

Lana Oura
43 Pohina St., Wailuku, HI 96793

Barbara L. Franklin, Esq.,
Attorney at Law

45-3438 Mamane Street, Bldg. 2
Honoka`a, HI 96727
Ph. (808) 775-0530 Fax: (808) 775-1040
barbara@island-law.com
www.island-law.com

March 22, 2017

Rep. Della Au Belatti
Rep. Bertrand Kobayashi
And Member of the
Committee on Health

Re: SB 1129 SD-2 Support

Dear Chairperson Belatti and Vice Chairperson Kobayashi:

I write in strong support **SB 1129, S.D. 2** which seeks to allow competent, terminally ill adults to obtain prescription medication to end their own lives. The constitutional right to bodily autonomy includes the right to make personal decisions about how to spend one's final days. Six states — Oregon, Montana, California, Vermont, Washington, and Colorado — have legalized medical aid-in-dying.

I support **SB 1129, S.D. 2**, and respectfully ask the Committee to approve this measure.

Thank you for your thoughtful consideration of this bill.

Sincerely,

Barbara L. Franklin, Esq.
Attorney at Law

Testimony of Benjamin B. Massenburg MD

Post Office Box 1565
Kahului, HI 96733

March 20, 2017
SB 1129 SD 2

House Health Hearing on Thursday March 23, 2017

To the Chairwoman Della Au Bellatti, Vice Chairman Bertrand Kobayashi, and Members Dee Morikawa, Andrea Tupola, Marcus Oshiro, Chris Todd, and Sharon Har,

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

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

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

And we have to acknowledge the doctor patient trust relationship so important to medicine which will be broken with this SB1129 SD 2.

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

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

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

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

March 21, 2017

STRONG SUPPORT FOR SB 1129 SD2 RELATING TO HEALTH
Hearing March 23, 8:30am, Room 329

TO: Chair Della Au Bellati, Vice-Chair Bertrand Kobayashi, and
Members of the House Committee on Health

FROM: Barbara Polk

I am writing as a woman in my mid-70s in strong support of this bill. While I am still in good health, I can't help but look ahead to what comes next. I support SB1129, which would give people in the last stages of illness the ability to terminate their lives.

I have a friend who made use of Oregon's Death With Dignity law, which was passed 20 years. He died at home, surrounded by friends and family, who were able to tell him what he had meant to them before he died (rather than at a funeral when he would not be there to hear). He was able to say a few words to the people around him as well. His favorite music was playing as he took the pill that ended his life. He went peacefully to sleep, leaving behind the severe pain he had been suffering for weeks. Isn't this a better way to die?

Not everyone would make this choice. None of use would know until the time came. But the possibility of choosing to end one's life a few months early, when it became unbearable is something that many people, myself included, would like to have.

I urge you to pass SB 1129.

House Health Hearing
3/23/17 Room 329
SB 1129 SD2

To Health Committee

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

Opposition to SB1129 from Dr. Gamboa

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

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

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

House Health Hearing
3/23/17 Room 329
SB 1129 SD2

To Health Committee

From Brian Delara

SB 1129 has been introduced. I want you to know that we don't need so called 'aid in dying' in Hawaii. What we need are increased services for those of us with medical challenges. I have been fortunate to be receiving medical care for chronic infections-I am writing you from the hospital. I appreciate that no one has offered me assisted suicide as my life is difficult and challenging. (If someone offered it to me I would think they just don't want to struggle to care for me). I have problems keeping my scooter in good repair and can't get around without it. I have been trying for months to find a place to live as few want to rent to someone bedbound with a scooter and who just wants a room big enough that my daughter can come and visit me occasionally. However, I appreciate that I am alive and have people in my life who love me. What about those who don't have anyone? Please don't make this bill real.

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

To the Hawaii House Health Committee for their discussion of SB1129 SD2 on March 23, 2017-Honorable members

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

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

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

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

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

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

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

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

Respectfully submitted,

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

Hi

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

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

Clayton Kanae
471 Lipo Place
Wailuku 96793
Sometimes I get my mail at this address. I would be happy to meet you and discuss this any time.
1/3/16

House Health Hearing
3/23/17 Room 329
SB 1129 SD2

To Health Committee

Emma B. Avilla-Delaney

1728 Dillingham Blvd

Honolulu, Hawaii 96819

House Health Hearing on March 23, 2017

Regarding SB1129 SD 2

I oppose.

Chair Della AuBelatti and members Kobayashi, Har, Tupola, Oshiro, Todd, Morikawa,

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

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

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

Thank you for considering my concerns.

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

Testimony in OPPOSITION to SB1129

House Health Committee Hearing on Thursday 3/23/17 at 8:30 AM

Madame Chair and Members,

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

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

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

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

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

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

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

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

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

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

IN **SUPPORT** OF SB1129

God gave us life…and God will take our lives when it's time for us to go. One of the ways our lives are taken is through illness. It is our signal that our life is coming to an end. It gives us time to review our lives, to reflect on our thoughts and deeds, and to reconcile matters before we go. It is meant to be a compassionate departure. Nobody said it would be easy.

But, there are those who defy God's plan. They prolong lives just for the sake of prolonging life. Prolonging life just because it can be done doesn't make it right. Prolonging life is not compassionate if it perpetuates pain and suffering. Maybe it makes them feel God-like. Does it make them feel powerful? Maybe they are projecting their own fears of dying upon others.

I don't see them acting on behalf of God. I don't think they understand the role of God in this important thing called life. I see them imposing their beliefs on others by wrongly exercising a prerogative to prevent the natural and inevitable end of life.

At a critical time when a dying person and God come into juxtaposition, those who intercede and interrupt this inevitable union don't serve either God or man. It is the height of human arrogance to usurp the relationship between man and God. It shows a lack of understanding of the role that man plays in life and it shows disrespect for the hand of God.

The fundamental credo of doctors is: "First do no harm." But doctors who insist that life must be preserved at any cost are the most harmful agents in a dying individual's life because they interfere with the person's end of life process that should be respected. I urge those doctors to stay out of my life.

Gary Saito
batfish@hawaii.rr.com

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

To: House Health Committee Chair Della AuBelatti and members
House Health Hearing on Thursday March 23,2017
Re: SB1129 SD 2
Position: Opposition to Physician Assisted Suicide

Honorable Committee Members,

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

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

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

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

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

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

Thank you,
Dr. Gabriel Ma

Hawaii State Legislature HOUSE HEALTH 3/23/17

RE: SB1129

COMMITTEE MEMBERS—

I am opposed to Senate Bill 1129 for a number of reasons, including:

1) Physician-assisted suicide leads to an increase in all suicides. This is often called the "contagion" effect. This has happened in Oregon. Here is an unedited abstract from the Southern Medical Journal (http://www.medscape.com/viewarticle/852658):

How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?

Authors- David Albert Jones, DPhil; David Paton, PhD

South Med J. 2015;108(10):599-604.

Objectives: Several US states have legalized or decriminalized physician-assisted suicide (PAS) while others are considering permitting PAS. Although it has been suggested that legalization could lead to a reduction in total suicides and to a delay in those suicides that do occur, to date no research has tested whether these effects can be identified in practice. The aim of this study was to fill this gap by examining the association between the legalization of PAS and state-level suicide rates in the United States between 1990 and 2013.

Methods: We used regression analysis to test the change in rates of nonassisted suicides and total suicides (including assisted suicides) before and after the legalization of PAS.

Results: Controlling for various socioeconomic factors, unobservable state and year effects, and state-specific linear trends, we found that legalizing PAS was associated with a 6.3% (95% confidence interval 2.70%–9.9%) increase in total suicides (including assisted suicides). This effect was larger in the individuals older than 65 years (14.5%, CI 6.4%–22.7%). Introduction of PAS was neither associated with a reduction in nonassisted suicide rates nor with an increase in the mean age of nonassisted suicide.

Conclusions: Legalizing PAS has been associated with an increased rate of total suicides relative to other states and no decrease in nonassisted suicides. This suggests either that PAS does not inhibit (nor acts as an alternative to) nonassisted suicide, or that it acts in this way in some individuals but is associated with an increased inclination to suicide in other individuals.

2) As many physicians will disclose, it is not possible to accurately determine the length of time that an individual with a terminal diagnosis will live. Many patients given a 6 month prognosis outlive that time frame. I have worked as a nurse in hospice and have seen firsthand that an individual's time on this earth is unpredictable. Further complicating this estimation is the individual's choice of treatment.

3) The disabled, elderly and infirm are vulnerable to abuse under the proposed Bill. As I care for my elderly mother with metastatic melanoma, I can appreciate how an impatient or greedy family member could influence the disabled or ill elderly to make a decision they would not normally consider.

4) Participation in causing the death of patients undermines public and patient trust in their medical providers. I am a nurse practitioner and am well aware that trust is crucial to providing optimal patient care. I personally would not want to receive care from a provider known to prescribe lethal drugs to their patients. I have been an educator of nurses for over 20 years. I am proud that the American Nurses Association has clear ethical guidance that nurses should not participate in assisted suicide nor execution of criminals. Here is the policy from the ANA:

Statement of ANA Position: The American Nurses Association (ANA) prohibits nurses' participation in assisted suicide and euthanasia because these acts are in direct violation of *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001; herein referred to as *The Code*), the ethical traditions and goals of the profession, and its covenant with society. Nurses have an obligation to provide humane, comprehensive, and compassionate care that respects the rights of patients but upholds the standards of the profession in the presence of chronic, debilitating illness and at end-of-life.

I will be teaching the above to my students in California this week. I was an assistant professor of nursing at University of Hawaii Maui College for many years. My primary home is on Maui. I am currently/temporarily teaching at California State University Long Beach as I oversee the care of my mother. I anticipate returning to my home on Maui in a few years.

Sincerely,

Gayle Early PhD, APRN, FNP-BC
30 Kewai Pl
Pukalani, HI 96768

2243 Stonewood Ct
San Pedro, CA 90732

(808) 344-7021
gayleearly@yahoo.com

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

Hearing March 23 2017 at 8:30 with the House Health Committee

I am in strong opposition to SB1129

Chair AuBellati, Vice Chair Kobayashi and members,

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

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

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

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

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

Physician opposition to assisted suicide bill before you.

House Health Chair Della AuBellatti and members of the health committee at this hearing on March 23 2017 regarding SB1129 SD2:

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

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

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

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

Thank you,
Dr. Harriet Pien

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

House Health Committee hearing on 3/23/17 Room 329

Subject: SB 1129 SD2 regarding assisted suicide

Honorable Chair Della AuBelatti, members Bertram Kobayashi, Sharon Har, Andrea Tupola, Dee Morikawa, Marcus Oshiro, and Chris Todd:

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

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

Physicians do not want to be involved. The doctor-patient trust relationship is important to protect and there is no need for assisted suicide especially disguised in your SB1129 words as medical treatment. Please remove those words from this bill-better yet- stop the bill in committee.

Thank you for the opportunity to express my concerns.

Philip D Hellreich, M.D.

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 12:21 PM
To: HLTtestimony
Cc: wolff.howard@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

Categories: Green Category

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Howard J. Wolff	Individual	Support	No

Comments: I strongly urge you to vote in favor of this bill. In its current iteration, it includes many safeguards against abuse. The issue to me is freedom of choice. It provides a compassionate option for those of sound mind who are terminally ill and in significant pain to end their own suffering at the time of their choosing. It doesn't force anyone to do anything.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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

Honorable Chair Bellatti, Vice Chair Kobayashi, and members of House Health,

I am testifying against SB1129 SD2 before you.

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

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

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

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

Thank you,
James McKoy, MD

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 11:16 AM
To: HLTtestimony
Cc: JAMESLOGUE412@GMAIL.COM
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
James Logue	Individual	Support	No

Comments: Please keep the suffering of others in mind when discussing this bill. I believe it is the right of an individual, after consultation with a medical professional, to determine the path best for them. I ask that you please aid and assist those who seek this option by passing this bill.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

Do not reply to this email. This inbox is not monitored. For assistance please email webmaster@capitol.hawaii.gov

Jason Kiaffas APRN
221 Mahalani Street
Wailuku Hawaii 96793

jkiaffas@hotmail.com

3/21/17

House Health Hearing on Thursday March 23, 2017 at 8:30 AM
Related to SB1129 Draft II Physician Assisted Suicide
I am in **strong opposition** to this bill and hope you do not pass it out of committee.

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

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

House Health Committee Hearing regarding SB1129 SD2 March 23 2017 8:30 AM Room 329

Honorable Chair Bellatti and members of the House Health Committee,

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

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

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

Suicide is not simply one more end of life choice.

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

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

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

Thank you for the opportunity to express my viewpoint.

Jeffrey M Drood, MD

House Health Committee Hearing on SB 1129 March 23, 2017 at 8:30 AM

I came to Hawaii and testified in person before your Senate Health Committee and though I can't be there in person this time, would like to share my opposition to SB1129.

My Experience with Assisted Suicide in Oregon

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

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

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

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

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

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

Physician's Role

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

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

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

Suicide

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

Assisted Suicide is Suicide – Beware of Deceitful & Dishonest Euphemisms

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

Assisted suicide death certificates are falsified by assisted suicide doctors

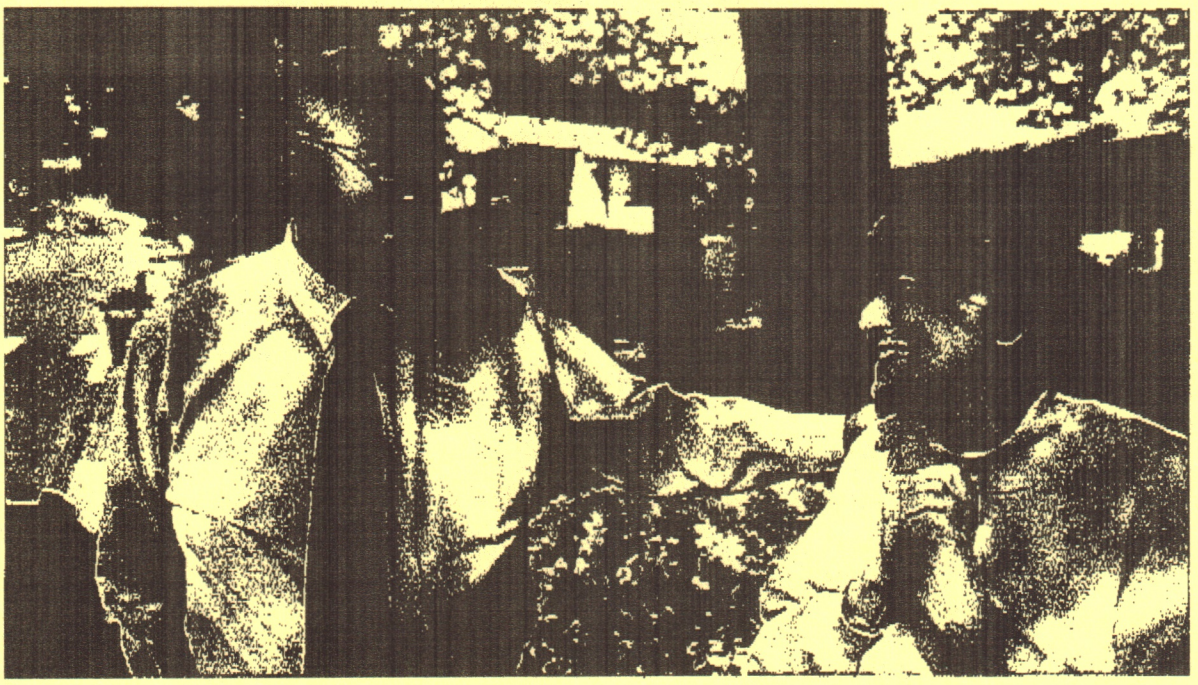
In Oregon, doctors are instructed to put the underlying disease as the cause of death. But the reality is the person died from an overdose of drugs resulting in an assisted suicide. Doctors are directed to falsify the death certificate. This undermines transparency in the record and the ability to investigate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

Pain is Not the Issue

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

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

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



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

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

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

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

For Jeanette, the mere presence of legal assisted suicide had steered her to suicide. She has now told me repeatedly that if I had believed in assisted suicide, she would be dead.
http://dailysignal.com/2015/05/18/assisted-suicide-how-one-woman-chose-to-die-then-survived/

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

I have treated many cancer patients who were told they had only a few weeks to a few months to live, who have lived much longer; some patients as long as 20 years after a "terminal" brain tumor diagnosis.
See my paper: "Terminal Illness, What Does it Mean?"
http://www.pccef.org/resources/documents/PRCUpdate_2011_4pg4-5.pdf

Financial Incentive for Assisted Suicide
Barbara Wagner – "They will pay for me to die but won't pay for me to live."
In Oregon, the combination of legal assisted suicide and prioritized medical care based on prognosis has created a danger for my patients on the Oregon Health Plan (Medicaid). First, there is a financial incentive for patients to commit suicide: the Plan will cover the cost of assisted suicide. Second, the Plan will not necessarily cover the cost of treatment. The story of Barbara Wagner was publicized in Oregon in 2008. She was informed that the Oregon Health Plan Insurance would not approve and pay for her lung cancer medication, but they would pay for Comfort Care, which included assisted suicide. She told the TV reporters, "Who do they think they are? They will pay for me to die, but won't pay for me to live." See http://abcnews.go.com/Health/story?id=5517492.

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

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

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

What message does legalization of assisted suicide send to those who are considering suicide because of life's problems?
See:
http://www.pccef.org/pressreleases/documents/AbsenceofresponsetoOregonssuicideproblem6115pressrelease7v_000.pdf

Legalization of physician-assisted suicide does not result in a decrease in regular suicides.
Researchers have recently reported that "legalizing physician assisted suicide has been associated with an increased rate of total suicides relative to other states and no decrease in nonassisted suicides.
(Jones DA, Paton, D. How does legalization of physician-assisted suicide affect rates of suicide?, South Med J. 2015; 108(10):599-604)

Lack of Oversight by Oregon Health Department
There is a serious problem with the Oregon Department of Health's oversight of assisted suicide. Following a failed assisted suicide attempt in 2005 (David Pruiett), the Department of Human Services (DHS) stated that they had "no authority to investigate individual Death with Dignity cases – the law neither requires nor authorizes investigations from DHS *"Press Release from DHS on 3/4/2005*"
The problems with the Oregon information is exemplified by the following: The 2011 year report (released in 2012) listed the underlying illness as "Unknown" for 3 patients. How can an "Unknown" diagnosis be terminal? Residence was "Unknown" for 3 patients. How can two doctors confirm that a patient is terminal when the diagnosis in "Unknown". In the past 5 years (2009-2013) the prescribing doctor has been present for only 65 of the 574 (11%) assisted suicide deaths in Oregon. Yet, doctors are asked to describe what happened at that time. They have no knowledge. Doctors are not required to care for the patient once the prescription for lethal overdose has been written.

Abuses and Complications

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

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

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

Coterie of Insiders Runs the Program

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

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

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

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

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

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

No safe harbor for patients

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

In Summary

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

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

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

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

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

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

TO: Chair AuBelatti, Vice-Chair Kobayashi, and Honorable House Health Committee Members,
HEARING: Thursday, March 23, 2017 Committee on Health

POSITION: As a physician, I oppose SB1129 SD1
From: Kevin K. Kurohara M.D.

Honorable committee,

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

SB1129 harms medical care. A study in Oregon found that dying patients in Oregon are twice as likely to experience pain during their last week of life then they did prior to the passage of their legislation. Though the majority of people in Oregon do not list pain and suffering as the reason they chose to use the drugs, you are basing your Hawaii vote on this non-issue due to tragic stories proclaimed by some.

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

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

SB112 authorizes 'treatment' that is not treatment and it is dangerous because it is cheaper than good care and eliminates real treatment options for the poorest and most vulnerable.

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

Thank you for your consideration of my point of view.

Kevin Kurohara, M.D.

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 12:01 PM
To: HLTtestimony
Cc: ltakagi1@hawaiiantel.net
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

Categories: Green Category

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Lee Takagi	Individual	Support	No

Comments: We have living wills with directions to not hook us up to keep us alive by artificial means. Now we need a way to quietly end a terminally ill life with dignity, in the privacy of one's home, saving much emotional, financial, and physical pain. Please pass this very reasonable bill. Mahalo nui loa.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

Do not reply to this email. This inbox is not monitored. For assistance please email webmaster@capitol.hawaii.gov

Laura DeVilbiss MD MPH
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Honolulu, HI 96813
devilbissjl@aol.com
(808) 595-7011

March 21, 2017

RE: SB 1129 SD2 to be heard on Thursday March 23, 2017 at 8:30 AM

Dear Hawaii House of Representatives, Committee on Health,

I am a Family Physician and have been practicing medicine in Honolulu for the last 20 years. I strongly oppose SB 1129 SD2. My objections fall in line with both the position statements of the American Medical Association and the American Geriatric Society.

The American Medical Association position statement is "Allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer and would be difficult or impossible to control, and would pose serious societal risks."

The American Geriatrics Society position statement is:

1. "The fundamental goal of the doctor/patient relationship has been to comfort and to cure. To change the physician's role to one in which comfort includes the intentional termination of life is to alter this alliance and could undermine the trust between physician and patient.
2. Allowing Physician Assisted Suicide opens the door to abuse of the frail, disabled, and economically disadvantaged of society, by encouraging them to accept death prematurely.
3. A thorough search for the underlying reason for the request for death may uncover several areas amenable to potential interventions (undertreated physical symptoms, psychosocial or spiritual crisis, clinical depression, etc.).
4. Legalization of physician assisted suicide might thwart society's resolve to expand services and resources aimed at caring for the seriously ill, eventually dying patient."

My thoughts on these statements are:

- I went into medicine to help my patients live a healthier life, and when this is not possible, help them to have comfort and peace in their remaining days on this earth. Changing the role of physician from healer/comforter to someone who aids in the suicide of a patient is a dangerous road to go down which threatens the doctor-patient relationship and the trust that is built up over years.
- The protections outlined in SB 1129 SD2 would be hard to control and could be abused by those close to the patient who have ulterior motives besides the well being of the patient. Once a patient gets a prescription for a life ending drug there is no protection for that patient if someone were to coerce them to take it against their will if they changed their mind. There is no mandate

for a witness to observe the death and so someone could force the patient to take the medications against their will and no one would know.

- Elders don't want to be a burden on their families. When medical and hospital bills are mounting up there would be too much pressure on a frail elderly person with limited financial resources to take the life ending medication so that they won't burden their loved ones anymore. Allowing the law to change so that a vulnerable patient would feel pressure to commit suicide against their true will (duty to die) is elder abuse.
- Instead of going down the road of physician assisted suicide, I would spend our resources on continued access to pain control, counseling for adjustment to terminal diagnosis, and time spent celebrating life rather than forcing a premature death.

I urge the committee to consider these arguments and choose not to pass SB 1129 SD2.

Thank you for giving me the chance to share my testimony.

Sincerely,

Laura DeVilbiss M D

Laura DeVilbiss MD MPH

Family Physician

Honolulu, Hawaii

Testimony on SB1129 SD2 from **Leonard Howard, MD** for House Health Hearing on 3/23/17

Chair Au Belatti and members of the House Health Committee:

Thank you for allowing me to testify on this highly controversial bill. The title you have given it is Medical Aid in Dying. This is somewhat misleading as the subject of the bill is Physician assisted suicide/physician assisted death. The furor over this topic has gone on since pathologist Dr. Jack Krevokian assisted Janet Adkins of Portland Oregon to commit suicide in Michigan. She was suffering from Alzheimer's disease. In those days pain was a serious problem. This is 2017 and things have changed tremendously.

SB1129 SD2 does not recognize those changes.

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

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

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

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

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

Thank you for your kind attention.

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

Leslie Williams
318 Makea Street
Makawao, Hawaii 96728
practical.dog@gmail
283-1887

House Hearing Thursday March 23 2017 at 8:30 AM

I oppose SB1129

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

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

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

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

Sincerely,

Leslie

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

TO House Health Committee hearing on Thursday March 23 at 8:30 AM
RE SB 1129 SD2
Please do not pass this bill out of your committee.

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

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

As a public minded citizen and a person with chronic pain, I have been studying this issue and am horrified at what I have learned.
1) In the Netherlands, euthanasia is sliding down the slippery slope of "termination without specific request".
2) The protections in the Oregon law are essentially meaningless if the action was taken with "good intent".
3) Some HMO administrators consider assisted suicide a reasonable cost-containment strategy.
4) Doctors are often too afraid of liability to offer enough medication to effectively manage pain.
5) Many doctors know little about pain management or end of life care.
6) Many people don't know that suicidal depression, even that which often accompanies terminal illness, is treatable.
7) Many people—including doctors—are ignorant about disability and think that needing to ask for help is worse than death.
I don't trust in our ability to write laws that are precise enough to guard against a poorly informed medical community or general public.

It is time for the medical community to give serious attention to relieving suffering and improving quality of life for both those with long-term disease and those reaching the end of their lives. Give them a simple solution like euthanasia and they will stop struggling to provide better care. Legalization of assisted suicide is not the answer.
I strongly oppose SB1129.

Thank you,
Linda Toms Barker

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

Hearing: Thursday 3/23/17 8:30 AM
House Health Committee Room 329
SB1129 SD 2

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

As a physician, I oppose SB1129 SD2. The definition of compassion is "deep awareness of the suffering of another coupled with the wish to relieve it". As a compassionate physician, my commitment to you the patient includes:
I value you as a person worthy of my efforts.
I will do all I can to find ways to relieve your pain, discomfort, and suffering.
I will be honest with you.
I will never intentionally kill you.

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

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

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

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

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

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

Please do not pass this bill out of committee.

Lloyd Jones, M.D.

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 11:32 AM
To: HLTtestimony
Cc: lon.putnam@yahoo.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

Categories: Green Category

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Lon K Putnam	Individual	Support	No

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 12:37 PM
To: HLTtestimony
Cc: stormlouises46@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

Categories: Green Category

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Louise Storm	Individual	Support	No

Comments: I worked in healthcare for over 30 years and I am old enough to have experienced not only patients, but several family members and friends pass away under various circumstances, some of them after experiencing extreme physical and existential pain. If you think it's excruciating to watch, can you imagine being the person experiencing the event? Why would you want to prolong it, even with palliative measures, at great expense to their survivors and to society? Why is it humane to put suffering animals "to sleep" and not offer the same relief to a human being? For people who think suffering has some kind of character-building component (as in Jesus suffering on the cross, perhaps), maybe they would change their mind if they could envision stepping into the sufferer's skin and feel the pain that they feel. (And I believe Jesus' dying for humanity's sins was supposed to cover everybody for all time, so further suffering is unnecessary.) My opinion has always been that the person who is responsible for the consequences should be the one to make the decision on helping to bring a terminal illness to an end. If this bill is about making that a reality, I am all for it.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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House Health Committee Hearing regarding SB1129 SD2 March 23 2017 8:30 AM Room 329

Honorable Chair Bellatti and members of the House Health Committee,

As an oncology nurse manager for 13 years of my career I am writing to hopefully put some perspective on the assisted suicide issue HB 201. During my 13 years as an oncology nurse I have known only 2 patients who took their own life. Most patients who were terminal passed away peacefully with their loved ones at their side. The common theme among those with terminal cancer was to live out their last days with their family and spend every moment in which they still have breath with their loved ones. The two who took their own life were able to do it without a physician assisting.

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

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

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

Marny Hall-Moriyasu

Marny Hall-Moriyasu

Michael R Savona M.D.
Internal Medicine, Oncology

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

March 21, 2017

Regarding: SB1129 SB2

Position: Opposition

Honorable Chair Belatti, Members of the House Health Committee:

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

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

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

In my opinion, SB1129 SD2 is an invitation for abuse. Safeguards protect no one. It will not and cannot ensure patient control, and physician competence in end of life matters.

Sincerely,

Michael R. Savona M. D.

Michael R. Savona M. D.

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 12:44 PM
To: HLTtestimony
Cc: mikemcguire87@msn.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

Categories: Green Category

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Michael McGuire	Individual	Comments Only	No

Comments: I support this bill because I watched my friend Jeri die of Ovarian Cancer on June 19th, 2009 in St Francis Hospice. I can tell your first hand that hospice and palliative care are wonderful, but sometimes death can be too complicated. How does hospice dea l with a dying patient who cannot breathe because their lungs collapsed? Remember, there is no intubation in hospice; hence no ventilators. I believe SB 1129 gives dying patients one more option at the end; it's there in case all else fails. Hopefully, they will not have to use it, but it's good to have this type of insurance: it would have given my friend Jeri peace of mind during her last days on this earth. 80% of the people of Hawaii support this option. Why? Probably, they witnessed some painful death somewhere along the line. Yes, our medical system does not have all the answers when it comes to dying: death is messy and may involve a lot of unnecessary suffering. Please vote for this bill to give the people of Hawaii the same option that people in Oregon, Washington, California, Vermont, Colorado and, DC now have. The option of having some type of insurance at the end, in case all else fails. It's life, our death, and our choice. Those who don't believe in this option don't have to use it. It's totally voluntary.

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Michael H Plumer, MD, MBA, HMDC
Kauai
mplumer44@gmail.com

FOUR MYTHS ABOUT ASSISTED SUICIDE IN HAWAII

Myth # 1. SB1129 is needed to protect patient choice at the end of life.

This is a complete untruth, peddled to a naïve society by a richly-funded marketing/lobbying group that has been trying for 20 years to sell the same story in every US state.

1. Everybody supports protecting patient choice. However, this bill is not about patient choice. The rich lobbying group employs classic misdirection to gather support for a bill that seems to be about choice, and is actually about power – power allowing doctors to be involved in killing their patients with little investigation or followup.

2. Patients can already choose their end-of-life course without this law.
   A. If suffering is the issue, palliative care and specialized hospice care are widely available to everyone.
   B. A patient who wants to end his or her own life is free to do so. Suicide is completely legal in Hawaii and every other US state.
      i. A doctor's prescription is not necessary for suicide, and in fact represents a less-effective approach to suicide.
      ii. Derek Humphry, founder of the Hemlock Society, forerunner of the current rich marketing/lobbying group, tells how to arrange one's death in his book "Final Exit," still available on Amazon.
         a. He favors inhalation of inert gas (helium, argon, or nitrogen – available over the counter everywhere) as the most effective and painless approach.
         b. He lists problems with the medical prescription approach.

3. SB1129 allows doctors to make decisions about who will die, to provide a Lethal Weapon in the form of a massive overdose of prescription medication, to cover up any details of the death that may seem unsavory, and to report as little as they choose to the state.

4. This bill will require that doctors lie about the cause of death on the official death certificate, even though these certificates become the basis for national medical planning and disease surveillance.

Myth #2. Medication for suicide is easily available in the form of a pill that doctors could prescribe.

1. This is completely untrue.

2. No prescription medication produces death with a single pill, or even a few pills. No such medication would ever be allowed by the FDA to reach the market because of its risks.

3. Death from prescription medications requires a massive overdose, up to 100 times the FDA-recommended therapeutic dose. At this point, the substance is no longer a medication but a Lethal Weapon.

4. There is no "best" Lethal Weapon drug. Manufacturers remove or restrict medications that are being used for killing, whether by legal lethal injection to serve a death penalty, or in a perversion of prescription use to commit suicide.

A. Pentothal is no longer available anywhere because manufacturers did not want to support lethal injection.

B. Darvon (propoxyphene) is no longer available as a pain medication because it was being used for suicide.

C. Pentobarbital, once the recommended medication of the rich assisted-suicide lobbying group, has become unavailable because it is also used in lethal injection.

D. Secobarbital is the only remaining sleep medication/barbiturate recommended by the rich lobbying group. Death requires at least a 100-fold overdose (100 bitter capsules emptied into a bowl and mixed to become a slurry, taken quickly so the person intending to die does not fall asleep before a lethal dose is taken in.

i. Barbiturates sometimes produce nausea or vomiting, raising the risk of breathing stomach contents into the windpipe and choking to death, or losing medication in the vomit so that death no longer occurs.

ii. Death with barbiturates is not always swift. Patients in Oregon have lived as long as 4 days before dying; six patients have failed to die at all.

E. Doctors in Washington, and now in Colorado, are experimenting with other drugs. None have been used to produce death previously in this way, so every use is an experiment. Some patients have died very badly, some screaming in pain with burning throats or other misery.

F. There is no FDA-approved Lethal Weapon dose of any medication. All use is untested, completely up to the prescribing doctors. The most frequent prescribers, those who work with the rich lobbying organization, do not publicly report their results.

Myth #3. Oregon has had an assisted suicide law for almost 20 years with neither fraud nor abuse. This proves it's OK.

1. Oregon's law was deliberately crafted in 1993 to appear to have safeguards and reporting requirements. The rich lobbying group has done a skillful job of having people believe that safeguards and reporting are effective, and they have skillfully resisted any attempt to change or improve this law in the face of criticism. This applies to every state. The rich lobbying group brings the law, sells it to legislators, appoints themselves guardians of the law, and finds that most of the patients seeking death come to physicians affiliated with the group, who are not required to share their information.

2. Episodes of difficulty with the Oregon law have surfaced, but the lack of valid information at the state level prevents followup or effective statistical statements. Most deaths are unattended, so the events are unreported. Did the patient take the drug? Voluntarily? Did somebody else "help out" by giving extra drug IV or rectally, or even by using a pillow or a plastic bag? Oregon has no such information, and does not conduct an anonymous survey as in Holland, depending entirely on individuals to report their own problems and face scrutiny.

3. Patients have no further protection after the prescription is issued. No scrutiny or reports are required.

4. Lethal Weapon doses that are unused because the patient changes his or her mind, or dies too soon to use the medication, remain in the community, with no requirement for disposal or return.

5. Death certificates will be falsified, with no evidence that patients died of barbiturate overdose.

i. Falsification of death certificates robs the CDC of accurate information about actual causes of death in the US, and prevents effective response to problems.

ii. Prior to the rich lobbying group's successful efforts to generate false death certificates in cases of assisted suicide, this was characteristic only of totalitarian regimes involved in actions that the regime did not want discovered.

a. All "euthanasia" patients killed in Germany between 1939 and 1941 had false death certificates listing a plausible cause of death.

b. All "final solution" victims who were killed in any of Germany's death camps also had death certificates indicating plausible causes of death.

Myth #4. Hawaiians overwhelming want physician assisted suicide. The rich lobbying group's surveys prove that as many as 80% support it.

1. It is true that Hawaiians overwhelmingly indicate an interest in control at the end of life, in freedom from suffering, and in dying with dignity. It is not true that Hawaiians want physician assisted suicide – this is more classical misdirection by the rich marketing/lobbying group.

2. No survey conducted by the lobbying group has ever shown that physicians are required to be agents of death in order to meet those interests of Hawaiians. There is no evidence that people answering these surveys have any idea at all what is actually involved in giving doctors the freedom to decide who will die.

3. The rich lobbying group does not disclose that its national agenda is to have doctors be agents of death in every state, and that it is prepared to move directly from "more palatable" assisted suicide to "more resisted" euthanasia, as is now happening in Oregon, where a "death by advance directive" bill is being considered. It equally does not disclose that it opposes *any* scrutiny of prescription requests or suicide deaths, and has attached the sham safeguards and reporting requirements in order to reduce resistance to initial passage of a bill.

Michael H Plumer, MD, MBA, HMDC
mplumer44@gmail.com
Kauai

(Dr. Plumer is board certified in hospice medicine and anesthesiology, with a graduate certificate in healthcare ethics, and practices on Kauai)

March 23 hearing on SB1129 SD2 in the House Health Committee
To the Honorable Members of the State Legislature House Health Committee,

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

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

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

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

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

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

5. In my work as a hospice physician, I witness many situations where the motives of caregivers, and at times family members, are questionable at best. Financial incentives are highly motivating at stressful times, and there is no clear way to know that a patient ingests the prescription himself, or if it is given by a caregiver or family member with a questionable motive.
6. Like every other physician in Hawaii, I have never been trained to write a prescription for a lethal dose of medication. I have never been trained on

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

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

Respectfully,
Nancy Long, MD
808-344-5166

kobayashi1- Oshiro

From: Naomi Loewe <nnloewe@hotmail.com>
Sent: Wednesday, March 22, 2017 10:17 AM
To: HLTtestimony
Subject: SB1129

Please have the courage to give the people of Hawaii the CHOICE to elect a "pain free" death for themselves and those who must survive them. People should not be forced to "live" in extreme pain by the government. Let us make our own CHOICE when OUR time comes.

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

House Health Committee Hearing March 23, 2017 at 8:30 AM concerning SB 1129 SD2

Honorable Members of this committee,

I am against SB1129

I've been there.

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

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

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

Please hold this bill. Thank you.

Aloha Madame Chair and members of the committee:

I am in favor of SB 1129. We are all going to die. Big news yeah? Well it 's true. The circumstances of that event are unknown. Most of us hope it will be in our sleep at a ripe old age. I know I pray every night that should be my fate. However I do not know.

I do know that if I were in pain, constantly, every second of the day, unable to eat (one of the great pleasures of life), or drink…just waiting for the excruciating end. I HATE TO WAIT!!! I would want to say ENOUGH ALREADY!!! I have a DO NOT RESUSCITATE ORDER and NO EXTRAORDINRY MEASURES order with the hospital in the case of an accident, but illness is another matter altogether.

Pain is not normal. Pain is the result of either injury or disease. Disease pain is much worse than injury. I want to have the option to peacefully leave when I choose. Please give me that right.

Mahalo nui loa,

Paul Janes-Brown, President 12-1
Vice Chair D -12
PO Box 851
Makawao, HI 96768-0851
pjbdem@gmail.com
572-8000

kobayashi1- Oshiro

From: plloewe@hawaii.rr.com
Sent: Wednesday, March 22, 2017 10:33 AM
To: HLTtestimony
Subject: SB 1129

Dear Senators,
It is the 21st century. The time has come to let human beings decide how they want to die. Please vote to pass SB 1129.
Mahalo,
Paul Loewe

Peter J Barcia MD

Opposition to SB1129 SD2

Hearing on March 23 2017 8:30 AM at the State Capitol

House Health Committee Chair Della AuBellatti, and members of the committee,

My wife and I have lived in Hawaii since 1965 where we have raised 10 children and 20 grandchildren, the majority of which still reside here. I retired in November of 2016 as general surgeon at Tripler Army Medical Center where I was on active duty until my military retirement in 1997.

While I believe that assisted suicide is morally repugnant, and will undermine the credibility of all physicians, I also believe it is unnecessary. I will tell you a story which will illustrate my point.

Years ago, Carol, a neighbor in her 50s came to our house with serious health concerns; this led over the next week to a tissue diagnosis of far advanced pancreatic cancer with proven spread to her liver. Currently there is no cure for her problem. Her health care team consisted of a general surgeon, a medical oncologist, and home health care nurses, who enabled her to be cared for at home with an IV central venous access: this provided for painless blood draws, IV fluid administration, and medication administration. Carol managed her pain with a device she controlled to deliver morphine as needed. The nurses trained her husband a adult children to care for her needs; these family members are competent, and obviously pleased to be helping. I visited her almost daily and though frequently somnolent, she easily awakened and joined in conversation. I asked her about her pain which was either none, or that it is under control. Clearly, she was ablating and managing her pain with the narcotic.

This is not an uncommon story and my point in telling it is that modern end-of-life care is now able to give patients and their families control over the old nemesis pain, allowing these patients to be humanely and compassionately cared for at home by those that love them.

Instead of killing them with assisted suicide!

If we offer a cheap and simple solution to a complex but manageable problem we will stop wrestling with how we can keep improving care.

Peter J. Barcia, MD, FACS
162 Mahealani Place
Kailua, Hawaii 96734261-4787

Peter Muthard MD
221 Mahalani Street
Wailuku, Hawaii 96793

March 21, 2017

House Health Hearing on Thursday, March 23, 2017 at 8:30 AM
Regarding Senate Bill #1129 Senate Draft 2

To the members of the House Health Committee, Chair Bellatti, Vice Chair Kobayashi, Members Sharon Har, Marcus Oshiro, Andrea Tupola, Chris Lee and Dee Morikawa,

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

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

Please stop this bill from moving out of your committee.

Thank you for this opportunity to testify.

Pete Muthard, M.D.

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

March 21, 2017

To the House Health Committee hearing on 3/23/2017 at 8:30 AM
From Dr. Reginald Buesa
Regarding the SB1129 SD2 for today's hearing
I am opposed to this bill, please do not move it forward.

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

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

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

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

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

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

Yours truly,

Reginald G. Buesa MD

Scott Moon, MD

To House Health Committee Chair Della AuBelatti and members

Regarding House Health Hearing Thursday 3/23/17 at 8:30 AM

I am a Radiation Oncologist practicing full-time at Kona Community Hospital.

I strongly urge you to defeat the SB 1129, SD1 doctor-assisted suicide bill. It is unnecessary and isn't why most patient choose to use it in Oregon. Pain can be managed by modern medicine. Suicide is not medical treatment and never should or could be as it is not a treatment – it is killing.

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

Safeguards in Oregon-- as proposed in Hawaii bill-- protect no one. HMO administrators have overruled their physicians to authorize PAS in Oregon. Doctors have given suicide drugs to depressed patients they met only 2 weeks earlier. In clear violation of the law, a family member administered suicide drugs to his brother. Nurses have openly admitted they killed their patient and are still practicing.

It is dangerous because it is cheaper than good medical care and eliminates treatment options for the poorest and most vulnerable. This could potentially create a path for insurance providers to basically force a patient to choose suicide over medical care using cost as a driver.

Many, many independent experts, state legislatures, state courts, and the United States Supreme Court have all rejected PAS.

Elder abuse is a real concern. Who is to say the request is not coerced? Once a family member has secured the suicide drugs, no one is required to witness the death. If the elderly patient changes his/her mind, they could be force-fed the drug for financial gain or other nefarious motives.

Again, I strongly urge you to defeat this dangerous bill. It is the perfect example of a wolf in sheep's clothing.

Scott D.M. Moon, MD

808 322-6948

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 9:59 AM
To: HLTtestimony
Cc: malikoestate@hawaii.rr.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
sydney smith	Individual	Support	No

Comments:

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TO Chair of House Health Committee Della Au Belatti and Members,
FOR Hearing on Thursday March 23, 2017 at 8:30 AM

I am a physician who opposes SB1129 SD2 before you today.
NCTERMULO@aol.com

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

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

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

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

Thank you,

Dr. Termulo

Timothy Jahraus MD
drj@hilogastro.com

SB 1129 SD 2 House Health Hearing 3/23/17

Venerable Chair AuBelatti, Vice Chair Kobayashi and members of House Health,

I want to indicate my strong opposition to the assisted suicide legislation making its way through the legislature-SB1129 SD2 especially- redefining medical treatment, allowing doctors to monitor their own performance, etc.

I personally am opposed to assisted suicide and believe that most of my colleagues are opposed as well. I see this as a terrible betrayal of our role as healers and promoting longer and better life.

Do you remember when Hawaii wanted to be known as the health state?

I hope that in your deliberations that you will strongly consider the physician community's voice in whether or not to enact this bill.

This certainly seems to be a hot button issue with lots of money and influence coming in from out of state. **Let's make sure that the Hawaii physician voices and patient voices are the ones being heard and heeded.**

Mahalo for your time and kokua.

Timothy Jahrus MD

To: Chair AuBelatti, Vice-Chair Kobayashi and Honorable House Health Committee members
HEARING: Thursday, March 23, 2017 House Health
POSITION: I oppose SB 1129 SD 2
FROM: William Fong, M.D., 1319 Punahou Street, Suite 801, Honolulu, HI 96826

Chair AuBelatti and Honorable Committee Members:

I am a physician and a practicing obstetrician-gynecologist and I am testifying against SB1129 SD 2.

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

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

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

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

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

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

Suicide is not a medical treatment and it never should be. It must be made clear that I share the opinion of many of my colleagues who strongly oppose PAS, who believe that it is not good for our society and who urge that SB1129 SD 2 be defeated.

FROM: DR. WILLIAM WON
1532 Laukahi Street
Honolulu, Hawaii 96821

TO: House Health Hearing on Thursday March 23, 2017
MY POSITION: As a physician, I vehemently oppose SB 1129 SD2

Honorable Chair Della Au Bellatti, Bert Kobayashi, Chris Todd, Dee Morikawa, Marcus Oshiro, Sharon Har and Andrea Tupola,

I am a retired neurosurgeon who has practiced in this community for over 30 years. During my active years of practicing neurosurgery, I can say with great confidence that I have never had a patient who asked me to help them commit suicide.

Advocates of suicide are misleading when they claim pain is the principle and significant reason that we need this bill. Even in Oregon, where they have assisted suicide, 92% of thepeople who used it admit that they used it for social reasons, not pain. There has been no documented case of it being used for intractable pain.

Doctors have the means to help manage pain. Fifty or so years ago we were taught in medical school that pain means a nerve is being pinched by something, and if you remove the offending structure or substance from the nerve involved, the pain will go away. Today, we know better—that that concept is a very simplistic view of the pain process, and that the mind-body perception of pain plays a more important role in the problem of pain. A good example of that is severe low back pain. All radiologists know that frequently the patient with the most sever low back pain can have spinal x-rays that are completely normal, and that other patients can have the most awful looking x-rays of the spine, and yet hardly ever complain of pain.

Treating terminally ill patients, like all doctor-patient relationships is a very personal matter. There are as many reasons to want to die as there are reasons not to want to die. And each situation is different. There are as many different reasons as there are patients, and therefore a general law to cover all patients in these situations is almost impossible.

I am assured the safeguards and contingencies written into SB1129 SD2 are supposed to protect and prevent mishaps. If I was asked to prescribe the medicines and I refused I am supposed to be protected from that patient suing me. I am sure that if such a law is passed (and we can see from anecdotal evidence in places where it is legal), some aggressive lawyer,, eager to make a name for himself or some advocacy group like C&C will be able to twist and turn the language of the law to make it seem like the doctor is a criminal in such a case.

Safeguards in Oregon are not protecting their citizens. They clearly cannot and haven't prevented abuse. As the innocent are dead, we can't ask them but doctors have given lethal medications to depressed patients they met only 2 weeks earlier. And if one doctor won't give you the medications because of one of the 'safeguards' another one will—that happened several documented times.

Everyone would like a dignified death. Calling it dignified or calling suicide a medical treatment doesn't make it so and it shouldn't as we all wrestle with our own mortality. Many states have strengthened their laws against PAS. <u>The profound social dangers of PAS should be self-evident.</u>

Zora Bulatovic MD
zbulatovic@mauimedical.com

For House Health Hearing on Thursday March 23, 2017 at 8:30 AM

Relating to SB1129SD2

Honorable Chair and members of the House Health committee,

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

Please stop this bill in your committee. Physicians don't want this. Thank you for this opportunity to express my opposition to SB1129SD2.

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 11:57 AM
To: HLTtestimony
Cc: deborah@imaginariums.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

Categories: Green Category

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Deborah Davis	Individual	Support	No

Comments: Thank you for supporting this legislative bill that allows us humans an option to die with dignity and not prolong suffering, physically, emotionally, mentally and financially. Mahalo nui loa!

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kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 1:03 PM
To: HLTtestimony
Cc: bestb002@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Barbara Best	Individual	Support	No

Comments: I strongly support adults being able to decide their own demise if life is intolerable to them. Mahalo!

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kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 2:21 PM
To: HLTtestimony
Cc: jceefay@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Constance Fay	Individual	Support	No

Comments: This is a humane option for people with terminal illnesses who are in unbearable pain that cannot be managed. Please vote for it. Aloha, Constance Fay

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kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 1:43 PM
To: HLTtestimony
Cc: dnbldr@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Dean Nelson	Individual	Oppose	No

Comments: Dear Chair Belatti, Co- Chair Kobayashi and Honorable Committee Members, My name is Dean Nelson and I am writing in strong OPPOSITION to SB1129 SD2 "Relating to Health". Thank you for your consideration.

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Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members,

My name is John Pang and I am writing in OPPOSITION to SB1129 SD2. Too general and not enforceable so poorly conceived and written.

John Pang

3227 Paliuli St

Honolulu, HI 96816

808-295-3545

Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair
House Committee on Health

March 23, 2017

TESTIMONY IN SUPPORT OF
SB 1129, SD2
RELATING TO HEALTH

Dear Chair Au Belatti, Vice-Chair Kobayashi and Members of the Committee,

My name is Kiani Oliveros, BSW and a current MSW student at the University of Hawaii at Manoa. I am writing to express my **strong support** for **SB 1129, SD2.** This measure establishes a medical aid in dying act that establishes a regulatory process under which an adult resident of the State with a medically confirmed terminal disease may obtain a prescription for medication to be self-administered to end the patient's life.

I believe that a terminally ill person's end-of-life choices should be his or hers alone, without the interference of government and without the interference of others' religious beliefs, values or opinions. In the medical setting, a terminally ill person who does not have the right to decide whether or not to end their life is something that I see as a social injustice. If we have the right to put down our animals, why shouldn't we as human beings have the right to put ourselves down when faced with a terminally ill situation? I use to have a very different opinion on this issue before I became a Social Work intern at a local hospital where I work with elderly patient's who have terminal illnesses. After seeing at first hand how some of my patients suffer day in and day out, I have come to accept the fact that we should all be able to practice personal autonomy. Why should the government or other's beliefs determine how we should live our last days here on earth? It is easy for others to oppose such a bill when they have not lived in the shoes of these terminally ill patients.

This is a bill about personal choice and freedom. Anyone opposed to assisted dying simply need not ask. This bill would give patients with terminal illnesses the power to choose, not life over death, but one form of death over another. This bill gives people the opportunity to have choices at life's end.

Thank you for considering my testimony.

Sincerely,
Kiani Oliveros
Ewa Beach, Hi]

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 2:12 PM
To: HLTtestimony
Cc: joshua@joshuakay.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Joshua Kay	Individual	Support	No

Comments: I strongly support this legislation. I believe it contains the necessary safeguards to prevent abuse.

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Loreen S. Farr
1030 Aoloa Place #302A
Kailua, HI 96734

March 22, 2017

RE: SB1129 SD2 "Relating to Health"

Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members,

My name is Loreen Farr and I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health." Thank you for your consideration.

Aloha,

Loreen S. Farr

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 1:22 PM
To: HLTtestimony
Cc: mz@conservehi.org
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Marjorie Ziegler	Individual	Support	No

Comments: Aloha. I support SB 1129, which establishes a bill to provide medical assistance in dying under certain circumstances. As long as protections are in place to protect innocent victims and as long as the conditions outline in the bill are met, we should have the choice of checking out with medical assistance. With all due respect, and quite frankly, how I check out is none of your business. This is a very personal decision, and the thought of the legislature prohibiting me from making such a choice is offensive and intrusive. Mahalo nui loa for the opportunity to express my views.

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To: Chair AuBelatti, Kobayashi, Members Har, Todd, Oshiro, Morikawa, Tupola:
Hearing: Thursday, March 23, 2017
Subject and Position: SB1129 SD2 and I oppose.
From: Dr. Emese Somogyi-Zalud Kailua, Hawaii 96734

Honorable Chair and Members of House Health:

I am a palliative medicine physician.

The questions we should be asking today are the following:

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

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

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

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

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

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

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

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

Just think about it. When somebody close to us becomes ill, what do we do? Are we more likely to offer them quick death in a bottle, or are we more likely to stop short of ending somebody's life, and instead do the best we can in order to relieve their suffering?
Doing our best in these situations is not easy. It takes commitment to relieve somebody's suffering, to put their needs above our own, and to advocate for them. It takes learning, creativity, and the wise use of material resources. Many of us do it. We do it as individuals for our parents, friends, children, and patients. However, there are limits to what we can do as individuals.

<u>It is time to demonstrate a larger commitment.</u>

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

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

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

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

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

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

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

Thank you,
Dr. Somogyi-Zalud

Rhodora Segunda Rojas, MS, CRC
2308 Farm Bridge Ave., North Las Vegas, NV 89081
(702) 629-5353; (808)647-0141 rhodorar@cox.net

March 23, 2017 Hearing House Health
RE : SENATE BILL 1129 SENATE DRAFT 2
HOUSE HEALTH COMMITTEE CHAIRMAN DELLA AUBELATTI

To Whom It May Concern:

I, Rhodora Rojas, a previous resident of Lihue Kauai would like to object the Senate Bill 1129 Senate draft 2 regarding the PASSAGE OF EUTHANASIA. On April 5, 1990, I met a vehicular accident, which caused me to incur traumatic brain injury and caused me to be in a comatose state for 3 months. Additionally, my circle of friends and family had to manually pump an ambo bag continuously for 7 days in order for me to breathe. Worst of all, all the surgeons who performed craniotomy on me told my entire family that I would either die or be a vegetable. I am very glad that my entire family did not give up on me and performed euthanasia. They still gave me an opportunity to live and to enjoy life. Currently, I am working as a Telephonic interpreter and has earned a Masters degree in Vocational Rehabilitation Counseling; I object this bill because of my personal experiences. I know that if my family had practiced euthanasia on me before, I would not be here in front of you testifying against this bill anymore. Additionally, if they cut my life that time, I would not be able to enjoy what life has to bring me. The most important thing is that if they practiced euthanasia on me on that time, I will not be able to provide services to my fellowmen.

I object this bill for the State of Hawaii because I know the entire state is composed of closely related people, who belong to a cultural minority. Most of the residents might have some issues in communicating or relaying their death wishes, therefore by just ending their lives because they are unable to speak for themselves is very much immature and illegal. I personally think this is a form of immaturely killing a terminally ill individual.

Therefore, I asked your office to disregard and prevent the Senate Bill 1129 Senate draft 2 from passing into the senate bill. This is for the sake of all and most of the Hawaiian people. Additionally, this is also to protect the sanctity of our island. I don't want to find our island in the future as a sanctuary of killing people immaturely. I believe the Hawaiian island is sacred and its citizens should be protected from all these immature killing due to terminal illness. I do believe that anybody should be given an opportunity to live and enjoy life as what I was given. Should you have any inquiries regarding this testimony, please don't hesitate to contact me at the above contact information.

Sincerely,
Rhodora Rojas

kobayashi1- Oshiro

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 2:29 PM
To: HLTtestimony
Cc: randftadda@aol.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Rosalie Tadda	Individual	Oppose	Yes

Comments:

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From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 3:40 PM
To: HLTtestimony
Cc: ltakayama@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Linda Chu Takayama	Individual	Support	No

Comments: Strong support. My mother passed 2 years after a stroke. I would prefer to have a better choice for my own end.

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Sent: Tuesday, March 21, 2017 9:50 AM
To: HLTtestimony
Cc: lgrand@hawaii.edu
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Lisa Grandinetti	Individual	Support	No

Comments: My grandmother had Alzheimer's for the last years of her life. Before the disease progressed too much, she was already 90 years old and expressed multiple times that she wanted to die. Because of the legal and cultural barriers preventing her from doing this, she suffered for years without knowing who here children were and then even who she herself was. This made the issue of medical aid in dying very personal and clear to me. We must establish ways for people to end their lives in the way they want to. I urge you to support this bill in order to do that.

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Sent: Tuesday, March 21, 2017 10:40 AM
To: HLTtestimony
Cc: radamshere2003@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Debra Adams	Individual	Support	No

Comments: Please allow individuals to make their own health care and life decisions. Do not forget the separation of church and state that is the foundation of our democracy. Please support the compassionate approach to death and dying by supporting this bill.

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Sent: Tuesday, March 21, 2017 9:11 AM
To: HLTtestimony
Cc: mattbinder@earthlink.net
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Matt Binder	Individual	Support	No

Comments: Dear Representatives, I recently had a very horrifying experience with an elderly family member. She was in extreme pain but, because of her state's laws, her only option to legally kill herself was to starve herself to death. This is not right. It was a long, painful process that was agonizing for her and her friends and family. It is not until you are in this type of situation yourself that you begin to see all the roadblocks and complexities. If you help the person die peacefully you can be prosecuted, as many people have been. Before this experience, I thought it was just a matter of a person getting sleeping pills or pain pills and taking a large dose, but it turns out that this usually results in a failed suicide and causes worse problems because of toxic effects from the overdose. Other common methods are even more grotesque. There are a few states that currently allow terminally ill people to get prescriptions for the only drug that really works - barbituates - so that they can die quickly, peacefully, and without pain. I urge the state legislature to add Hawaii to the list of states that treat its terminally ill patients with dignity and compassion by allowing them to die on their own terms. Thank you, Matt Binder, Waimea

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:41 AM
To: HLTtestimony
Cc: boyne@hawaii.edu
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Jonathan Boyne	Individual	Support	No

Comments:

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HLTtestimony

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:44 AM
To: HLTtestimony
Cc: cpaul@hawaii.edu
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Paul M Chandler	Individual	Support	No

Comments: Please support this bill. It has worked well in Oregon for many years. Those who are suffering terribly with no hope must be allowed some dignity as long as they are able to make their own decisions in consultation with their families and their doctors. Sincerely, Paul

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:37 AM
To: HLTtestimony
Cc: alysononoahu@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Alyson Easton	Individual	Support	No

Comments: Aloha I am writing in support of SB1129. I have both personal and professional experiences that have led me to testify today. I have watched both my sister and my brother die. My sister at age 42; my brother at age 65. Additionally, as a Social Worker/MSW working at an SNF (skilled nursing facility) I have also sat with the dying. It has been an honor to do so. To a person, they have all asked for mercy and relief. In this, the greatest nation on earth, it is our duty to oblige them. Passing of this bill provides a choice, a freedom for our citizens. For the past 12 years I have worked with our kupuna, our elderly, and this field is growing. We must grow with it. I am 59 years old, and personally, passage of SB1129 would afford me a great deal of peace of mind. Finally, passage of SB1129 will create jobs as others find ways to better provide for our elders and the ill. Thank you in advance, ALYSON EASTON, MSW

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:30 AM
To: HLTtestimony
Cc: freemanp001@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Paul Freeman	Individual	Support	No

Comments: Aloha, I am very happy to see that SB 1129 has now moved to the House from the Senate. I am strongly in favor of the bill because I want to see all terminally ill people have the option to die peacefully without having to experience needless suffering. Please vote to make this bill into law. Mahalo, Paul Freeman

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March 20, 2017

To: Chair, Vice-Chair and Members of the House Health Committee

From: Malachy Grange / retired Registered Nurse.
To: HOUSE COMMITTEE ON HEALTH
Date of Hearing: Thursday March 23, 2017, 8:30 AM
Concerning: SB 1129.

I am Malachy Grange and I am retired Registered Nurse.
I speak in favor of SB 1129, Hawaii's Medical Aid-in-Dying Act. I practiced Nursing in Oregon and Hawaii for 30 years, 25 of which were in Oregon. There I saw first hand the difference that a Medical Aid-in-Dying option can make. I have included two stories from my experience from my end-of-life care in Oregon at the end of my testimony below.

SB 1129 addresses a serious gap in the medical care of all Hawaii residents. This is the option of choice at the end of their life. Many times, despite excellent hospice care, people suffer in the last months of their life. They experience a loss of dignity, loss of autonomy and loss of any significant social or family connections and pleasures as poorly controlled pain and other disabling symptoms become the focus of their existence.

Many would like to have a choice on how, when and where to end their lives in a dignified, autonomous manner. There are efficient and humane medicines available for people in the last 6 months of their life that will accomplish this choice. Medical Aid-in-Dying is not suicide. Suicide is choosing death over life and we usually and rightly try to stop this. Medical Aid-in-Dying is choosing *how, when and where to die in the face of impending death*. Beginning with the Death with Dignity law that Oregon put into practice in 1997, this option for those facing the last 6 months of their life is now available in several states. It is time for Hawaii to join them.

Oregon instituted safeguards that include screening for mental health concerns, having two physicians corroborate the 6 month prognosis and verification that there is no medical, financial, social or other coercion involved in the situation. NO abuses have been reported in the 19 years of annual statistics reported by the Oregon Department of Health. These safeguards are part of SB 1129, the Hawaii Medical-Aid-in-Dying law you are considering.

Before 1997 when there were no options for Medical Aid in Dying in Oregon or anywhere else, I had a patient whose progressive symptoms of weight loss, pain, immobility, incontinence and bed sores, along with her loss of autonomy and dignity, brought her great suffering. Hospice helped, but could not successfully treat her main symptoms. She wanted to end her life but could not access medical help for this. She tried to end her life with street drugs and she

unfortunately failed, leaving her in a comatose condition. She spent the last week of her life in a nursing home, attended by strangers, which was her worst nightmare come true.

In 2002, a man in my care with metastatic cancer decided to use prescription medications to end his life, in accord with the Oregon Death with Dignity law. He had symptoms at the time, and hospice was helping him to control most of them, but he did not want the loss of autonomy and dignity that he knew would be part of his dying process. He wanted to die when he still had quality of life. He called his family and friends together and told them of his plan. They supported me, gathered together as was his wish and they had several good days together. There was love, enjoyment and closure for all. At his chosen time, he took the medication and died peacefully in his sleep, surrounded by his loved ones. He had embraced both the best of his life and his inevitable death.

I ask you as elected officials, shouldn't Hawaii citizens have the option of the second story above? Please expedite SB 1129.

Mahalo

Malachy Grange RN

1487 Hiikala Place #26

Honolulu, HI 96816

808-226-5894

the.malachy@gmail.com

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:21 AM
To: HLTtestimony
Cc: kit@lava.net
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Kit Grant	Individual	Support	No

Comments: Thank you for hearing this important bill. Like most of Hawaii's voters, I strongly support end of life options for competent adults. Like many Hawai'i families, I cared for my mother and father through their final days. We miss them both every day. End of life should include a robust hospice and palliative care program as well as physician assisted death in cases where a person is terminally ill and chooses this option without coercion. Who are we to tell a person how much pain and debility they must endure? As the brilliant free-jazz saxophone legend Ornette Coleman said: "Freedom is the right to die YOUR WAY." Let's get hip to that. Mahalo!

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:11 AM
To: HLTtestimony
Cc: edhirata@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Edward Y. Hirata	Individual	Support	No

Comments: I strongly support passage of the SB 1129, SD2, Medical Aid in Dying bill it will save our terminally ill individuals thousands of dollars in medical bills. We need to be very pragmatic when dealing with this issue and not let religious views prevail over common sense.

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I strongly support SB1129 so that I and my loved ones might have this option if the need arises. I understand that many vocal opponents claim that this bill will lead to people being coerced or tricked into using this option. However, this appears very unlikely in view of the bill's requirement of a "medically confirmed terminal disease" and numerous safeguards to ensure this is the true wish of the individual.

Thank you,
David Leake
46-395A Kahuhipa Street, Kaneohe, HI 96744
(808) 247-4737

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:26 AM
To: HLTtestimony
Cc: keenerees@hawaii.rr.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Keene H Rees	Individual	Support	No

Comments: Please pass this bill. It will give comfort to many just knowing it is an available choice. Mahalo!

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:16 AM
To: HLTtestimony
Cc: kshimata@hawaiiantel.net
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Kathy Shimata	Individual	Support	No

Comments: As a senior, I strongly support this bill.

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:33 AM
To: HLTtestimony
Cc: frankiestapleton@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Frances K. (Frankie) Stapleton	Individual	Support	No

Comments: Aloha e Chair Belatti and members of the House Committee on Health, I am Frances K. Stapleton, a 47-year resident of the state of Hawaii and I strongly support this bill that would enable a undeniable and legal option for people facing end-of- life certainties. It has been disheartening to see this issue come before the State Legislature so many times in the past only to be denied apparently based on religious issues, religions to which the majority of the population here do not subscribe. And for religious objectors to make it so that individuals suffering lengthy, lingering, painful terminal illnesses have no recourse but to continue suffering is inhumane. Please do all within your power to help make this bill become law in the state of Hawaii ASAP. Mahalo nui for your attention to my testimony. I am a retired journalist and public school teacher; I live at 14-803 Crystal Circle, Pahoa, HI 96778. Respectfully, Frances K. (Frankie) Stapleton

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From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 9:17 AM
To: HLTtestimony
Cc: asumberg@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
alex sumberg	Individual	Support	No

Comments: Do it. It has been too long. It is a basic human right to make your own decision to end your own suffering. There are enough safeguards in this to make it responsible, and there are not enough problems here to make it impossible. Any God that wants you to suffer, is not one that should be listened to. Any person who says their imaginary friend who lives in a cloud knows better than somebodies own self as to what is best, then they too should be considered as suspicious in their motives and their humanity. This is important. The details can be worked out. We all know someone with cancer or worse, and we all fear it or worse. I can't imagine how mad I would be at the end if I am forced to twist and writhe in my bed and some condescending authority in a collar or behind a desk telling me I need to do out screaming. No. That is not what we need to be about.

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HLTtestimony

From:	mailinglist@capitol.hawaii.gov
Sent:	Tuesday, March 21, 2017 9:34 AM
To:	HLTtestimony
Cc:	emmaharberwhite@gmail.com
Subject:	Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Emily White	Individual	Support	No

Comments: Dear Legislators, Please support SB 1129, the Medical Aid in Dying Bill. Hawaii is a state of aloha, compassion, and this is what medical aid in dying is all about. Additionally, Medical Aid in Dying supports diginity and liberty, rights cherished by Americans. Mahalo, Emma White, JD, MA Resident, Kahului, Maui

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S H I R L E Y T H O M P S O N
619 Lawelawe Street, Honolulu, HI, phone 808-457-7924, me@shirleythompson.net

March 21, 2017

The Hawaii State House of Representatives
29th Legislature, 2017
Honolulu, HI

Subject: I strongly favor SB 1129 Medical Aid in Dying

Dear Representatives:
I am writing to express my strong support for SB 1129 in favor of Medical Aid in Dying.

Within the past two years, our family has suffered the loss of my husband's mother and father, with whom we lived. These close deaths have given us reason to spend time talking and carefully considering what we would like for our own last days, and we have taken steps to ensure that our wishes will be granted by creating Advance Health Care Directives. Right now we are healthy and strong, but we know we won't always be. We want the right to legally access medical aid in dying when the time of death is close in order to prevent needless suffering. We want the peace of mind of knowing that medical aid in dying is accessible for us, should the circumstance of great suffering arise. This is not suicide. This is the shortening of suffering for an inevitable death of a terminal patient. This is also to protect doctors from legal action for providing this medical aid in dying when they deem it is the best action for their patient. I implore you to support SB 1129

With aloha,

Shirley Thompson
Honolulu, Hi
96821

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 10:28 AM
To: HLTtestimony
Cc: pohaku@ilhawaii.net
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Cynthia Gillette-Wenner	Individual	Support	No

Comments: It is time for the State of Hawaii to adopt procedures to allow all of its residents to be able to chose Death with Dignity when the patient makes that decision. This is a very personal matter, and choice, which should be guaranteed to everyone.

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Sent: Tuesday, March 21, 2017 9:56 AM
To: HLTtestimony
Cc: wwyoshida@msn.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Wilbert W Yoshida	Individual	Support	No

Comments:

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

House Health Committee hearing on Thursday 3/23/17 at the State Capitol; 8:30 AM
Subject: Senate Bill 1129 SD 2

To the Chair and members of the House Health Committee,

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

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

In Dorland's

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

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

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

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

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

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

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

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

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

TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
TWENTY-NINTH LEGISLATURE, 2017

ON THE FOLLOWING MEASURE:
S.B. NO. 1129, S.D. 2, RELATING TO HEALTH.

BEFORE THE:
HOUSE COMMITTEE ON HEALTH

LATE

DATE: Thursday, March 23, 2017 **TIME:** 8:30 a.m.

LOCATION: State Capitol, Room 329

TESTIFIER(S): Douglas S. Chin, Attorney General, or
Angela A. Tokuda, Deputy Attorney General

Chair Belatti and Members of the Committee:

The Department of the Attorney General provides the following comments.

The purpose of this bill is to enact a medical aid in dying law modeled after Oregon's death with dignity law. The bill provides safeguards to ensure that a terminally ill adult who chooses to make end-of-life decisions is able to do so and also retain the right to rescind the request.

We recommend that several issues in this measure be addressed.

(1) On page 16, in the new section -15 of the new chapter being added to the Hawaii Revised Statutes by section 2 of the bill, there are no clear consequences for noncompliance with this section. We recommend including wording to identify what the consequences are, if any.

(2) On page 16, line 7, we recommend deleting the phrase, "by delivering it" as it is redundant.

(3) On page 17, line 17, in the new section -18, the phrase "any other criminal conduct under the law"

is overly broad and vague. We recommend clarifying the other offenses that are intended to be covered by this wording.

(4) There are two recommendations for the new section -19(a)(1). First, on page 18, line 3, the word "or" in the phrase "participating or acting in good faith compliance with this chapter" is ambiguous. As the sentence currently reads,

"participating or acting in good faith compliance" is difficult to disprove as one could simply claim that he or she was "participating or acting in good faith compliance" without additional justification. We recommend deleting the words "participating or" in order to establish a more clear, objective standard for liability. Doing so will also make this wording consistent with the wording in section -19(a)(5), on page 19, line 12. Second, on page 18, line 4, we recommend replacing the word "including" with the word "or." The act of "being present" has no relation to being in "compliance with this chapter." The revised provision would then read:

> (1) No person shall be subject to civil or criminal liability or professional disciplinary action for ~~participating or~~ acting in good faith compliance with this chapter, [~~including~~] or being present when a qualified patient takes the prescribed medication to end the qualified patient's life in a humane and dignified manner;

(5) In the new section -19(a) on page 18, lines 12, 15, and on page 19, line 12, we recommend deleting the term "good faith" in order to establish a more clear, objective standard for liability. Good faith compliance is difficult to disprove as one could simply claim that he or she was "acting in good faith compliance" without additional justification.

(6) On page 23, lines 1-2, in the definition of the phrase "participate in actions covered by this chapter," the terms "consulting provider function" and "counseling referral function" do not make sense as written. The definition refers to performing the duties or actions of a particular person, rather than to the actual provider. For clarification, we recommend the following:

> "Participate in actions covered by this chapter" means to perform the duties of an attending provider pursuant to section -4, the duties of a consulting provider [~~function~~] pursuant to section -5, or [~~the counseling referral function~~] the referral of a qualified patient for counseling pursuant to section -6.

(7) On pages 24-25, we recommend making the following amendments to the new section -20 to conform with Hawaii's penal code:

> **§ -20 Prohibited acts; penalties.** (a) A person who without the written authorization of a qualified patient intentionally [~~alters or forges~~] makes, completes, alters, or endorses a request for medication or conceals or destroys a rescission of that request to cause the patient's death shall be guilty of a class A felony.

(b) A person who knowingly coerces or [~~exerts undue influence on a qualified patient~~] induces a patient by force, threat, fraud, or intimidation to request medication for the purpose of ending the patient's life, or to destroy a rescission of the request, shall be guilty of a class A felony. For purposes of this subsection, "fraud" means making material false statements, misstatements, or omissions.

(c) A person who, knowingly and without authorization of a qualified patient, intentionally [~~alters, forges, conceals, or destroys~~] completes, alters, endorses, conceals, or destroys an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting a qualified patient's desires and interests, with the intent [~~and~~] or effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition and hydration that hastens the death of the qualified patient, shall be guilty of a class A felony.

(d) Except as provided in subsection (c), [~~it shall be a misdemeanor for~~] a person who knowingly and without authorization of a qualified patient to intentionally [~~alter, forge, conceal, or destroy~~] complete, alter, endorse, conceal, or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the [~~principal's~~] qualified patient's desires and interests with the intent or effect of affecting a health care decision[~~.~~] shall be guilty of a misdemeanor.

(8) On page 31, we recommend amending sections 5 and 6 of this measure as follows:

SECTION 5. Section 707-701.5, Hawaii Revised Statutes, is amended by amending subsection (1) to read as follows:

"(1) Except as provided in section 707-701, a person commits the offense of murder in the second degree if the person intentionally or knowingly causes the death of another person[~~.~~]; provided that this section shall not apply to actions taken [~~under~~] in compliance with chapter ___ . "

SECTION 6. Section 707-702, Hawaii Revised Statutes, is amended by amending subsection (1) to read as follows:

"(1) A person commits the offense of manslaughter if:

(a) The person recklessly causes the death of another person; or

(b) The person intentionally causes another person to commit suicide[~~.~~]; provided that this section shall not apply to actions taken [~~under~~] in compliance with chapter ___ . "

If the Committee proceeds with this measure, we respectfully request that the recommended amendments be made.

LATE

SANDRA G.Y. YOUNG
Attorney at Law
P.O. Box 2897
Aiea, HI 96701
Telephone: (808) 487-8464

March 22, 2017

Members of the House Health Committee
State Capitol
415 S. Beretania Street
Honolulu, HI 96813

Re: Strong Opposition to SB 1129 SD 2 **(Physician Assisted Suicide**)
Hearing Date and Time: March 23, 2017; 8:30 p.m.

Dear Chair Bellati, Vice-Chair Kobayashi and Members of the Health Committee:

I strongly oppose the Physician Assisted Suicide Bill SB 1129 SD 2for following reasons.

1. Physician Assisted Suicide would be destructive to the physician-patient relationship. The doctor, now an instrument of life and healing, would become an instrument of death. How can the infirm, poor or elderly or the families of these people trust the doctor when the doctor helps or is willing to assist the patient in ending his/her life? Physician assisted suicide is fundamentally incompatible with the physician's role as a healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling and other modalities. Patients near the end of life should continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. "Decisions Near the End of Life," adopted June 1991, and "Physician-Assisted Suicide," adopted December 1993 (JAMA. 1992; 267: 2229-2233); updated June 1996.

2. Physician assisted suicide would destroy the value of human life. Under current criminal laws, human life is sacred and accorded the highest protection, as violations can result in severe criminal penalties. Modifying the policy to allow physicians to terminate the lives of their patients would diminish the value of human life and open the doors to abuse, injustice, and a host of problems.

3. Our social policy should be on suicide prevention, as it is the eighth leading cause of death in the country. "Studies that examine the psychological background of individuals who kill themselves show that 95 percent have a diagnosable mental disorder at the time of death.

Furthermore, "[l]ike other suicidal individuals, patients who desire suicide or an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly depression." New York State Task Force Report, When Death is Sought – Assisted Suicide and Euthanasia in the Medical Context (May 1994), at 9, 11, 13 (footnotes omitted).

4. The focus for patients who are suffering from physical illness or disease should be on providing palliative care. If PAS were legalized, palliative care may be diminished. Oregon, the first state to legalize PAS, ranks dead last in palliative care. It also ranks last in paid ombudsmen who advocate for the elderly. In addition, patients suffering from mental illness, particularly depression, should receive appropriate treatment for their condition.

5. The most vulnerable members of our society would be susceptible to exploitation, abuse, coercion and undue influence. The "right to die" will become a "duty to die" because patients do not want to be a burden to their families and to society. Where will be the dignity in that?
For these reasons and others, I ask that you do not pass the Physician Assisted Suicide bill. Thank you for your attention and time, as well as your service to the people of Hawai'i.

Very truly yours,

SANDRA YOUNG

kobayashi2 - Jessi

LATE

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 11:50 PM
To: HLTtestimony
Cc: jabezinc@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
David Wong	Universal Life Church	Oppose	No

Comments: Please vote no to SB1129. As an educator and wedding officiant, I am optimistic that our human spirit calls us endure hardship for the past 200,000 years, to constantly evolve, to rise above pain and suffering. It is inhumane, anti-American, and irresponsible to give up and die. This Bill only tells our young and future generations to quit and make room for the healthy, that pain and suffering is not an option. That is an historical lie.

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kobayashi1- Oshiro

LATE

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 5:45 PM
To: HLTtestimony
Cc: souzabigisland@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Charles	Individual	Oppose	No

Comments: I strongly oppose assisted physician suicide. First of all it goes against the Hippocratic oath. It sends a message to all our people that life is not worth living especially to the young who may be confused and suicidal to make this mainstream and acceptable will have catastrophic results. I was at my fathers side every day for the last weeks of his life I would not trade that experience for anything it is a precious memory as he transitioned into eternity. Life is precious and should be honored from conception until natural death. For those people who are bent on taking their lives as sad as that is The lack of this law does not preclude them from doing so. Aloha, Charles Souza

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kobayashi1- Oshiro

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From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 5:32 PM
To: HLTtestimony
Cc: debbie.heyler@gmail.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Debra Heyler	Individual	Oppose	No

Comments: Honorable Representatives: I urge you vote "no" on this bill. It is a slippery slope; one that will be open to abuse as elderly people, especially, may feel compelled to take their lives in the interest of cost. Countries such as the Netherlands have legalized assisted suicide years ago, and there are now reported thousands of cases of doctors administered lethal injections without the patients' consent and thousands that have gone unreported. I recognize that this bill is proposing the use of pills, however, these are those same marginalized people who will take their lives, but instead through pills. This bill allows those taking their life to do it without anyone present; there are not enough safeguards. I urge you to not support this bill. There needs to be more public awareness of this bill before you, as our state lawmakers, decide to make decisions that will impact so many. Please, as representatives of your constituents, please take the time to educate and inform the people of a highly controversial topic. Thank you. Sincerely, Debra Heyler Aiea, Hawaii

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LATE

PLEASE OPPOSE any legislation to make

ASSISTED SUICIDE a medical treatment in Hawai'i.

Assisted suicide is a direct violation of the intrinsic dignity of each human person.

What is now touted as "a merciful right to die" will easily erode and become an overwhelming "responsibility to die" for the poor, disabled and powerless.

Medical and psychological research have shown the primary reason for suicide is depression, not because of physical pain or debilitation. Depression and all forms of pain can be managed with other treatments that are sensitive to the needs of each person.

Enclosed is a petition which opposes assisted suicide. Please take a moment to provide your name, address, phone number and email.

kobayashi1- Oshiro

From: Lee Slater <leeslater75@gmail.com>
Sent: Wednesday, March 22, 2017 6:13 PM
To: HLTtestimony
Subject: SB 1129

LATE

Aloha, I wish to submit my testimony on SB1129. I am sure that we all know people whose choice was to end their pain and suffering but was not permitted to do so because of legislation based on religious prohibitions. I want you to pass this legislation to afford me the choice and dignity to end my pain and suffering, if it be so, by making my own decision as to when. Mahalo for hearing my voice. Lee Slater

Sent from my iPad

kobayashi1- Oshiro

From: Steven Hedlund <kohalabaptist@gmail.com>
Sent: Wednesday, March 22, 2017 4:54 PM
To: HLTtestimony
Subject: Vote NO to SB 1129 SD 2

To Whom it may concern, I am writing to encourage you all to vote NO to SB 1129 Sd 2. I worked in the healthcare field for eleven years and am currently serving as Pastor of Kohala Baptist Church here on the Big Island. I would encourage you all to research advancements and options in palliative care and strongly oppose Physician Assisted Suicide. Thankyou for your attention. Sincerely, pastor Steven Hedlund Sent from my iPhone

BETH ARNOULT
185 Anamuli Street
Kahului, Maui HI 96732
808/205-7412 cell
BArnoult@aol.com

LATE

March 22, 2017

Position: I oppose SB 1129

To Whom It May Concern,

Hello, my name is Beth Arnoult, and I am a resident of Maui, Hawaii.

I know this bill is being proposed with many guidelines and regulations to prevent abuse, but look at the states and countries that have passed it, like the Netherlands. They had guidelines in place and over time they have evaporated or are overlooked. Now Physician Assisted Suicide is available to teenagers, even for depression, for parents to put down their disabled children, for the disabled, and for the elderly....we all go through a bad stretch of time in our lives, when we don't feel worthy of being on this earth, but time heals and we all have a purpose, every minute of your life has a purpose, including this one!

Twenty-five years ago, I was in an ATV 4-wheeler accident and broke my back, leaving me paralyzed from the waist down with excruciating pain and bouts of depression. I'm sad to say, that if Physician Assisted Suicide had been available to me at that time in my life, even up to several years after, I'm afraid I would have opted for that route. If it was legal and readily available, that would have taken all of the guilt out of my decision, because 'hey, if it's the law, then it must be OK!' Right? Wrong!!!

There was purpose for my life! I just needed to go through a time of suffering, years to be exact, to get to where I am now. I have a 20 year old son, who was born 6 years **after** my accident! I even travelled the world for 10 years playing professional wheelchair tennis and represented the US in the 2008 Beijing Paralympics. Since then I joined a crew of adaptive paddlers and have paddled the Molokai Channel in a six-man outrigger. Since my accident I have taught 8 years of mathematics in middle and high schools, including Baldwin High School on Maui. I now have my own bookkeeping business. I make a positive impact on

many lives every day.

I had no right to take my own life nor does anyone else. Even if we are in an extremely incapacitated state, we have a purpose….it could be for family members to be drawn together and allow old wounds to be healed, or it could be to give someone else courage and hope, or it could be to allow others the honor of helping us. The possible reasons why we go through pain and suffering are endless, but there's always a reason, even if we don't understand or comprehend why it is allowed.

As a high school teacher and the mother of a teenager, I also fear the message we are sending to our teens. Did you know that in 2016, that Suicide was the 2nd leading cause of death in Hawai'i for ages 15-24 (according to American Foundation for Suicide Prevent)? We, as a society, try and help our teens and show them that they have a purpose in life; we try and talk them out of having suicidal thoughts. But now we are going to tell them it's ok to commit suicide if you are in pain and suffering. It's OK for tutu to commit suicide if she has less than 6 months to live, according to the doctor? Really?

Thanks for taking the time to listen! Please don't allow Physician Assisted Suicide in the State of Hawaii.

Aloha,

Beth Arnoult

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 21, 2017 11:52 AM
To: HLTtestimony
Cc: dkraus@paulinemedia.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

Categories: Red Category, Green Category

SB1129
Submitted on: 3/21/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Diane Kraus	Individual	Oppose	No

Comments: I urge the House Health Committee to vote NO on SB1129, Medical Aid in Dying Act. This measure is not in keeping with the commitment made by physicians to work toward preserving life. When a person is close to natural death, due to a terminal illness, and no more treatments will be beneficial, then a physician is to give appropriate pain management medications. The last months of a person's life are precious. It is a time to prepare to leave loved ones and friends and let them be there for support and comfort. This is true Aloha.

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kobayashi2 - Jessi

LATE

From: Gail Ishikawa <gailkumiko@gmail.com>
Sent: Wednesday, March 22, 2017 10:49 PM
To: HLTtestimony
Subject: Support for SB 1129

I support SB 1129 and ask that you vote for its passage.
I have witnessed two uncles die prolonged and excruciating deaths from colon cancer and had this bill been law at the time, they would have had the CHOICE of medical aid in dying. For those who oppose the bill, most often for religious reasons, then don't choose it!
But don't prevent others from their right to die with dignity.
Therefore I strongly support SB 1129.

Gail Ishikawa
66 Kaluhea Street
Wahiawa 96786

LATE

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 11:18 PM
To: HLTtestimony
Cc: joshuaim@hawaii.edu
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Joshua Mueller	Individual	Oppose	No

Comments:

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LATE

Testimony in Opposition to SB1129, SD2
Submitted by: Lisa Shorba, Honolulu Resident
To: The House of Representatives Committee on Health
Date: Thursday, March 23, 2017
Time: 8:30am
Place: Conference Room 329
Measure Number: SB1129, SD2

Dear Rep. Della Au Belatti, Chair, Rep. Bertrand Kobayashi, Vice Chair, Rep. Sharon E. Har, Rep. Chris Todd, Rep. Dee Morikawa, Rep. Andria P.L. Tupola, and Rep. Marcus R. Oshiro

I write in **STRONG OPPOSITION to SB 1129, SD2**. In Hawaii, we provide the best of care to our sick, elderly, and dying. We do not abandon our loved ones to suicide. The deliberate act of "ending one's life" is no different from "killing one's self." Legalizing the act of "killing" will never make it right, no matter how you phrase it. Only God gives and ends life. We are the stewards of this precious gift of life… and we must do our best to treat each person with the utmost in medical care. Killing is never a medical option.

With SB11229, a terminally-ill Hawaii resident would be allowed to "...receive a prescription medication for self-administration so that they can die in a peaceful, humane manner." It is never humane to permit a loved one to end their own life. Also, medications are not designed to end life; they are made to save lives, to promote good health and patient well-being. SB1129 seeks to redefine "medicine or medication" to include lethal drugs and I strongly oppose this!

There are several other reasons to oppose this bill. Here is a list of the major concerns: 1. Terminal prognoses are often wrong. Many individuals outlive their diagnoses by months and even years. Assisted suicide legislation is discouraging and leads people to give up on treatment and lose good years of their lives. 2. Assisted suicide is not popular. Assisted suicide legalization has failed significantly more times than it has succeeded. There have been more than 140 legalization attempts in the past 20 years, yet only 3 states have actually legalized it through legislative or voter action. 3. Opens the door to abuse of the elderly or infirm. Once a lethal prescription is written, an abusive caregiver or relative who stands to inherit from the patient can pick it up and give it to the patient in food or drink. Since no witness is required at the time of death, who would know if the patient consented? 4. Cheapens life. If assisted suicide is made legal, it quickly becomes just another form of treatment. It will always be the cheapest option, especially in a cost-conscious healthcare environment. Two Oregon residents, Barbara Wagner and Randy Stroup, were each denied coverage for their cancer treatments but received letters from the Oregon Health Plan stating the plan would cover their assisted suicides. 5. A threat to the most vulnerable. Those living with disabilities or who are in vulnerable healthcare circumstances have justifiable concerns should assisted suicide become an option. Financial pressure, peer pressure, and even pressure from uncaring family members can be placed on these individuals to take the suicide option. In fact, nothing in the Oregon or Washington style laws can protect from explicit or implicit family pressures to commit suicide, or personal fears of "being a burden." There is NO requirement that a doctor evaluate family pressures the patient may be under, nor compel the doctor to encourage a patient to even notify their family. 6. Bad data puts patients at risk. Oregon's data on assisted suicide is flawed, incomplete, and tells us very little. The state does not investigate cases of abuse, and has admitted, "We cannot determine whether physician assisted suicide is being practiced outside the framework of the Death with Dignity Act." The state has also acknowledged destroying the underlying data after each annual report.1 7. "Safeguards" don't work. Experience in Washington and Oregon has shown that the mental health and other safeguards are easily circumvented. Patients seeking a lethal prescription are not required to receive it from their attending physician and, thus, can "doctor-shop" to find someone who will. This is especially troubling for the families of patients diagnosed with depression. 8. Can turn treatable depression deadly. Most cases of depression among the terminally ill can be successfully treated. Yet, lethal prescription requests from terminally ill individuals are often based on fear and depression. Primary care physicians are not generally expert in diagnosing or treating depression, and nothing in the Oregon or Washington assisted suicide laws compels doctors to refer patients for evaluation by a licensed psychologist or psychiatrist to screen for depression or mental illness. 9. An often painful death. Barbiturates are the most common substances used for assisted suicide in Oregon and Washington, but barbiturates do not assure a peaceful death. Overdoses of barbiturates are known to cause distress and have associated issues like: extreme gasping and muscle spasms; vomiting and inhaling vomit while losing consciousness; panic and feelings of terror and assaultive behavior from the drug-induced confusion; failure of the drugs to induce unconsciousness; a number of days elapsing before death occurs; and sometimes death does not occur. 10. A slippery slope. Countries such as the Netherlands, where assisted suicide has been legal for decades, show that assisted suicide cannot be contained or limited to the terminally ill. (See Dr. Herbert Hendon commentary, click here: http://www.psychiatrictimes.com/articles/ commentary-case-against-physician-assisted-suicide-right-end-life-care) For more information visit www.HPACC.org 1. Dr. Katrina Hedberg, 9 December 2004, House of Lords, Select Committee on the Assisted Dying for the Terminally Ill Bill, Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence, (London: The Stationery Office Ltd., 2005), 262.)

Consider the way in which the actual “cause of death” on death certificates will be reported if SB1129 passes. SB1129, SD2 states that “...the attending provider may sign the patient's death certificate, which shall list the underlying terminal disease as the cause of death.” This promotes dishonesty and falsification of patient records. The documentation of historical facts and biographical information on Hawaii’s families will no longer be accurate or trustworthy.

SB 1129, SD2 also sends the wrong message to our youth that suicide is an acceptable way to solve problems. PTSD is another problem that may increase as a result of legalized physician-assisted suicide. The National Center for PTSD (http://www.ptsd.va.gov/ professional/co-occurring/ptsd-suicide.asp) reported that, “Researchers have also examined exposure to suicide as a traumatic event. Studies show that trauma from exposure to suicide can contribute to PTSD. In particular, adults and adolescents are more likely to develop PTSD as a result of exposure to suicide if one or more of the following conditions are true: if they witness the suicide, if they are very connected with the person who dies, or if they have a history of psychiatric illness (22-24). Studies also show that traumatic grief is more likely to arise after exposure to traumatic death such as suicide (25,26).”

I am very concerned for the safety and proper medical care of my own parents and family members if this bill passes. I don’t want any of my loved ones or myself to be victimized by SB1129, SD2; our lives are too precious. **Please vote NO on SB1129, SD2.**

Thank you very much for your kokua,

Lisa Shorba
Honolulu Resident

LATE

kobayashi2 - Jessi

From: Mary-Helen Leet <mary-helen@prodigy.net>
Sent: Thursday, March 23, 2017 4:44 AM
To: HLTtestimony
Subject: Bill 1129 SD2 (SB1129 SD2)

Dear Senators,

I am one of the 80% of Hawaiians who would like to see this Bill become law. Our culture teaches us not to be cruel and this Law would allow for patients to avoid subjecting their families as well as themselves to unnecessarily prolonged suffering and financial depletion. It is humane. Please vote it into law.

Thank You. MH & Wm Leet

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LATE

Testimony in Strong Opposition to SB 1129 SD1
House Health Committee
Hearing: Thursday March 23,2017; 8:30 a.m.; Conference Room 329

To: Representative Della Au Belati, Chair
Representative Bert Kobayashi
Representative Dee Morikawa
Representative Chris Todd

I submit this testimony in strong OPPOSITION to physician assisted suicide under any description for the following reasons:

* Proper medical care includes only treating diseases NOT killing the patient.
* Legalizing physician assisted suicide sends the wrong message to our troubled teens that's suicide is an acceptable way to solve problems.
* In Hawaii, we take care and love our Kupuna, we don't abandon them to suicide.

Additionally, passage of the physician assisted suicide threatens to undermine an individual's Advance Health Care Directive which specifies treatment preferences and pain management in the event a person has an incurable, irreversible and/or terminal medical condition.

I humbly urge you to vote no on SB1129 SD1,

Respectfully,

Sara Ann Tompkison
Licensed Clinical Social Worker
3174 Kaohinani Drive
Honolulu, HI 96817

LATE

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 11:11 PM
To: HLTtestimony
Cc: fei@comcast.net
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Stuart S Feinberg	Individual	Support	No

Comments: Dear Committee Members: I support the Hawai‘i Medical Aid in Dying Act (SB 1129) because it gives individuals the right to choose how they wish to die while protecting these same individuals from coercion or the ability of 3rd parties to pressure them. To die with dignity is the last right of the living and I urge you to support SB 1129. Sincerely, Stuart Feinberg

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kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 9:37 PM
To: HLTtestimony
Cc: dritchey@hawaii.rr.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Denise Ritchey	Individual	Oppose	No

Comments:

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From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 7:35 PM
To: HLTtestimony
Cc: nuctrngspec@yahoo.com
Subject: *Submitted testimony for SB1129 on Mar 23, 2017 08:30AM*

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
gary burbage	Individual	Oppose	No

Comments:

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LATE

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

March 22, 2017

Rep. Della Au Belatti, Chair
Rep. Bert Kobayashi, Vice-Chair
House Health Committee

SUPPORT SB 1129 - Relating to Health, establishing a Death with Dignity Act – Hearing 3/23/2017

Dear Chair Belatti and House Members of the Health Committee:

In 2002 the Hawaii legislature almost passed Death with Dignity legislation. Since that time I have been involved closely with this issue. I do end of life care. So I want to impress upon you that my opinion is not purely intellectual, I have hands on experience with the daily care of dying people.

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

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

Sincerely,

Juliet Begley

LATE

kobayashi2 - Jessi

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, March 22, 2017 8:13 PM
To: HLTtestimony
Cc: k_cadinha@yahoo.com
Subject: Submitted testimony for SB1129 on Mar 23, 2017 08:30AM

SB1129
Submitted on: 3/22/2017
Testimony for HLT on Mar 23, 2017 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Kelly Cadinha	Individual	Comments Only	No

Comments: Aloha Chair Belatti, Co-Chair Kobayashi and Honorable Committee Members, My name is Kelly Cadinha. I'm writing in OPPOSITION to SB1129 SD2 "Relating to Health." Please consider how precious life is. Kelly Cadinha 91-1134 Kea'ali'i place Ewa Beach, HI 96706 384-3187

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LATE

Kevin S. Kimura, Esq.
2333 Kapiolani Blvd. Suite 610
Honolulu, HI 96826
SB1129 SD1

House Health Hearing on 3/23/17 8:30 AM in Room 329
Chair Belatti, members Todd, Kobayashi, Har, Oshiro, Tupola, and Morikawa,

I am an attorney, a disability aficionado, and opposed to physician assisted suicide and SB1129 SD2.

There is a basic tenant in our legal system. All life should be cherished. This is precisely why the accused has multiple appeals to be vindicated, before being executed. If the criminally guilty have the right to defend against the taking of their life, shouldn't the terminally ill likewise have this same right?

Of course, the difference between the death row inmate and the terminally ill seeking to commit suicide is **CONSENT**. Whereas the death row criminal is losing his or her life against his or her will, the terminally ill patient is consenting to forfeit his or her life.

I believe that an equal number of safeguards should be built in to the physician assisted suicide process as the death row process, meaning that the terminally ill patient should go through multiple levels of evaluation before being allowed to end life. Since the terminally ill individual does not have as much time as the death row inmate by the very definition of "terminally ill," the time between the multiple evaluations would have to be shortened (from years to months).

In regard to the issue of **consent,** how can we ensure that the terminally ill individual is truly consenting to forfeiting his or her life? Adequate safeguards must be in place to ensure that the terminally ill person is truly consenting to committing suicide. What safeguards are there for ensuring that the terminally ill have the mental capacity to decide to die, are not emotionally unbalanced when making their decision to die, are fully educated about their decision to commit suicide, and are not being coerced or unduly influenced into committing suicide by parties who have vested interest in their early demise?

Next, have the issue of the rights of the disabled been fully explored, considered and addressed? How are the disabled to carry out getting physician assisted suicide? This problem is indeed significant, because there is such a wide range and degree of disabilities. Unless each and every type of disability is addressed, the physician assisted suicide bill will not do justice to the disabled, and as such **may be discriminatory to the disabled community**. Thus, the type and degree of disability would need to be assessed, and a process for carrying out physician-assisted suicide would have to be tailored to the specific disability. This would need to be stipulated in the Bill.

Also, I am **troubled by the scope of SB1129 SD2**. What age group will the law apply to? What medical conditions will be covered by the law? What is incurable today will possibly be treatable tomorrow, with the advance of medical science. If the Bill specifically spells out what conditions are covered, then the law will become obsolete in part, in the future. If the Bill leaves the medical conditions covered by

physician assisted suicide general and vague, then the law could be over broad and be subject to abuses.

What is the threshold for deciding that the terminally ill individual can commit suicide? Using a fixed period of time, such as six months, is arbitrary. What is the rationale behind using six months as the threshold for committing suicide? Roe v. Wade faces a similar situation. Viability of the fetus is the threshold for having the fetus aborted. The fetus that was not viable thirty plus years ago is viable today.

Finally, **there is an inherent conflict in allowing a physician to assist a patient to commit suicide**. The doctor takes an oath to heal, do no harm, not to take life. Do you propose to have physician assisted suicide be part of the patient treatment plan if the patient is terminally ill? Will the physician have authority to inform terminally ill patients that suicide is an option in the patient care plan? Or must the terminally ill patient ask about physician-assisted suicide on his or her own**? I can envision tremendous psychological harm to the terminally ill patient who is advised by their doctor to consider suicide as a viable option.**

Submitted by,

Kevin S Kimura, Esq.

kobayashi2 - Jessi

LATE

From: membership@hawaiiphysicians.org
Sent: Wednesday, March 22, 2017 8:39 PM
To: HLTtestimony
Subject: SB 1129 SD 2 Testimony

Chair Belatti and members of House Health at Hearing 3/23/17 Room 329

My name is Luz Medina MD, past president of the Maui County Medical Association and I think assisted suicide is unnecessary and bad public policy. I hope that this bill dies in your Health Committee as I don't want it and neither do many of my colleagues.

Thank you for your service to us all. Stop this bill today.
Luz Medina, MD

LATE

TESTIMONY IN SUPPORT OF BILL 1129 SD 2

SCHEDULED FOR HEARING BY THE HOUSE ON MARCH 23, 2017

From: Mary Y. Matayoshi 760 Onaha St., Honolulu, HI 96816

I hereby voice my strong support of Bill 1129 SD 2 under consideration by the House which gives us options for care towards the end of life and relieves the doctor of liability from decisions made by the patient's own choosing.

I have watched too many of my friends pass under terrible duress, just waiting to be released from unbearable conditions.

We choose to make decisions on how we wish to pass …. whether it be with hospice, nursing care or care by a family member, medication, or help from a doctor to have a peaceful and desired end to an undesired living death. It should be a decision made by each individual, not a doctor keen on keeping a patient alive no matter what the painful or undesired condition may be.

Please have the courage to support what the great majority of Hawaii's citizens desire.

LATE

kobayashi2 - Jessi

From: Ursula D'Angelo <beautycallsursula@hawaiiantel.net>
Sent: Wednesday, March 22, 2017 8:07 PM
To: HLTtestimony
Subject: Bill 1129 SD2 (SB1129 SD2)

In support of Bill 1129 SD2: I feel that it is important for humans to realize and take responsibility for our choices of how we live and die...as well as all other responsibilities that we have given over to "others." In the name of choice, comfort, responsibility and compassion, please support this Bill and let us all decide for ourselves how we choose. Aloha and thank you.

Ursula D'Angelo and Dennis Riordan

--

Ursula D'Angelo
dba Beauty Calls
808-896-2624
www.beautycallsursula.com

****

Connect * Benefit * Thrive
"What you think about grows..."

Michael Weaver

LATE

I wish to state my opposition to SB 1129 relating to physician-assisted suicide.

Instead of passing legislation that many have argued against from a variety of perspectives, I would encourage our legislators to pass bills that support the hospice movement inn our state. The modern hospice movement, which began in Great Britain in the late 1950s, is a worldwide effort to assist those who are dying, and their families, to bring their lives to an end in a pain-free, dignified manner. The autonomy of the patient is uppermost. There are safeguards against abuse at all levels. Families can enjoy the ending of a loved ones life with respect and compassion and care. Supporters of this bill are well meaning and I am sure care for and love their families and friends. But, all the stated goals of the assisted suicide programs can be met with the hospice program.

This is not a religious issue. It is a medical issue. I agree that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so. But not by assisted suicide. The hospice programs across the nation have provided quality, compassionate care for thousands of people facing a life-limiting illness or injury. Hospices provide a team-oriented approach to medical support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well. The dignity of the individual is uppermost in their minds and actions. Cost is minimal and often free. THIS is the way in which we can offer "death with dignity"

Hospices receive funds from government programs or private insurance, from donations made by the public or other corporations, and from grants donated by charitable foundations. Hospices are reimbursed by Medicare, Medicaid, or private insurance for care provided to the terminally ill. Hospices are not reimbursed on a fee for service basis: rather, hospices are paid, on a basis of how many days the patient is enrolled in the program and received services: the per-diem basis. In return for payment, Medicare, Medicaid and private insurance companies expect the hospices to provide all services which the patient and family need which are related to the terminal illness. The Centers for Medicare Services (CMS) regulations mandate that the hospice comply with the regulations.

While nonprofit hospices can solicit as well as receive charitable donations, for-profit hospices can only receive donations. After the death of their loved one, some families suggest making memorial donations to the hospice they used. This is a very significant source of funds to the hospice and helps to cover expenses incurred in running the hospice.

Nonprofit charitable hospices are supposed to provide hospice services to those persons who do not have coverage and cannot afford to pay for care. So when you donate to a nonprofit hospice, there is a greater likelihood that charitable hospice services will be provided. Whether or not your loved one has Medicare, Medicaid or private insurance, you should never have to pay out of your own pocket for hospice covered services. If you do not have any coverage by Medicare, Medicaid or private insurance, a nonprofit hospice can provide services to you FREE OF CHARGE as part of its charitable mission. The nonprofit status of the hospice often requires it to provide charitable services. You can find a larger nonprofit hospice if you have no coverage; the nonprofit hospices are dedicated to the mission of serving those in need.

I once again oppose the passage of this bill. Hospice, not euthanasia, is the answer to this issue.

TO: The Hawaii House Committee on Health

FROM: Margaret Dore, Esq., MBA, President
Choice is an Illusion, a nonprofit corporation[1]

RE: Reject SB 1129 S.D. 2

- No Assisted Suicide
- No Euthanasia
- Preserve Informed Consent
- Prevent People With Years to Live From Throwing Away Their Lives
- Stop Legal Elder Abuse
- Stop Legal Murder
- Don't Put Older People in the Crosshairs of Their Heirs and Other Predators

HEARING: **Thursday, March 23, 2017 at 8:30 a.m.**
State Capitol Conference Room 329
415 South Beretania Street
Honolulu HI

MEMO DATE: March 21, 2017

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* Margaret Dore, Law Office of Margaret K. Dore, PS, Choice is an Illusion, a nonprofit corporation, www.margaretdore.com, www.choiceillusion.org 1001 4th Avenue, Suite 4400, Seattle, WA 98154, 206 697 1217

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APPENDIX

I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal.[1] Our law is based on a similar law in Oregon. Both laws are similar to the proposed act in SB 1129 SD 2.

The proposed act seeks to legalize physician-assisted suicide and euthanasia as those terms are traditionally defined. The act calls these practices "aid in dying." This is misleading. "Eligible" persons may have years or decades to live. The act is also sold as a promotion of patient choice and control, which is not true. The act is stacked against the patient and a recipe for elder abuse. I urge you to vote "No" on SB 1129 SD2.

II. DEFINITIONS

A. Physician-Assisted Suicide; Assisted Suicide; and Euthanasia

The American Medical Association (AMA) defines physician-assisted suicide as occurring when "a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act."[2] For example:

---

[1] I am an elder law and appellate attorney licensed to practice law in Washington State since 1986. I am also a former Law Clerk to the Washington State Supreme Court. I am president of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide and euthanasia. My CV is attached hereto in the Appendix at A-1 to A-4. See also www.margaretdore.com, www.choiceillusion.org and www.hawaiiagainstassistedsuicide.org

[2] The AMA Code of Medical Ethics, 2016, Opinion 5.7, "Physician-Assisted Suicide. (Attached hereto at A-5)

> [The doctor] provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide.[3]

Assisted suicide is a general term in which an assisting person is not necessarily a physician. Euthanasia is the administration of a lethal agent to cause another person's death.[4]

B. Withholding or Withdrawing Treatment

Withholding or withdrawing treatment ("pulling the plug") is not euthanasia if the purpose is to remove burdensome treatment, as opposed to an intent to kill the patient. More importantly, the patient will not necessarily die. Consider this quote from Washington State regarding a man removed from a ventilator:

> [I]nstead of dying as expected, [he] slowly began to get better.[5]

III. ELDER ABUSE

A. Elder Abuse Is a Pervasive Problem That Includes the Financial Exploitation and Murder of Older Adults

Elder abuse is a problem in Hawaii and throughout the United

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[3] Id.

[4] AMA Code of Medical Ethics, 2016, Opinion 5.8, "Euthanasia," attached hereto at A-5 (lower half of the page).

[5] Nina Shapiro, "Terminal Uncertainty — Washington's new 'Death with Dignity' law allows doctors to help people commit suicide — once they've determined that the patient has only six months to live. But what if they're wrong?," *The Seattle Weekly*, 01/14/09; article at A-6, quote at A-8.

States.[6] Perpetrators are often family members who start out with small crimes, such as stealing jewelry and blank checks, before moving on to larger items or to coercing victims to change their wills or to liquidate their assets.[7]

Perpetrators can also be calculating criminals. Consider Melissa Ann Shepard, the "Internet Black Widow," who preyed on lonely men.[8] A 2016 article states:

> [These men] sought companionship and found instead someone who siphoned their savings, slipped drugs into their food and, in the case of one man, ran him over . . . and left him dead on a dirt road.[9]

B. Victims Rarely Report

Elder abuse is a largely hidden problem, in part, due to the reluctance of victims to report. It is estimated that only 1 in 14 cases ever comes to the attention of the authorities.[10] In

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[6] See: State of Hawaii Executive Office on Aging, "Prevention of Elder Abuse Is in Our Hands: A Guide to Identify, Report and Prevent Abuse, Neglect and Exploitation," published July 2014, available at https://www.hawaiiadrc.org/Portals/_AgencySite/Diane/EA-Prevention-07-2014.pdf ; and Met Life Mature Market Institute, Broken Trust: Elders, Family and Finances," March 2009, at https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

[7] Met Life Mature Market Institute, supra.

[8] Cassie Williams, CBC News, "Internet Black Widow Melissa Ann Shepard arrested in Halifax," April 12, 2016, attached hereto at A-9 & A-10.

[9] Yanan Wang, "This 80-year-old 'Black Widow,' who lured lonesome old men to horrible fates, is out of prison again," *The Washington Post*, March 21, 2016. (Attached hereto at A-11 through A-13).

[10] Nat'l Center on Elder Abuse, http://www.ncea.aoa.gov/Library/Data/

another study, it was 1 out of 25 cases.[11] Reasons include the following:

> • [Victims f]eel ashamed and embarrassed, particularly if a family member is the abuser.
>
> • [Victims are] afraid that if they report, the abuse will get worse.[12]

IV. ASSISTED SUICIDE AND EUTHANASIA

A. Assisting Persons Can Have Their Own Agendas

Persons who assist a suicide or euthanasia can have their own agendas. For an Oregon example, there is the Thomas Middleton case. Two days after he died of physician-assisted suicide, his trustee sold his home and deposited the proceeds into bank accounts for her own benefit.[13] She was charged with fraud, but the case did not go forward.[14] Middleton's son was dismayed with the outcome.[15]

B. Few States Allow Assisted Suicide

Oregon and Washington legalized physician-assisted suicide by ballot measures in 1997 and 2008, respectively. Since then,

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[11] Id.

[12] State of Hawaii Executive Office on Aging, supra at note 7, page 5.

[13] KTVZ.com, "Sawyer Arraigned on State Fraud Charges," updated July 14, 2011. (Attached hereto at A-14).

[14] KTVZ.com, "State dropping Tami Sawyer fraud case: DOJ says prosecution likely would not add time behind bars," updated October 30, 2013. (Attached hereto at A-15).

[15] Id.

allow euthanasia.[16]

C. Other States Push Back

In the last six years, five states have strengthened their laws against assisted suicide: Arizona, Louisiana, Georgia, Idaho and Ohio.[17]

Last year, the New Mexico Supreme Court overturned a lower court case recognizing a right to physician aid in dying, meaning physician assisted suicide.[18] Physician-assisted suicide is no longer legal in New Mexico.

V. THE ACT

A. How the Act Works

The act has an application process to obtain the lethal dose, which includes a written lethal dose request form with two required witnesses.[19] One of the witnesses is allowed to be the patient's heir who will financially benefit from the patient's

---

[16] Consider, for example, Washington's law, which was sold to voters as assisted suicide in which a patient would "self-administer" the lethal dose. In Washington's law, the term, "self-administer" is specially defined to allow someone else to administer the lethal dose to the patient, which is euthanasia. Cf. Margaret K. Dore, "'Death with Dignity': What Do We Advise Our Clients?," at A-16 to A-18.

[17] See: Associated Press, "Brewer signs law targeting assisted suicide," *Arizona Capitol Times*, 04/30/14, attached at A-19; Associated Press, "La. assisted-suicide ban strengthened," *The Daily Comet*, 04/24/12, attached at A-20); Georgia HB 1114 (attached hereto at A-21); Margaret Dore, "Idaho Strengthens Law Against Assisted Suicide," Choice is an Illusion, 07/04/11, at A-22 ("Governor Butch Otto signed Senate law 1070 into law. The law explicitly provides that causing or aiding a suicide is a felony"); and Ohio HB 470, at https://choiceisanillusion.files.wordpress

[18] *Morris v. Brandenburg*, 376 P.3d 836 (2016). (Excerpt attached at A-23).

[19] The form can be viewed at SB 1129 SD 2, Section 2, § -23, attached hereto at A-126 to A-128. The witness section can be viewed at A-128.

death.[20]

After the lethal dose is issued by the pharmacy, there is a complete lack of oversight. No doctor, not even a witness, is required to present at the death.[21]

B. A Comparison to Probate Law

When signing a will, having an heir act as one of two witnesses can support a finding of undue influence. Washington's probate code, for example, provides that when one of two witnesses inherits under a will, there is a rebuttable presumption that the inheritance was procured "by duress, menace, fraud, or undue influence."[22]

The act's lethal dose request process, which allows an heir to act as one of two witnesses on the lethal dose request form, does not promote patient choice. It invites coercion.

C. "Eligible" Persons May Have Decades to Live

The act applies to persons with a "terminal disease" who are predicted to have less than six months to live.[23] Such persons may, in fact, have decades to live. This is true for three reasons:

---

20 Id.

21 See SB 1129 SD 2 in its entirety, attached hereto at A-101 to A-132.

22 Wash. Rev. Code Ann. § 11.12.160(2), attached hereto at A-24.

23 SB 1129 SD 2, Section 2, §§ -1 & 2, attached hereto at A-105 to A-106.

1. The six months to live is determined without treatment

The act states:

> "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.[24]

Oregon's law has this same definition:

> "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.[25]

In Oregon, this same definition is interpreted to include chronic conditions such as "diabetes mellitus," better known as diabetes.[26] Oregon doctor, William Toffler, explains:

> [P]eople with chronic conditions are "terminal" [for the purpose of Oregon's law] if without their medications, they have less than six months to live. This is significant when you consider that a typical insulin-dependent 20 year-old . . . will live less than a month without insulin. Such persons, with insulin, are likely to have decades to live . . . . (Emphasis changed).[27]

If Hawaii enacts the proposed bill and follows Oregon's interpretation of "terminal disease," assisted suicide and euthanasia will be legalized for people with chronic conditions

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[24] Id., attached hereto at A-105, lines 19 to 21.

[25] Or. Rev. Stat. 127.800 s.1.01(12), attached hereto at A-25.

[26] Declaration of William Toffler, MD, ¶3, at A-26. See also Oregon's annual report for 2015, attached hereto at A-34 & A-35 (listing chronic conditions, such as "chronic lower respiratory disease" and "diabetes mellitus" as underlying illnesses sufficient to justify assisted suicide).

[27] Toffler Declaration., ¶4, attached hereto at A-26 to A-27.

such as insulin dependent diabetes. People who, with their medications, can have decades to live.

2. Predictions of life expectancy can be wrong

Eligible persons may also have years to live because doctor predictions of life expectancy can be wrong. This is due to misdiagnosis and the fact that predicting life expectancy is not an exact science.[28] Consider John Norton, who was diagnosed with ALS (Lou Gehrig's disease) at age 18.[29] He was told that he would get progressively worse (be paralyzed) and die in three to five years.[30] Instead, the disease progression stopped on its own.[31] In a 2012 affidavit, at age 74, he states:

> If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come.[32]

3. Treatment can lead to recovery

Consider also Oregon resident, Jeanette Hall, who was diagnosed with cancer in 2000 and made a settled decision to use

---

[28] See Jessica Firger, "12 million Americans misdiagnosed each year," CBS NEWS, 4/17/14 (attached at A-36); and Nina Shapiro, supra, attached at A-6.

[29] Affidavit of John Norton, ¶ 1 (Attached hereto at A-37).

[30] Id., ¶ 1.

[31] Id., ¶ 4, attached hereto at A-38.

[32] Id., ¶ 5.

Oregon's law.[33] Her doctor convinced her to be treated instead.[34] In a 2016 affidavit, she states:

> This July, it will be 16 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.[35]

D. Patients Will Lose the Right to Informed Consent: They Will Lose the Right to Be Told About Alternatives For Cure

1. Present law

Under present law, a person making a health care decision has the right to "informed consent." This includes the right to be supplied with information concerning "recognized alternative treatments" and their "recognized benefits," for example, regarding a cure for cancer. HRS § 671-3(b) states:

> The following information shall be supplied to the patient . . . prior to obtaining consent to a proposed medical or surgical treatment . . .
>
> (4) The recognized alternative treatments or procedures,. . . and . . .
>
> (6) The recognized benefits of the recognized alternative treatments or procedures. (Emphasis added).[36]

2. The proposed act

Under the proposed act, a person considering the lethal dose

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[33] Affidavit of Kenneth Stevens, MD, attached at A-40 to A-46; Jeanette Hall discussed at A-40 to A-41. Affidavit of Jeanette Hall, attached at A-47.

[34] Id.

[35] Affidavit of Jeanette Hall, ¶4, at A-47.

[36] Attached hereto at A-48.

instead has the right to an "informed decision." The act states:

> "Informed decision" means a decision . . . that is based on an appreciation of the relevant facts and after being fully informed . . . of . . .
>
> (5) the feasible alternatives, including but not limited to comfort care, hospice care, and pain control. (Emphasis added)[37]

With this language, the patient no longer has the right to be told of "recognized alternative treatments" and their "recognized benefits," for example, to cure cancer. This is due to the rule of statutory construction, *ejusdem generis*.

Per the rule, a general reference in a statute only applies to the same kind of things specifically listed.[38] As set forth above, the proposed act has a general reference to "feasible alternatives" and also refers to a list of specific alternatives: "comfort care, hospice care, and pain control."

Per the rule, these specific alternatives, all having to do with death and dying, limit "feasible alternatives" to those involving death and dying. Patients no longer have the right to be told of "recognized alternatives" and their "recognized benefits" such as a cure for cancer. With the act, they lose that right. So much for empowering patient choice and control.

---

[37] SB 1129 SD2, Section 2, § -1, page 4, line 11 to page 5, line 4. Attached hereto at A-104 and A-105.

[38] See http://dictionary.law.com/Default.aspx?selected=607

E. There Is No Requirement of Voluntariness, Capability or Consent When the Lethal Dose is Administered

The act does not require administration of the lethal dose to be voluntary.[39] Similarly, the act does not require that the patient be capable or even aware when the lethal dose is administered.[40] There is no language requiring patient consent to administration.[41] Without these requirements, patient choice and control is an illusion.

---

[39] The act repeatedly uses the word "voluntary" in relation to a request for the lethal dose. The act does not require that administration of the lethal dose be voluntary. See the act attached hereto at A 101, A-102, A-106 to A-108, A-111, A-113 to A-114 and A-127.

[40] See the act in its entirety, attached hereto at A-101 to A-132. Note also that the term, "capable," is only relevant during the lethal dose request process when a patient is to "make and communicate" a decision. The act states:

> "Capable" means that in the opinion of a court or in the opinion of the patient's attending provider or consulting provider, psychiatrist, or psychologist, a patient has the ability to make and communicate health care decisions to health care providers. (Emphasis added).

SB 1129 SD2, Section 2, § -1, attached hereto at A-103, lines 8-12.

[41] The act uses the word, "consent" just once, in the context of the obtaining the lethal dose from a pharmacist (not with regard to administration of the lethal dose). The act, § -4(a) states:

> The attending provider shall: . . .
>
> (12)(B) With the qualified patient's written consent:
>
> (i) Contact a pharmacist of the qualified patient's choice and inform the pharmacist of the prescription; and
>
> (ii) Transmit the written prescription personally, by mail, or electronically to the pharmacist, who will dispense the medications to either the qualified patient, the attending provider, or an expressly identified agent of the qualified patient. (Emphasis added).

Attached hereto at A-110.

F. Someone Else Is Allowed to Administer the Lethal Dose to the Patient: "Self-Administration" Is Not Required

Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer medication to a patient.[42]

Common examples of persons who administer medication under the direction of a doctor, include: nurses who administer prescription drugs to patients in a hospital setting; parents who administer prescription drugs to their children in a home setting; and adult children who administer prescription drugs to their parents in a home setting.[43]

The proposed act allows a doctor to prescribe the lethal dose as part of his or her medical practice.[44] The act also describes the lethal dose as being self-administered by the

---

[42] See Declaration of Kenneth Stevens, MD, 01/06/16, at A-51, ¶ 10, which states:

> Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer prescription drugs to a patient.
>
> Common examples of persons acting under the direction of a doctor, include: nurses and other healthcare professionals who act under the direction of a doctor to administer drugs to a patient in a hospital setting; parents who act under the direction of a doctor to administer drugs to their children in a home setting; and adult children who act under the direction of a doctor to administer drugs to their parents in a home setting. (Spacing changed)

[43] Id.

[44] The act allows an attending provider, which includes a physician licensed to practice medicine pursuant to chapter 453, to prescribe the lethal dose. See: SB 1129 SD2, § -1 (defining "attending provider" as "a physician licensed to practice pursuant to chapter 453"). See also HRS §453-1 (defining the practice of medicine as including "the use of drugs and medicines").

patient.[45] There is, however, no language stating that administration "must" be by self-administration.[46]

With self-administration not mandatory, generally accepted medical practice allow a doctor or a person acting under the direction of a doctor to administer the medication (lethal dose). Someone else is allowed to administer the lethal dose to the patient.

G. Allowing Someone Else to Administer the Lethal Dose is Euthanasia

Allowing someone else to administer the lethal dose to a patient is euthanasia under generally accepted medical terminology. The AMA Code of Ethics, Opinion 5.8 states:

> Euthanasia is the administration of a lethal agent <u>by another person to a patient</u> . . . . (Emphasis added.)[47]

H. The Act Does Not Prohibit Euthanasia

The act appears to prohibit euthanasia, which is also known as lethal injection and mercy killing.[48] The act states:

> Nothing in this chapter shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia.[49]

---

[45] See SB 1129 SD2 in its entirety, attached hereto at A-101 to A-132.

[46] Id.

[47] Attached hereto at A-5 (lower half of the page).

[48] For definitions of "lethal injection" and "mercy killing," see attachments at A-52 and A-53, respectively.

[49] The act, Section 2, § - 18, attached at A-117, lines 11 to 14.

This apparent prohibition is defined away in the next sentence:

> Actions taken in accordance with this chapter shall not, for any purpose, constitute suicide, assisted suicide, mercy killing [another word for euthanasial, or homicide. (Emphasis added).[50]

I. There Is a Complete Lack of Oversight at the Death

If for the purpose of argument, the act does not allow euthanasia, patients are nonetheless at risk to the actions of other people. This is due to the complete lack of oversight at the death.[51]

Without oversight, the opportunity is created for someone else to administer the lethal dose to the patient. The drugs used are water and alcohol soluble, such that they can be injected into a sleeping or restrained person.[52] Even if the patient struggled, who would know?

Alex Schadenberg, Executive Director for the Euthanasia Prevention Coalition, puts it this way:

> With assisted suicide laws in Washington and Oregon [and with the proposed act], perpetrators can . . . take a "legal" route, by getting an elder to sign a lethal dose request. Once the prescription is filled,

---

[50] Id., lines 14 to 17.

[51] Again, see the act in its entirety (no oversight required when the lethal dose is administered)

[52] The drugs used for assisted suicide in Oregon and Washington include Secobarbital and Pentobarbital (Nembutal). See "Secobarbital Sodium Capsules, Drugs.Com, at http://www.drugs.com/pr/seconal-sodium.html and http://www.drugs.com/pro/nembutal.html See also Oregon's government report, page 5, attached at A-34 (listing these drugs).

there is no supervision over administration. . . . [I]f a patient struggled, "who would know?" (Emphasis added).[53]

J. The Death Certificate Is Required to List a Terminal Disease as the Cause of Death, Which Prevents Prosecution for Murder

The proposed act states:

> The death certificate shall list the terminal disease as the immediate cause of death. (Emphasis added).[54]

The significance of requiring a terminal disease to be listed as the cause of death is that it creates a legal inability to prosecute: The official legal cause of death is a terminal disease (not murder) as a matter of law.

K. The Act Prevents Prosecution of Criminal Conduct For Actions Taken in "Accordance" With the Act

The act says that actions taken in accordance with the act "shall not" constitute criminal conduct. The act states:

> Actions taken in accordance with this chapter shall not, for any purpose, constitute suicide, assisted suicide, mercy killing, murder, manslaughter, negligent homicide, or any other criminal conduct under the law. (Emphasis added).[55]

The Act does not define "accordance."[56] Dictionary

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[53] Alex Schadenberg, Letter to the Editor, "Elder abuse a growing problem," *The Advocate*, Official Publication of the Idaho State Bar, October 2010, page 14, available at http://www.margaretdore.com/info/October_Letters.pdf

[54] SB 1129 SD2, Section 2, § -4(b), attached hereto at A-110, lines 18-19.

[55] SB 1129 SD2, Section 2, § -18, attached at A-117, lines 14 to 17.

[56] See the act in its entirety, attached hereto at A-101 to A-116.

definitions include "in the spirit of," meaning "in thought or intention though not physically."[57]

For an example of how "accordance" is interpreted in practice, see Section L below regarding Washington State.

L. If Hawaii Follows Washington State, There Will Be an Official Legal Cover Up

Again, the act states:

> The death certificate shall list the terminal disease as the immediate cause of death
>
> [and]
>
> Actions taken in accordance with this chapter shall not, for any purpose, constitute suicide, assisted suicide, mercy killing, murder, manslaughter, negligent homicide, or any other criminal conduct under the law. (Emphasis added).[58]

In Washington State, similar language is interpreted by the Washington State Department of Health (the "Department") to require the death certificate to list a natural death without even a hint that the actual cause of death was assisted suicide or euthanasia. The only relevant inquiry is whether Washington's Act was "used."

The Department's "Death Certificate Instructions for Medical Examiners, Coroners and Prosecuting Attorneys," states:

> Washington's [law] states that "...the patient's death certificate ... shall list the underlying terminal disease as the cause

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[57] Definitions are attached hereto at A-54 and A-55.

[58] SB 1129 SD2, Section 2, §§ -4(b) & -18.

> of death." [Washington's law] also states that, "Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide under the law."
>
> If you know the decedent used [Washington's law], you must comply with the strict requirements of the law when completing the death record:
>
> 1. The underlying terminal disease must be listed as the cause of death.
>
> 2. The manner of death must be marked as "Natural."
>
> 3. The cause of death section may not contain any language that indicates that [Washington's law] was used, such as:
>
> a. Suicide
> b. Assisted suicide
> c. Physician-assisted suicide
> d. Death with Dignity
> e. I-1000 [Washington's law was passed by I-1000]
> f. Mercy killing
> g. Euthanasia
> h. Secobarbital or Seconal
> i. Pentobarbital or Nembutal (Emphasis added.)[59]

If Hawaii enacts the proposed act and follows Washington State, death certificates will not even hint that the actual cause of death was assisted suicide or euthanasia. This will happen as long as the act was "used" and regardless of whether there was compliance with other act provisions. There will be an official legal cover up.

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[59] A copy of the Washington State Department of Health death certificate instruction is attached hereto at A-58.

VI. OREGON IS NOT A VALID CASE STUDY

Oregon is not a valid case study due to a near complete lack of transparency regarding its law.[60] Even law enforcement does not have access to the information collected.[61] Source documentation is destroyed.[62] The bottom line, Oregon's official data cannot be verified.

VII. OTHER CONSIDERATIONS

A. Compassion & Choices' Mission is to Promote Suicide

The bill's passage is being spearheaded by the suicide advocacy group, Compassion & Choices.

Compassion & Choices was formed in 2004 as the result of a merger/takeover of two other organizations.[63] One of these

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[60] See: "Declaration of Testimony" by Oregon attorney Isaac Jackson, dated September 18, 2012, attached hereto at A-57 to A-62 (regarding the run-around he got when he attempted to learn whether his client's father had died under Oregon's law - the Oregon Health Authority would neither confirm nor deny whether the father had died under the law); E-mail from Alicia Parkman, Oregon Mortality Research Analyst, to Margaret Dore, dated January 4, 2012, attached at A-63-A-64 (law enforcement cannot get access to information); Excerpt from Oregon's website at A-67 (patient identities "not recorded in any manner"); E-mail from Parkman to Dore, January 4, 2012, attached at A-65 to A-66 ("all source documentation" destroyed after one year); and the "Confidentiality of Death Certificates" policy issued by the Oregon Department of Human Resources Health Division, December 12, 1997, attached at A-68 to A-69 (clarifying that employees failing to comply with confidentiality rules "will immediately be terminated"), as published in the *Issues in Law & Medicine*, Volume 14, Number 3, 1998. See also documents attached at A-70 to A-72.

[61] Id.

[62] Id.

[63] Ian Dowbiggin, A Concise History of Euthanasia 146 (2007)("In 2003, [the] Hemlock [Society] changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices."). Accord. Compassion & Choices Newsletter attached at A-73 ("Years later, the Hemlock Society would become End of Life Choices and then merge with Compassion in Dying to become Compassion & Choices").

organizations was the former Hemlock Society, originally formed by Derek Humphry.[64]

In 2011, Humphry was the keynote speaker at Compassion & Choices' annual meeting in Washington State.[65] He was also in the news as a promoter of mail-order suicide kits.[66] This was after a depressed 29 year old man used one of the kits to kill himself.[67] Compassion & Choices' newsletter, promoting Humphry's presentation, references him as "the father of the modern movement for choice."[68] Compassion & Choices' mission is to promote suicide.

B. In Oregon, Other Suicides Have Increased with Legalization of Physician-Assisted Suicide; the Financial Cost Is "Enormous"

Government reports from Oregon show a positive statistical correlation between the legalization of physician-assisted suicide and an increase in other (conventional) suicides. This statistical correlation is consistent with a suicide contagion in which legalizing physician-assisted suicide encouraged other

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64 Id.

65 Compassion & Choices Newsletter, regarding Humphry's October 22, 2011 speaking date. (Attached hereto at A-73.)

66 See Jack Moran, "Police kick in door in confusion over suicide kit," *The Register-Guard*, September 21, 2011 (""A spotlight was cast on the mail-order suicide kit business after a 29-year-old Eugene man committed suicide in December using a helium hood kit. The Register-Guard traced the $60 kit to [the company, which] has no website and does no advertising; clients find [the] address through the writings of Humphry.") (Attached hereto at A-74 to 75)(Emphasis added)

67 Id.

68 Compassion & Choices Newsletter, at A-73.

suicides. Consider the following:

> Oregon's assisted suicide act went into effect "in late 1997."[69]
>
> By 2000, Oregon's conventional suicide rate was "increasing significantly."[70]
>
> By 2007, Oregon's conventional suicide rate was 35% above the national average.[71]
>
> By 2010, Oregon's conventional suicide rate was 41% above the national average.[72]

There is a significant financial cost associated with these other suicides. One reason is that people who attempt suicide (and fail) can injure themselves or become disabled by the attempt. A government report from Oregon states:

> [T]he estimate of total lifetime cost of suicide in Oregon was over 680 million dollars.[73]

C. The Swiss Study: Physician-Assisted Suicide Can Be Traumatic for Family Members

In 2012, a European research study addressed trauma suffered by persons who witnessed legal physician-assisted suicide in

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[69] Oregon's assisted suicide report for 2014, first line, at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf

[70] *See* Oregon Health Authority News Release, 09/09/10. ("After decreasing in the 1990s, suicide rates have been increasing significantly since 2000"). (Attached at A-76)

[71] *Id.*

[72] Oregon Health Authority Report, Suicides in Oregon, Trends and Risk Factors (2012 Report), at A-78.

[73] See report at A-78.

Switzerland.[74] The study found that one out of five family members or friends present at an assisted suicide was traumatized. These people,

> experienced full or sub-threshold PTSD (Post Traumatic Stress Disorder) related to the loss of a close person through assisted suicide.[75]

D. My Clients Suffered Trauma in Oregon and Washington State

In Washington State and Oregon, I have had two cases where my clients suffered trauma due to legal assisted suicide. In the first case, one side of the family wanted the father to take the lethal dose, while the other side did not. The father spent the last months of his life caught in the middle and torn over whether or not he should kill himself. My client, his adult daughter, was severely traumatized. The father did not take the lethal dose and died a natural death.

In the other case, it's not clear that administration of the lethal dose was voluntary. A man who was present told my client that my client's father had refused to take the lethal dose when it was delivered, stating, "You're not killing me. I'm going to bed," but then he (the father) took it the next night when he was intoxicated on alcohol. The man who told this to my client

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[74] "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide," B. Wagner, J. Muller, A. Maercker; *European Psychiatry* 27 (2012) 542-546, available at http://choiceisanillusion.files.wordpress.com/2012/10/family-members-traumatized-eur-psych-2012.pdf (Cover page attached hereto at A-80)

[75] Id., at A-80.

subsequently changed his story.

My client, although he was not present, was traumatized over the incident, and also by the sudden loss of his father.

E. The Felony for Undue Influence Is Illusory, and Unenforceable

The act has a felony for undue influence, which is not defined and has no elements of proof. The proposed act states:

> A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of the request, shall be guilty of a class A felony. (Emphasis added).[76]

The act allows the patient's heir to be one of two witnesses on the lethal drug request form, which as noted above can provide proof of undue influence.[77]

How do you prove that undue influence occurred when the act does not define it and the act also allows conduct used to prove it? You can't. The felony for undue influence is illusory, contradictory and unenforceable.

VIII. CONCLUSION

The proposed act is sold as completely voluntary, but does not even have a provision requiring administration of the lethal dose to be voluntary. Administration of the lethal dose is allowed to occur in private without a doctor or witness present.

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[76] SB 1129 SD 2, Section 2, § -20(b), attached at A-124.

[77] Again, see Washington State's probate statute attached hereto at A-24).

If the patient objected or even struggled, who would know?

Don't make Oregon and Washington's mistake. I urge you to vote "No" on SB 1129 SD2.

Respectfully Submitted,

Margaret Dore, Esq., MBA
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Attachments

Margaret Dore Memo

Reject SB 1129 S.D. 2

as of

March 21, 2017

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Attorney/President. Work has included litigation, civil appeals, probate, guardianship and bankruptcy. Also participate in legislation and court cases involving assisted suicide and euthanasia in the US, Canada, Australia, South Africa and other jurisdictions. (October 1994 to present).

Lanz & Danielson, Seattle, Washington USA.
Attorney: Private practice emphasizing real estate litigation, bankruptcy, guardianship and appeals. (December 1990 to October 1994).

Self-Employed Attorney, Seattle, Washington USA.
Worked for other attorneys and private clients. Work emphasized appeals and litigation generally. (September 1989 to December 1990).

The United States Department of Justice, Office of the United States Trustee, Seattle, Washington USA.
Attorney: Government practice, emphasizing bankruptcy. (September 1988 to August 1989)

JUDICIAL CLERKSHIPS:

The Washington State Supreme Court, Olympia, Washington USA.
Law Clerk to Chief Justice Vernon R. Pearson. (August 1987 to August 1988).

The Washington State Court of Appeals, Tacoma, Washington USA.
Law Clerk to Judge John A. Petrich. (August 1986 to August 1987).

ADMITTED TO PRACTICE:

- Supreme Court of the United States, 2000-present.
- United States Court of Appeals for the Ninth Circuit, 1988-present.
- United States District Court, Western District of Washington 1988-present.
- Washington State Bar Association, 1986-present.

PROFESSIONAL MEMBERSHIPS:

- American Bar Association, 2001 to present.
- American Bar Association, Elder Law Committee of the Family Law Section, Chair 2007.
- Choice is an Illusion, President, 2010 to present.
- Fellows of the American Bar Foundation, Life Fellow, 2007 to present.
- King County Bar Association, 1989 to present.
- King County Bar Elder Law Section, Chair,1995-96.
- National Association of Elder Law Attorneys, 1996, 2001, present.
- Vision Awareness of Washington, President, 1993-2001.
- Washington State Trial Lawyers Association, 1996, other years.

PUBLICATIONS:

Assisted Suicide and Euthanasia

Margaret Dore, "California's New Assisted Suicide Law: Whose Choice Will it Be?," *JURIST* - Professional Commentary, October 24, 2015;

Margaret Dore, "Preventing Abuse and Exploitation: A Personal Shift in Focus" (An article about elder abuse, guardianship abuse and assisted suicide), *The Voice of Experience*, ABA Senior Lawyers Division Newsletter, Winter 2014;

Margaret K. Dore, "Physician-Assisted Suicide: A Recipe for Elder Abuse and the Illusion of Personal Choice," *The Vermont Bar Journal*, Winter 2011;

State Senator Jim Shockley & Margaret Dore, "No, Physician-Assisted Suicide is not Legal in Montana: It's a recipe for elder abuse and more." *The Montana Lawyer*, November 2011;

Margaret K. Dore, "Aid in Dying: Not Legal in Idaho; Not About Choice," *The Advocate*, official publication of the Idaho State Bar, Vol. 52, No. 9, pages 18-20, September 2010;

Margaret Dore, "'Death with Dignity': A Recipe for Elder Abuse and Homicide (Albeit not by Name)," *Marquette Elder's Advisor*, Vol. 11, No. 2, Spring 2010;

Margaret K. Dore, "Death with Dignity: What Do We Tell Our Clients?," Washington State Bar Association, *Bar News*, July 2009; and

Margaret K. Dore, "'Death with Dignity': What Do We Advise Our Clients?," King County Bar Association, *Bar Bulletin*, May 2009.

Guardianship, Elder Abuse and Family Law

Margaret K. Dore, Ten Reasons People Get Railroaded into Guardianship, 21 *American Journal of Family Law* 148, Winter 2008;

Margaret K. Dore, The Time is Now: Guardians Should be Licensed and Regulated Under the Executive Branch, Not the Courts, Washington State Bar Association, *Bar News*, March 2007;

Margaret K. Dore, A Call for Executive Oversight of Guardians, King County Bar Association, *Bar Bulletin*, March 2007;

Margaret K. Dore, The Case Against Court Certification of Guardians: The Case for Licensing and Regulation, National Academy of Elder Law Attorneys, *NAELA News*, Vol. 18, No. 1, February/March 2006;

Margaret K. Dore, The Stamm Case and Guardians ad Litem, King County Bar Association, *Bar Bulletin*, June 2005, Washington State Bar Association, *Elder Law Section Newsletter*, Winter 2004-2005, p. 3;

Margaret K. Dore, The "Friendly Parent" Concept: A Flawed Factor for Child Custody, 6 *Loyola Journal of Public Interest Law* 41 (2004);

Margaret K. Dore and J. Mark Weiss, "Washington Rejects 'Friendly Parent' Presumption in Child Custody Cases," Washington State Bar Association, *Bar News*, August 2001;

Margaret K. Dore and J. Mark Weiss, "Lawrence and Nunn Reject the 'Friendly Parent' Concept", *Domestic Violence Report*, Vol. 6, No. 6, August/September 2001;

Margaret K. Dore, "The Friendly Parent Concept (Access to Justice denied)," Washington State Trial Lawyers Association, *Trial News*, Volume 36, No. 9, May 2001;

Margaret K. Dore, "Parenting Evaluators and GALs: Practical Realities," King County Bar Association, *Bar Bulletin*, December 1999; and

Margaret K. Dore, "The Friendly Parent Concept--A Construct Fundamentally at Odds With The Parenting Act, RCW 26.09," Washington State Bar Association, *Family Law Section Newsletter*, Spring 1999.

AWARDS/RECOGNITIONS:

- Butch Blum Award of Excellence in the Legal Arena, for 2005, in association with *Law & Politics Magazine* (One of nine nominees, only solo practitioner).

- Wendy N. Davis, "Family Values in Flux: Some Lawyers are growing hostile to the 'friendly parent' idea in custody fights," *ABA Journal*, Vol. 87, p. 26, October 2001 (featuring Margaret Dore after victory in Washington State).

PUBLISHED DECISIONS:

- *In re Guardianship of Stamm*, 121 Wn. App. 830, 91 P.3d 126 (2004) (3-0 opinion limiting the admissibility of guardian ad litem testimony);

- *Lawrence v. Lawrence*, 105 Wn. App.683, 20 P.3d 972 (2001) (3-0 opinion re: the "friendly parent" concept, that its use in a child custody determination would be an abuse of discretion);

- *Kelly-Hansen v. Kelly-Hansen*, 87 Wn. App. 320, 941 P.2d 1108 (1997) (3-0 opinion re: post-dissolution dispute);

- *Jain v. State Farm*, 130 Wn.2d 688, 926 P.2d 923 (1996), (7-2 opinion re: insurance coverage and retroactive application of decisional law); and

- *In Re Alpine Group, Inc.*, 151 B.R. 931 (9th Cir. BAP 1993) (3-0 opinion re: attorney fees in bankruptcy).

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University of Washington School of Law, Seattle, Washington USA.
Juris Doctorate, 1986.

University of Washington Foster School of Business, Seattle, Washington USA.
Masters of Business Administration, 1983; Concentration: Finance.

University of Washington Foster School of Business, Seattle, Washington USA.
Bachelor of Arts, Business Administration, 1979; Concentration: Accounting.
Honors: Graduated Cum Laude; Phi Beta Kappa.

Passed the C.P.A. examination in 1982.

Physicians may offer palliative sedation to unconsciousness to address refractory clinical symptoms, not to respond to existential suffering arising from such issues as death anxiety, isolation, or loss of control. Existential suffering should be addressed through appropriate social, psychological or spiritual support.

AMA Principles of Medical Ethics: I,VII

5.7 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that cure is impossible.

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

(d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I,IV

5.8 Euthanasia

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life.

However, permitting physicians to engage in euthanasia would ultimately cause more harm than good.

Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life.

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Terminal Uncertainty

Washington's new "Death With Dignity" law allows doctors to help people commit suicide—once they've determined that the patient has only six months to live. But what if they're wrong?

By Nina Shapiro
published: January 14, 2009

Nina Shapiro

Maryanne Clayton with her son, Eric, in the Fred Hutch waiting room: "I just kept going."

Details:

— Study: Why Now? Timing and Circumstances of Hastened Deaths

— Dilemmas by caretakers and other Oregon studies

— Stats on people who have used Oregon's Death with Dignity law.

— Harvard professor Nicholas Christakis looking at the accuracy of prognosis.

— JAMA study examining the accuracy of prognosis.

UPDATE: "It Felt Like the Big One"

She noticed the back pain first. Driving to the grocery store, Maryanne Clayton would have to pull over to the side of the road in tears. Then 62, a retired computer technician, she went to see a doctor in the Tri-Cities, where she lived. The diagnosis was grim. She already had Stage IV lung cancer, the most advanced form there is. Her tumor had metastasized up her spine. The doctor gave Clayton two to four months to live.

That was almost four years ago.

Prodded by a son who lives in Seattle, Clayton sought treatment from Dr. Renato Martins, a lung cancer specialist at Fred Hutchinson Cancer Research Center. Too weak to endure the toxicity of chemotherapy, she started with radiation, which at first made her even weaker but eventually built her strength. Given dodgy prospects with the standard treatments, Clayton then decided to participate in the clinical trial of a new drug called pemetrexate.

Her response was remarkable. The tumors shrunk, and although they eventually grew back, they shrunk again when she enrolled in a second clinical trial. (Pemetrexate has since been approved by the FDA for initial treatment in lung cancer cases.) She now comes to the Hutch every three weeks to see Martins, get CT scans, and undergo her drug regimen. The prognosis she was given has proved to be "quite wrong."

"I just kept going and going," says Clayton. "You kind of don't notice how long it's been." She is a plain-spoken woman with a raspy voice, a pink face, and grayish-brown hair that fell out during treatment but grew back newly lustrous. "I had to have cancer to have nice hair," she deadpans, putting a hand to her short tresses as she sits, one day last month, in a Fred Hutchinson waiting room. Since the day she was given two to four months to live, Clayton has gone with her children on a series of vacations, including a cruise to the Caribbean, a trip to

Hawaii, and a tour of the Southwest that culminated in a visit to the Grand Canyon. There she rode a hot-air balloon that hit a snag as it descended and tipped over, sending everybody crawling out.

"We almost lost her because she was having too much fun, not from cancer," Martins chuckles.

Her experience underscores the difficulty doctors have in forecasting how long patients have to live—a difficulty that is about to become even more pertinent as the Washington Death With Dignity Act takes effect March 4. The law, passed by initiative last November and modeled closely on a 14-year-old law in Oregon, makes Washington the only other state in the country to allow terminally ill patients to obtain lethal medication. As in Oregon, the law is tightly linked to a prognosis: Two doctors must say a patient has six months or less to live before such medication can be prescribed.

The law has deeply divided doctors, with some loath to help patients end their lives and others asserting it's the most humane thing to do. But there's one thing many on both sides can agree on. Dr. Stuart Farber, head of palliative care at the University of Washington Medical Center, puts it this way: "Our ability to predict what will happen to you in the next six months sucks."

In one sense, six months is an arbitrary figure. "Why not four months? Why not eight months?" asks Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania, adding that medical literature does not define the term "terminally ill." The federal Medicare program, however, has determined that it will pay for hospice care for patients with a prognosis of six months or less. "That's why we chose six months," explains George Eighmey, executive director of Compassion & Choices of Oregon, the group that led the advocacy for the nation's first physician-assisted suicide law. He points out that doctors are already used to making that determination.

To do so, doctors fill out a detailed checklist derived from Medicare guidelines that are intended to ensure that patients truly are at death's door, and that the federal government won't be shelling out for hospice care indefinitely. The checklist covers a patient's ability to speak, walk, and smile, in addition to technical criteria specific to a person's medical condition, such as distant metastases in the case of cancer or a "CD4 count" of less than 25 cells in the case of AIDS.

No such detailed checklist is likely to be required for patients looking to end their lives in Washington, however. The state Department of Health, currently drafting regulations to comply with the new law, has released a preliminary version of the form that will go to doctors. Virtually identical to the one used in Oregon, it simply asks doctors to check a box indicating they have determined that "the patient has six months or less to live" without any additional questions about how that determination was made.

Even when applying the rigid criteria for hospice eligibility, doctors often get it wrong, according to Nicholas Christakis, a professor of medicine and sociology at Harvard University and a pioneer in research on this subject. As a child, his mother was diagnosed with Hodgkin's disease. "When I was six, she was given a 10 percent chance of living beyond three weeks," he writes in his 2000 book, *Death Foretold: Prophecy and Prognosis in Medical Care*. "She lived for nineteen remarkable years...I spent my boyhood always fearing that her lifelong chemotherapy would stop working, constantly wondering whether my mother would live or die, and both craving and detesting prognostic precision."

Sadly, Christakis' research has shown that his mother was an exception. In 2000, Christakis published a study in the *British Medical Journal* that followed 500 patients admitted to hospice programs in Chicago. He found that only 20 percent of the patients died approximately when their doctors had predicted. Unfortunately, most died *sooner*. "By and large, the physicians were overly optimistic," says Christakis.

In the world of hospice care, this finding is disturbing because it indicates that many patients aren't being referred early enough to take full advantage of services that might ease their final months. "That's what has frustrated hospices for decades," says Wayne McCormick, medical director of Providence Hospice of Seattle, explaining that hospice staff frequently don't get enough time with patients to do their best work.

Death With Dignity advocates, however, point to this finding to allay concerns that people might be killing themselves too soon based on an erroneous six-month prognosis. "Of course, there is the occasional person who outlives his or her prognosis," says Robb Miller, executive director of Compassion & Choices of Washington. Actually, 17 percent of patients did so in the Christakis study. This roughly coincides with data collected by the National Hospice and Palliative Care Organization, which in 2007 showed that 13 percent of hospice patients around the country outlived their six-month prognoses.

It's not that prognostication is completely lacking in a scientific basis. There is a reason that you can pick up a textbook and find a life expectancy associated with most medical conditions: Studies have followed *populations* of people with these conditions. It's a statistical average. To be precise, it's a median, explains Martins. "That means 50 percent will do worse and 50 percent will do better."

Doctors also shade their prognoses according to their own biases and desires. Christakis' study found that the longer a doctor knew a patient, the more likely their prognosis was inaccurate, suggesting that doctors who get attached to their patients are reluctant to talk of their imminent demise. What's more, Christakis says, doctors see death "as a mark of failure."

Oncologists in particular tend to adopt a cheerleading attitude "right up to the end," says Brian Wicks, an orthopedic surgeon and past president of the Washington State Medical Association. Rather than talk about death, he says, their attitude is "Hey, one more round of chemo!"

But it is also true that one more round of chemo, or new drugs like the one that helped Clayton, or sometimes even just leaving patients alone, can help them in ways that are impossible to predict. J. Randall Curtis, a pulmonary disease specialist and director of an end-of-life research program at Harborview Medical Center, recalls treating an older man with severe emphysema a couple of years ago. "I didn't think I could get him off life support," Curtis says. The man was on a ventilator. Every day Randall tested whether the patient could breathe on his own, and every day the patient failed the test. He had previously made it clear that he did not want to be kept alive by machines, according to Curtis, and so the doctor and the man's family made the wrenching decision to pull the plug.

But instead of dying as expected, the man slowly began to get better. Curtis doesn't know exactly why, but guesses that for that patient, "being off the ventilator was probably better than being on it. He was more comfortable, less stressed." Curtis says the man lived for at least a year afterwards.

Curtis also once kept a patient on life support against his better judgment because her family insisted. "I thought she would live days to weeks," he says of the woman, who was suffering from septic shock and multiple organ failure. Instead she improved enough to eventually leave the hospital and come back for a visit some six or eight months later.

"It was humbling," he says. "It was not amazing. That's the kind of thing in medicine that happens frequently."

Every morning when Heidi Mayer wakes up, at 5 a.m. as is her habit, she says "Howdy" to her husband Bud—very loudly. "If he says 'Howdy' back, I know he's OK," she explains.

Internet Black Widow Melissa Ann Shepard arrested in Halifax

Shepard, 80, charged with breaching her release conditions

By Cassie Williams, CBC News Posted: Apr 12, 2016 2:37 PM AT Last Updated: Apr 12, 2016 2:59 PM AT

Less than a month after she agreed to abide by certain rules following her release from prison, an 80-year-old woman dubbed the Internet Black Widow has been charged with breaching those conditions.

Melissa Ann Shepard is accused of accessing the internet at the Halifax Central Library on Spring Garden Road, in violation of conditions imposed by a Nova Scotia provincial court in March.

Police said that at 3:40 p.m. on Monday a community response officer saw her using the internet on a computer. The officer arrested her and took her to the police station.

There, officers say, they found she had with her "a device capable of accessing the internet," in violation of her court conditions.

She was charged with three counts of breaching a recognizance and released on conditions that she not visit any libraries in the Halifax Regional Municipality. She's due in court May 24.

High risk to re-offend

Shepard left prison last month after serving her full sentence for administering a noxious substance and failing to provide the necessaries of life to Fred Weeks, who was her newlywed husband. Weeks fell ill at a bed-and-breakfast in Cape Breton in September 2012, just a few days after marrying Shepard.

Halifax police allege she is a high risk to re-offend. Shepard has agreed to 22 temporary conditions but will fight longer term restrictions to her freedom in court this fall.

Her current conditions include not accessing the internet, abiding by a curfew, providing an up-to-date photo of herself to police and that she not possess any drugs for which she doesn't have a prescription.

She must also inform police of any romantic involvements so officers can tell prospective boyfriends of her criminal past.

Criminal past

Shepard has a long history with the law.

In 1991, she was convicted of manslaughter and served two years of a six-year prison term after killing her husband, Gordon Stewart, on a deserted road near Halifax. Stewart, from P.E.I., was heavily drugged when she ran over him twice with a car.

A-9

Shortly after she was released from prison, she travelled to Florida and met Robert Friedrich at a Christian retreat.

They married in Nova Scotia in 2000. A year later, Friedrich's family noticed his health was faltering. He had mysterious fainting spells and slurred speech and was in and out of hospitals.

Friedrich's family also alleged his money had started to disappear. Friedrich died in 2002 of cardiac arrest. No one was charged.

In 2005, Shepard was sentenced to five years in prison on a slew of charges stemming from a relationship she had with another Florida man she met online.

She pleaded guilty to seven charges, including three counts of grand theft from a person 65 years or older, two counts of forgery and two counts of using a forged document.

With files from Blair Rhodes

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The Washington Post

Morning Mix

This 80-year-old 'Black Widow,' who lured lonesome old men to horrible fates, is out of prison again

By Yanan Wang March 21, 2016

Like the men before him, Melissa Ann Shepard's last victim fell for her in more than one sense of the word.

When Fred Weeks met Shepard in 2012, they were both in their late 70s and living in the same retirement community in the picturesque Canadian coastal province of Nova Scotia. The start of their romance was simple, according to court documents cited by the BBC: Shepard knocked on Weeks's door and told him that she was lonely. She'd heard that he was lonely, too.

From there, the dalliance took on a familiar rhythm, one unbeknownst to the smitten Weeks at the time. After being wed in a civil union ceremony in his living room, the BBC reported, the couple embarked on their honeymoon across neighboring Newfoundland.

It was then that things started to go amiss for the man, who had lost his first, and longtime, wife just one year before. His mind became hazy while driving on the journey, unable to distinguish between gears and forgetting how to start the car. Soon, his condition worsened: He needed a wheelchair and couldn't put on his shoes.

Upon the newlyweds' return to Nova Scotia, they checked into a bed and breakfast, where Weeks told the owner of the establishment, Cheryl Chambers, that they were both ill and had been up "vomiting all night."

Chambers told the CBC investigative program "The Fifth Estate" that only one of them appeared to be sick.

ADVERTISING

"Mr. Weeks didn't look well at all. He looked a little green, very gaunt-looking," she recounted. "Mrs. Weeks, on the other hand, she was beautifully groomed, in a lovely red suit."

The next day, Weeks fell out of bed, hit the hardwood floor and had to be hospitalized. Doctors found him heavily drugged — the result, it was later found, of Shepard spiking his coffee with tranquilizers.

This act of "administering a noxious substance" (reduced from an earlier charge of attempted murder) landed her nearly three years in Canadian federal prison in 2013. It was just the latest in a long rap sheet of crimes as numerous as the last names she had accumulated over the years.

Now, the alarm is being sounded around Shepard once more. Last Friday, she completed her sentence for the offense against Weeks and was released from a federal women's prison in Nova Scotia.

Melissa "Millie" Ann was born a Russell, but made herself by turns a Shepard, a Stewart, a Friedrich and a Weeks. All but her first known husband, Russell Shepard (the two later divorced), would become victims of a methodical, practiced ruse.

All were elderly men who had recently lost their spouses. They sought companionship and found instead in the hazel-eyed Shepard someone who siphoned their savings, slipped drugs into their food and, in the case of one man, ran him over with a car and left him dead on a dirt road.

Of all Shepard's monikers, "Black Widow" is the one that has stuck over the decades in the news media. It befits someone who has been convicted of manslaughter, theft and forgery in connection with spontaneous marriages and subsequent illnesses and deaths.

(Romances aside, she also has 30 fraud convictions since 1977.)

Each time she struck, the headlines lamented her ever-growing web.

The Halifax Regional Police advised Friday, upon Shepard's release, that "a high risk offender is residing in our community." Authorities have ordered her not to use the Internet, to report any changes to her appearance and to abide by an

11 p.m. curfew. Any romantic relationships must also be reported to the police, so that prospective partners can be informed of her history.

These conditions offer little comfort to Alex Strategos, 84, whom Shepard dated in 2005.

"I don't think she should be released," Strategos told the BBC. "What she was, she still is — she's the Black Widow. Some guys better watch out, that's all I can say."

Strategos, a Florida man, learned this the hard way after meeting Shepard on an online dating site. "I was just lonely, and I figured this was a good chance for me to find somebody and get together, and start a perfect life," Strategos told the CBC.

But from the start, Strategos's relationship with her was far from idyllic. Shepard drove down from Canada in a white Cadillac to meet Strategos for their first date, and spent the night in his bed. While she slept, he awoke to go to the bathroom and felt dizzy, his vision blurred.

The nausea continued night after night, and Strategos started to regularly fall and pass out. He eventually surmised that she was spiking the ice cream that she fed to him every night. By the time Shepard was sentenced to five years in prison for stealing $20,000 from Strategos, his savings were depleted, but he was still alive. The same couldn't be said for Shepard's prior two male companions.

Before Strategos and Weeks, there was Robert Friedrich, a successful engineer whom Shepard met at church in 2001.

"The Holy Spirit told me that this man would be my next husband," Shepard explained to the CBC in 2005, in a rare interview from prison. Three days after meeting, the pair was engaged and soon embarked on a five-month honeymoon across North America, paid for by Friedrich's life savings of approximately $250,000.

Friedrich's deteriorating health during that period would be a harbinger of Shepard's later experiences with Strategos and Weeks: He started falling constantly and was often in the hospital.

After the honeymoon, Shepard left Friedrich's son Bob a menacing voice mail, the CBC reported, announcing that he and his two brothers were being taken out of Friedrich's will.

"I have something to share with you this morning," Shepard said to Bob, according to the CBC, which broadcast her voice mail on television. "Your father is going to change his will. ... You guys are getting nothing, a big fat zero. So try that on for size, and have a nice day."

No more than a year after Shepard was supposedly moved to make Friedrich her husband, he passed away, leaving her some $100,000. Shepard has never been charged for anything in connection with that marriage.

KTVZ.COM
CENTRAL OREGON'S NEWS LEADER

Sawyer Arraigned on State Fraud Charges

Judge Sets Plea Entry for Sept. 6

News sources
POSTED: 11:35 PM PDT September 7, 2011 UPDATED: 4:36 AM PDT July 14, 2011
BEND, Ore. -

Former Bend real estate broker Tami Sawyer was arraigned Thursday on state charges of criminal mistreatment and aggravated theft, four days after her arrest at Portland International Airport.

Sawyer was taken into custody by Port of Portland police after arriving on a flight back from Mexico, where she was allowed to go and check on rental property.

She appeared before Deschutes County Circuit Judge Wells Ashby, who continued her bond at $50,000 but set no travel restrictions, prosecutors said.

Ashby said she can travel outside of Oregon but has to sign and submit a waiver of extradition, should that be needed.

Sawyer faces charges of first-degree criminal mistreatment and aggravated theft., accused of selling Thomas Middleton's home and pocketing the proceeds.

The judge set her next court appearance for Sept. 6 at 8:30 a.m., when she is scheduled to enter a plea.

Sawyer and husband Kevin are scheduled for trial in December on federal fraud and money-laundering charges.

Former Bend real estate broker Tami Sawyer was arrested Sunday night at Portland International Airport on a Deschutes County warrant issued late last week after her indictment on felony charges of criminal mistreatment and aggravated theft.

Sawyer, 48, was booked into the Multnomah County Jail around 9 p.m. Sunday, about a half-hour after her arrest, reportedly having just flown back to Oregon after a judge agreed to let her go check on rental property that she and husband Kevin own in Cabo San Lucas, Mexico.

Deschutes County Circuit Judge Alta Brady signed an arrest warrant with $50,000 bail last Thursday, two days after she was indicted on a first-degree criminal mistreatment charge that alleges she took custody of Thomas Middleton, ? a dependent or elderly person,? for the purpose of fraud.

The first-degree aggravated theft charge alleges that in October 2008, Sawyer stole more than $50,000 from the Thomas Middleton Revocable Trust.

State and court documents show Middleton, who suffered from Lou Gehrig?s disease, moved into Sawyer?s home in July 2008, months after naming her trustee of his estate, The Bulletin reported Saturday. Middleton deeded his home to the trust and directed her to make it a rental until the real estate market improved.

Instead, Sawyer signed documents that month to list the property for sale, two days after Middleton died by physician-assisted suicide. The property sold in October of that year for more than $200,000, the documents show, and it was deposited into an account for one of Sawyer?s businesses, Starboard LLC, and $90,000 of that was transfered to two other Sawyer companies, Genesis Futures and Tami Sawyer PC.

Sawyer and her husband, a former Bend police captain, face trial scheduled for December in Eugene on federal charges of money laundering, wire fraud and conspiracy to commit wire fraud. They are accused of using investor money to pay for personal property, causing investors to lose $4.4 million.

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Sunday, July 10, 2016 | 10:49 pm

State dropping Tami Sawyer fraud case

DOJ says prosecution likely would not add time behind bars

Barney Lerten

POSTED: 10:59 AM PST December 24, 2013
UPDATED: 2:21 PM PDT October 30, 2013

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A A A

Lane County Jail

Tami and Kevin Sawyer were booked into the Lane County Jail in Eugene last spring after their federal sentencing on fraud charges

BEND, Ore. - With former Bend real estate broker Tami Sawyer already serving a nine-year federal prison term on fraud and money-laundering convictions, the Oregon Department of Justice said Wednesday it has moved to dismiss another fraud case against her.

MORE FROM KTVZ.COM

- Sawyers' tenants still will pay the couple in prison
- Sawyers go to prison; victims see justice - but money?
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- Sawyers Agree To $809,000 Lawsuit Settlement

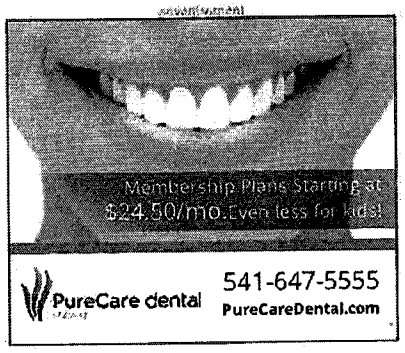
Sawyer and her husband, Kevin, a former Bend police captain, were sentenced last spring to years in prison – two for him – for fraud, money-laundering and other crimes. They also were ordered by the federal judge to pay nearly $6 million to their victims.

Another fraud case brought by the Oregon Department of Justice has been pending, involving Tami Sawyer's handling of the Thomas Middleton Trust. The state accused her of pocketing part of the proceeds when she sold Middleton's home in 2008, after his death, putting proceeds into her now-defunct firm, Starboard LLC, then transferring $90,000 to two of her other companies.

One of Middleton's sons, David Middleton of Redmond, expressed dismay at learning the state was dropping its case. But state Department of Justice spokesman Michael Kron told NewsChannel 21 they had to take a "hard look" at the costs vs. likely outcome of continuing to pursue a case that likely would not add to her time behind bars.

"We understand, of course, their preference would be to get the conviction," Kron said. "In taking a hard look at it, our sense of it was that there was no additional money to go after, and it's very unlikely we'd get additional jail time for Mrs. Sawyer, given the fact they (the Middleton heirs) were victims in both cases."

"It's unlikely the court would add jail time on top of the existing (federal) sentence, so they would be



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May 2009 Bar Bulletin

'Death with Dignity':

What Do We Advise Our Clients?

By Margaret Dore

A client wants to know about the new Death with Dignity Act, which legalizes physician-assisted suicide in Washington.[1] Do you take the politically correct path and agree that it's the best thing since sliced bread? Or do you do your job as a lawyer and tell him that the Act has problems and that he may want to take steps to protect himself?

Patient "Control" is an Illusion

The new act was passed by the voters as Initiative 1000 and has now been codified as Chapter 70.245 RCW.

During the election, proponents touted it as providing "choice" for end-of-life decisions. A glossy brochure declared, "Only the patient — and no one else — may administer the [lethal dose]."[2] The Act, however, does not say this — anywhere. The Act also contains coercive provisions. For example, it allows an heir who will benefit from the patient's death to help the patient sign up for the lethal dose.

How the Act Works

The Act requires an application process to obtain the lethal dose, which includes a written request form with two required witnesses.[3] The Act allows one of these witnesses to be the patient's heir.[4] The Act also allows someone else to talk for the patient during the lethal-dose request process, for example, the patient's heir.[5] This does not promote patient choice; it invites coercion.

Interested witness

By comparison, when a will is signed, having an heir as one of witnesses creates a presumption of undue influence. The probate statute provides that when one of the two required witnesses is a taker under the will, there is a

Originally published in the May 2009 issue of the King County Bar Association Bar Bulletin. Reprinted with permission of the King County Bar Association.

"We almost lost her because she was having too much fun, not from cancer," [her son chuckles].[11]

Conclusion

As lawyers, we often advise our clients of worst-case scenarios. This is our obligation regardless of whether it is politically correct to do so. The Death with Dignity Act is not necessarily about dignity or choice. It also can enable people to pressure others to an early death or even cause it. The Act also may encourage patients with years to live to give up hope. We should advise our clients accordingly.

Margaret Dore is a Seattle attorney admitted to practice in 1986. She is the immediate past chair of the Elder Law Committee of the ABA Family Law Section. She is a former chair of what is now the King County Bar Association Guardianship and Elder Law Section. For more information, visit her website at www.margaretdore.com.

1 The Act was passed by the voters in November as Initiative 1000 and has now been codified as RCW chapter 70.245.

2 I-1000 color pamphlet, "Paid for by Yes! on 1000."

3 RCW 70.245.030 and .220 state that one of two required witnesses to the lethal-dose request form cannot be the patient's heir or other person who will benefit from the patient's death; the other may be.

4 id.

5 RCW 70.245.010(3) allows someone else to talk for the patient during the lethal-dose request process; for example, there is no prohibition against this person being the patient's heir or other person who will benefit from the patient's death. The only requirement is that the person doing the talking be "familiar with the patient's manner of communicating."

6 RCW 11.88.160(2).

7 RCW 70.245.010(12).

8 People v. Stuart, 67 Cal. Rptr. 3rd 129, 143 (2007).

9 RCW 70.245.010(11) & (13).

10 Nina Shapiro, "Terminal Uncertainty," Washington's new "Death with Dignity" law allows doctors to help people commit suicide - once they've determined that the patient has only six months to live. But what if they're wrong? The Seattle Weekly, January 14, 2009. http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty.

11 id.

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rebuttable presumption that the taker/witness "procured the gift by duress, menace, fraud, or undue influence."[6]

Once the lethal dose is issued by the pharmacy, there is no oversight. The death is not required to be witnessed by disinterested persons. Indeed, no one is required to be present. The Act does not state that "only" the patient may administer the lethal dose; it provides that the patient "self-administer" the dose.

"Self-administer"

In an Orwellian twist, the term "self-administer" does not mean that administration will necessarily be by the patient. "Self-administer" is instead defined as the act of ingesting. The Act states, "'Self-administer' means a qualified patient's act of ingesting medication to end his or her life."[7]

In other words, someone else putting the lethal dose in the patient's mouth qualifies as "self-administration." Someone else putting the lethal dose in a feeding tube or IV nutrition bag also would qualify. "Self-administer" means that someone else can administer the lethal dose to the patient.

No witnesses at the death

If, for the purpose of argument, "self-administer" means that only the patient can administer the lethal dose himself, the patient still is vulnerable to the actions of other people, due to the lack of required witnesses at the death.

With no witnesses present, someone else can administer the lethal dose without the patient's consent. Indeed, someone could use an alternate method, such as suffocation. Even if the patient struggled, who would know? The lethal dose request would provide an alibi.

This situation is especially significant for patients with money. A California case states, "Financial reasons [are] an all too common motivation for killing someone."[8] Without disinterested witnesses, the patient's control over the "time, place and manner" of his death, is not guaranteed.

If one of your clients is considering a "Death with Dignity" decision, it is prudent to be sure that they are aware of the Act's gaps.

What to Tell Clients

1. Signing the form will lead to a loss of control

By signing the form, the client is taking an official position that if he dies suddenly, no questions should be asked. The client will be unprotected against others in the event he changes his mind after the lethal prescription is filled and decides that he wants to live. This would seem especially important for clients with money. There is, regardless, a loss of control.

2. Reality check

The Act applies to adults determined by an "attending physician" and a "consulting physician" to have a disease expected to produce death within six months.[9] But what if the doctors are wrong? This is the point of a recent article in The Seattle Weekly: Even patients with cancer can live years beyond expectations[10]. The article states:

> Since the day [the patient] was given two to four months to live, [she] has gone with her children on a series of vacations . . . .

ARIZONA CAPITOL TIMES
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OCTOBER 13, 2016
5:30 - 7:30 PM

Brewer signs bill targeting assisted suicide

By: The Associated Press April 30, 2014 , 5:32 pm

Rep. Justin Pierce, R-Mesa. (Cronkite News Service Photo by Laura Dickerson)

Gov. Jan Brewer has signed a bill that aims to make it easier to prosecute people who help someone commit suicide.

Republican Rep. Justin Pierce of Mesa says his bill will make it easier for attorneys to prosecute people for manslaughter for assisting in suicide by more clearly defining what it means to "assist."

House Bill 2565 defines assisting in suicide as providing the physical means used to commit suicide, such as a gun. The bill originally also defined assisted suicide as "offering" the means to commit suicide, but a Senate amendment omitted that word.

The proposal was prompted by a difficult prosecution stemming from a 2007 assisted suicide in Maricopa County.

Brewer signed the bill on Wednesday.

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La. assisted-suicide ban strengthened

The Associated Press

Published: Tuesday, April 24, 2012 at 8:37 a.m.

Last Modified: Tuesday, April 24, 2012 at 8:37 a.m.

BATON ROUGE -- The House unanimously backed a proposal Monday to strengthen Louisiana's ban on euthanasia and assisted suicide.

House Bill 1086 by Rep. Alan Seabaugh, R-Shreveport, would spell out that someone authorized to approve medical procedures for another person may not approve any procedure that would be considered assisted suicide. That prohibition also would be extended to include surgical or medical treatment for the developmentally disabled or nursing home residents who may be unable to make their own medical decisions.

Louisiana already has a prohibition in criminal law against euthanasia and assisted suicide. But Seabaugh said he wanted to make sure it was clear in the state's medical consent law.

Georgia General Assembly

2011-2012 Regular Session - HB 1114
Homicide; offering to assist in commission of suicide; repeal certain provisions

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First Reader Summary

A BILL to be entitled an Act to amend Article 1 of Chapter 5 of Title 16 of the O.C.G.A., relating to homicide, so as to repeal certain provisions regarding offering to assist in the commission of a suicide; to prohibit assisted suicide; to provide for definitions; to provide for criminal penalties; to provide for certain exceptions; to provide for certain reporting requirements with respect to being convicted of assisting in a suicide; to amend Title 51 of the O.C.G.A., relating to torts, so as to provide for civil liability for wrongful death caused by assisted suicide; to provide for definitions; to provide an effective date; to repeal conflicting laws; and for other purposes.

Status History

May/01/2012 - Effective Date
May/01/2012 - Act 639
May/01/2012 - House Date Signed by Governor
Apr/10/2012 - House Sent to Governor
Mar/29/2012 - Senate Agreed House Amend or Sub
Mar/29/2012 - House Agreed Senate Amend or Sub As Amended
Mar/27/2012 - Senate Passed/Adopted By Substitute
Mar/27/2012 - Senate Third Read
Mar/22/2012 - Senate Read Second Time
Mar/22/2012 - Senate Committee Favorably Reported By Substitute
Mar/07/2012 - Senate Read and Referred
Mar/07/2012 - House Immediately Transmitted to Senate
Mar/07/2012 - House Passed/Adopted By Substitute
Mar/07/2012 - House Third Readers
Feb/28/2012 - House Committee Favorably Reported By Substitute
Feb/23/2012 - House Second Readers
Feb/22/2012 - House First Readers
Feb/21/2012 - House Hopper

Footnotes

3/7/2012 Modified Structured Rule; 3/7/2012 Immediately transmitted to Senate; 3/29/2012 House agrees to the Senate Substitute as House amended; 3/29/2012 Senate agreed to House amendment to Senate substitute

Votes

Mar/29/2012 - Senate Vote #888	Yea(38)	Nay(11)	NV(7)	Exc(0)

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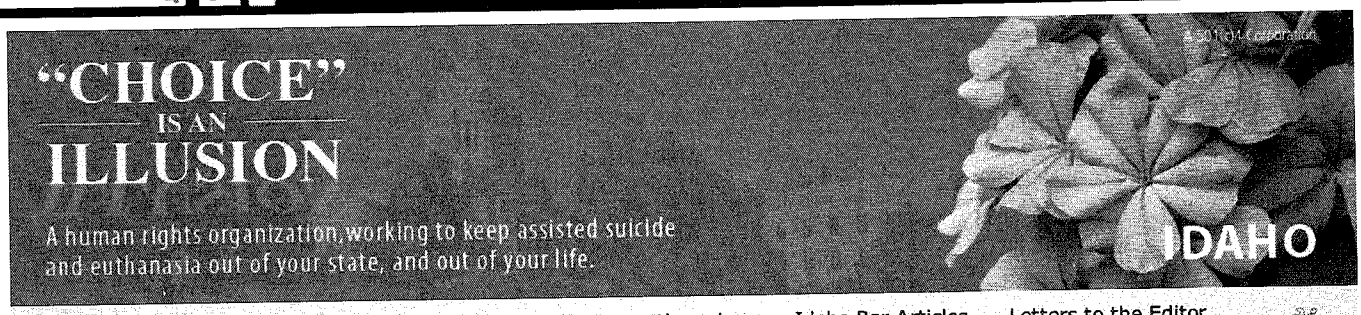

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VOICES AGAINST ASSISTED SUICIDE AND EUTHANASIA

- "I was afraid to leave my husband alone"
- "In Oregon, the only help my patient received was a lethal prescription, intended to kill him."
- "It wasn't the father saying that he wanted to die"
- "He made the mistake of asking for information about assisted suicide"
- "If Dr. Stevens had believed in assisted suicide, I would be dead"
- "Mild stroke led to mother's forced starvation"

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MONDAY, JULY 4, 2011

Idaho Strengthens Law Against Assisted-Suicide

By Margaret Dore

On April 5, 2011, Idaho Governor Butch Otto signed Senate Bill 1070 into law.[1] The bill explicitly provides that causing or aiding a suicide is a felony.[2]

Senate bill 1070 supplements existing Idaho law, which already imposed civil and criminal liability on doctors and others who cause or aid a suicide.[3] The bill's "Statement of Purpose" says: "This legislation will supplement existing common law and statutory law by confirming that it is illegal to cause or assist in the suicide of another."[4]

The bill was introduced in response to efforts by Compassion & Choices to legalize physician-assisted suicide in Idaho. The issue came to a head after that organization's legal director wrote articles claiming that the practice, which she called "aid in dying, was already legal in Idaho. Compassion & Choices was formerly known as the Hemlock Society.[5]

The legal director's articles included "Aid in Dying: Law, Geography and Standard of Care in Idaho," published in *The Advocate*, the official publication of the Idaho State Bar.[6] Responding letters to the editor stated that the article was "a gross misunderstanding of Idaho law" and that "[f]alse claims about what the law of Idaho actually is, published in *The Advocate*, cannot possibly benefit public debate on this issue."

These letters and other letters can be viewed here, here and here. A direct rebuttal to the article can be viewed here.

The vote to pass the new bill was overwhelming: the Senate vote was 31 to 2; the house vote was 61 to 8.[7] The new law will be codified as Idaho Code Ann. Section 18-4017 and go into effect on July 1, 2011.[8]

* * *

[1] Bill Status S1070, entry for April 5, 2011.
[2] *See* here for bill text.
[3] Then existing civil law included *Cramer v. Slater*, 146 Idaho 868, 878, 204 P.3d 508 (2009), which states that doctors "can be held liable for [a] patient's suicide." Existing law also included a common law crime in which an "aider and abettor" of suicide is guilty of murder. Assisted suicide can also be statutorily charged as murder. *See* Margaret K. Dore, "Aid in Dying: Not Legal in Idaho; Not About Choice," *The Advocate*, official publication of the Idaho State Bar, Vol. 52, No. 9, pages 18-20, September 2010 (describing existing law prior to the new bill's enactment); and The Hon. Robert E. Bakes, Retired Chief Justice of the Idaho Supreme Court, Letter to the Editor, "Legislature rejected euthanasia," *The Advocate*, September 2010 ("in both the Idaho criminal statutes as well as I.C.6-1012, the Idaho legislature has rejected physician-assisted suicide"). Entire issue, available here:
http://www.isb.idaho.gov/pdf/advocate/issues/adv10sep.pdf
[4] Revised Statement of Purpose, RS20288.
[5] Ian Dowbiggin, A CONCISE HISTORY OF EUTHANASIA: LIFE, DEATH, GOD AND MEDICINE, Rowman & Littlefield Publishers,

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- Montana's Campaign Against Assisted Suicide (Following Idaho's Lead!)

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- assisted suicide (1)
- common law (1)
- Compassion and Choices (1)
- Hemlock Society (1)
- Kathryn Tucker (1)
- Margaret Dore (1)
- Robert E. Bakes (1)
- S1070 (1)

IDAHO ARCHIVE

▼ 2011 (1)
▼ July (1)
Idaho Strengthens Law Against Assisted-Suicide

by the protections outlined in the UHCDA and the Pain Relief Act, and therefore the government interests we have identified, similar to those in *Glucksberg*, are supported by a firm legal rationale. Applying this to Petitioners' challenge, we conclude that there is a firm legal rationale behind (1) the interest in protecting the integrity and ethics of the medical profession; (2) the interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes due to the real risk of subtle coercion and undue influence in end-of-life situations or the desire of some to resort to physician aid in dying to spare their families the substantial financial burden of end-of-life health care costs; and (3) the legitimate concern that recognizing a right to physician aid in dying will lead to voluntary or involuntary euthanasia because if it is a right, it must be made available to everyone, even when a duly appointed surrogate makes the decision, and even when the patient is unable to self-administer the life-ending medication. *See* 521 U.S. at 731–33, 117 S.Ct. 2258; Part III, ¶ 27, *supra*. Petitioners nonetheless maintain that the *Glucksberg* Court either did not have the same evidence before it that we do today, including data from several states and established practices in those states, and therefore concerns addressed in *Glucksberg* are no longer valid, or never came to fruition. However, in New Mexico these very concerns are addressed in the UHCDA, which was most recently amended in 2015, indicating not only the desirability of legislation in areas such as aid in dying, but also reflecting legitimate and ongoing legal rationales that *Glucksberg* raised nearly twenty years ago which endure today. Although it is unlawful in New Mexico to assist someone in committing suicide, the exceptions contained within the UHCDA and the Pain Relief Act narrow the statute's application, provided that physicians comply with the rigorous requirements of each act. Therefore, when the relevant legislation is read as a whole, Section 30–2–4 is rationally related to the aforementioned legitimate government interests. If we were to recognize an absolute, fundamental right to physician aid in dying, constitutional questions would abound regarding legislation that defined terminal illness or provided for protective procedures to assure that a patient was making an informed and independent decision. Regulation in this area is essential, given that if a patient carries out his or her end-of-life decision it cannot be reversed, even if it turns out that the patient did not make the decision of his or her own free will.

VIII. CONCLUSION

{58} Pursuant to New Mexico's heightened rational basis analysis, and based on the record before us and the arguments of the parties, we conclude that although physician aid in dying falls within the proscription of Section 30–2–4, this statute is neither unconstitutional on its face nor as it is applied to Petitioners. For the foregoing reasons, we reverse the district court's contrary conclusion and remand to the district court for proceedings consistent with this opinion.

{59} **IT IS SO ORDERED.**

WE CONCUR:

CHARLES W. DANIELS, Chief Justice

PETRA JIMENEZ MAES, Justice

BARBARA J. VIGIL, Justice

JAMES M. HUDSON, District Judge, Sitting by designation

All Citations

376 P.3d 836, 2016 -NMSC- 027

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Morris v. Brandenburg
376 P.3d 836

RCW 11.12.160

Interested witness—Effect on will.

(1) An interested witness to a will is one who would receive a gift under the will.

(2) A will or any of its provisions is not invalid because it is signed by an interested witness. Unless there are at least two other subscribing witnesses to the will who are not interested witnesses, the fact that the will makes a gift to a subscribing witness creates a rebuttable presumption that the witness procured the gift by duress, menace, fraud, or undue influence.

(3) If the presumption established under subsection (2) of this section applies and the interested witness fails to rebut it, the interested witness shall take so much of the gift as does not exceed the share of the estate that would be distributed to the witness if the will were not established.

(4) The presumption established under subsection (2) of this section has no effect other than that stated in subsection (3) of this section.

[**1994 c 221 § 16; 1965 c 145 § 11.12.160.** Prior: **1917 c 156 § 38;** RRS § 1408; prior: Code 1881 § 1331; **1863 p 209 § 67; 1860 p 171 § 34.**]

NOTES:

Effective dates—1994 c 221: See note following RCW **11.94.070.**

In Washington State, having 1 of 2 witnesses an a will be an heir creates a presumption of duress, menace, fraud, or undue influence.

Oregon Revised Statute

Chapter 127

Contact Us
dwda.info@state.or.us

Note: The division headings, subdivision headings and leadlines for 127.800 to 127.890, 127.895 and 127.897 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

Please browse this page or download the statute for printing - (*or read the statute at* https://www.oregonlegislature.gov)

127.800 s.1.01. Definitions.

The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

(1) "Adult" means an individual who is 18 years of age or older.

(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

(4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

(c) The potential risks associated with taking the medication to be prescribed;

(d) The probable result of taking the medication to be prescribed; and

(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 s.1.01; 1999 c.423 s.1]

(Written Request for Medication to End One's Life in a Humane and Dignified Manner)

(Section 2)

127.805 s.2.01. Who may initiate a written request for medication.

(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and

IN THE STATE OF COLORADO

IN RE PROPOSED INITIATIVE #124	**DECLARATION OF WILLIAM TOFFLER, MD**

I, WILLIAM TOFFLER, declare the following under penalty of perjury.

1. I am a professor of Family Medicine and a practicing physician in Oregon for over 30 years. I write to provide some insight on the issue of physician-assisted suicide, which is legal in Oregon, and which I understand has been proposed for legalization in Colorado.

2. Oregon's law applies to "terminal" patients who are predicted to have less than six months to live. Our law defines terminal as follow:

> "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

Exhibit A, attached hereto.

3. In practice, this definition is interpreted to include people with chronic conditions such as "chronic lower respiratory disease" and "diabetes mellitus," better known as "diabetes."

4. In Oregon, people with chronic conditions are "terminal," if

without their medications, they have less than six months of live. This is significant when you consider that a typical insulin-dependent 20 year-old-year *will live less than a month without insulin*. Such persons, with insulin, are likely to have decades to live; in fact, most diabetics have a normal life span given appropriate control of their blood sugar.

5. I am concerned that by labelling people with chronic conditions "terminal," there will be an excuse to deny such persons medical treatment so that they can continue to live healthy and productive lives. Oregon's Medicaid program is already denying treatment to some patients based on a statistical prognosis.

6. To read the most recent Oregon government report on our law, listing chronic conditions as an "underlying illness" to justify assisted-suicide, please see Exhibit B attached hereto.

Signed under penalty of perjury, this 11th day of April 2016

William L. Toffler MD

William L. Toffler MD
Professor of Family Medicine
3181 SW Sam Jackson Park Road
Portland, OR 97239

Oregon Revised Statute

Chapter 127

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Note: The division headings, subdivision headings and leadlines for 127.800 to 127.890, 127.895 and 127.897 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

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(5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

(c) The potential risks associated with taking the medication to be prescribed;

(d) The probable result of taking the medication to be prescribed; and

(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

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(Written Request for Medication to End One's Life in a Humane and Dignified Manner)

(Section 2)

127.805 s.2.01. Who may initiate a written request for medication.

TOFFLER EXHIBIT A
A-28

OREGON DEATH WITH DIGNITY ACT: 2015 DATA SUMMARY

Oregon Public Health Division
February 4, 2016

For more information:
http://www.healthoregon.org/dwd
Contact: DWDA.info@state.or.us

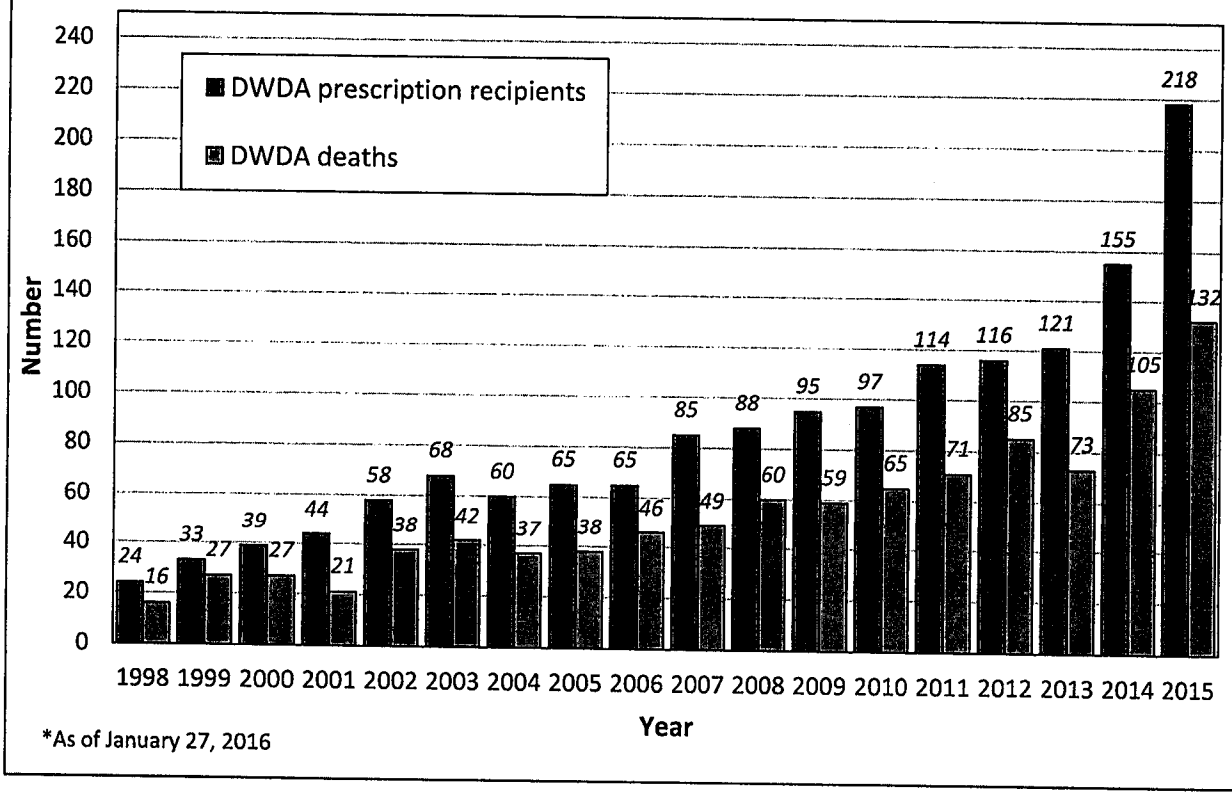
Oregon Health Authority

TOFFLER EXHIBIT B

Introduction

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. Data presented in this summary, including the number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of the medications (DWDA deaths), are based on required reporting forms and death certificates received by the Oregon Public Health Division as of January 27, 2016. More information on the reporting process, required forms, and annual reports is available at: http://www.healthoregon.org/dwd.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2015



*As of January 27, 2016

Participation Summary and Trends

During 2015, 218 people received prescriptions for lethal medications under the provisions of the Oregon DWDA, compared to 155 during 2014 (Figure 1, above). As of January 27, 2016, the Oregon Public Health Division had received reports of 132 people who had died during 2015 from ingesting the medications prescribed under DWDA.

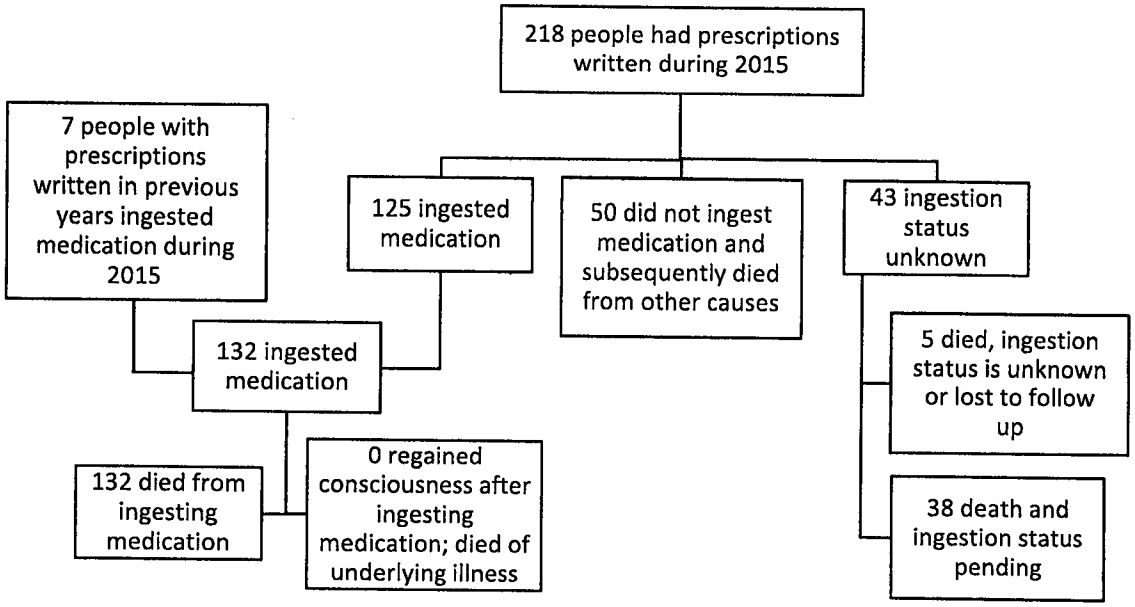
Since the law was passed in 1997, a total of 1,545 people have had prescriptions written under the DWDA, and 991 patients have died from ingesting the medications. From 1998 through 2013, the number of prescriptions written annually increased at an average of 12.1%; however, during 2014 and

2015, the number of prescriptions written increased by an average of 24.4%. During 2015, the rate of DWDA deaths was 38.6 per 10,000 total deaths.[1]

A summary of DWDA prescriptions written and medications ingested are shown in Figure 2. Of the 218 patients for whom prescriptions were written during 2015, 125 (57.3%) ingested the medication; all 125 patients died from ingesting the medication without regaining consciousness. Fifty of the 218 patients who received DWDA prescriptions during 2015 did not take the medications and subsequently died of other causes.

Ingestion status is unknown for 43 patients prescribed DWDA medications in 2015. Five of these patients died, but they were lost to follow-up or the follow-up questionnaires have not yet been received. For the remaining 38 patients, both death and ingestion status are pending (Figure 2).

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2015, as of January 27, 2016



[1] Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2014 (34,160), the most recent year for which final death data are available.

TOFFLER EXHIBIT B

Patient Characteristics

Of the 132 DWDA deaths during 2015, most patients (78.0%) were aged 65 years or older. The median age at death was 73 years. As in previous years, decedents were commonly white (93.1%) and well-educated (43.1% had a least a baccalaureate degree).

While most patients had cancer, the percent of patients with cancer in 2015 was slightly lower than in previous years (72.0% and 77.9%, respectively). The percent of patients with amyotrophic lateral sclerosis (ALS) was also lower (6.1% in 2015, compared to 8.3% in previous years). Heart disease increased from 2.0% in prior years to 6.8% in 2015.

Most (90.1%) patients died at home, and most (92.2%) were enrolled in hospice care. Excluding unknown cases, most (99.2%) had some form of health care insurance, although the percent of patients who had private insurance (36.7%) was lower in 2015 than in previous years (60.2%). The number of patients who had only Medicare or Medicaid insurance was higher than in previous years (62.5% compared to 38.3%).

Similar to previous years, the three most frequently mentioned end-of-life concerns were: decreasing ability to participate in activities that made life enjoyable (96.2%), loss of autonomy (92.4%), and loss of dignity (75.4%).

DWDA Process

A total of 106 physicians wrote 218 prescriptions during 2015 (1-27 prescriptions per physician). During 2015, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements. During 2015, five patients were referred for psychological/ psychiatric evaluation.

A procedure revision was made in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. For 27 patients, either the prescribing physician or another healthcare provider was present at the time of death. Prescribing physicians were present at time of death for 14 patients (10.8%) during 2015 compared to 15.7% in previous years; 13 additional cases had other health care providers present (e.g. hospice nurse). Data on time from ingestion to death is available for only 25 DWDA deaths during 2015. Among those 25 patients, time from ingestion until death ranged from five minutes to 34 hours. For the remaining two patients, the length of time between ingestion and death was unknown.

Table 1. Characteristics and end-of-life care of 991 DWDA patients who have died from ingesting DWDA medications, by year, Oregon, 1998-2015

Characteristics	2015 (N=132)	1998-2014 (N=859)	Total (N=991)
Sex	N (%)	N (%)	N (%)
Male (%)	56 (42.4)	453 (52.7)	509 (51.4)
Female (%)	76 (57.6)	406 (47.3)	482 (48.6)
Age at death (years)			
18-34 (%)	1 (0.8)	7 (0.8)	8 (0.8)
35-44 (%)	5 (3.8)	18 (2.1)	23 (2.3)
45-54 (%)	2 (1.5)	61 (7.1)	63 (6.4)
55-64 (%)	21 (15.9)	184 (21.4)	205 (20.7)
65-74 (%)	41 (31.1)	247 (28.8)	288 (29.1)
75-84 (%)	30 (22.7)	229 (26.7)	259 (26.1)
85+ (%)	32 (24.2)	113 (13.2)	145 (14.6)
Median years (range)	73 (30-102)	71 (25-96)	71 (25-102)
Race			
White (%)	122 (93.1)	831 (97.1)	953 (96.6)
African American (%)	0 (0.0)	1 (0.1)	1 (0.1)
American Indian (%)	0 (0.0)	2 (0.2)	2 (0.2)
Asian (%)	4 (3.1)	9 (1.1)	13 (1.3)
Pacific Islander (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	0 (0.0)	3 (0.4)	3 (0.3)
Two or more races (%)	1 (0.8)	3 (0.4)	4 (0.4)
Hispanic (%)	4 (3.1)	6 (0.7)	10 (1.0)
Unknown	*1*	*3*	*4*
Marital status			
Married (including Registered Domestic Partner) (%)	52 (39.7)	395 (46.1)	447 (45.3)
Widowed (%)	34 (26.0)	198 (23.1)	232 (23.5)
Never married (%)	9 (6.9)	69 (8.1)	78 (7.9)
Divorced (%)	36 (27.5)	194 (22.7)	230 (23.3)
Unknown	*1*	*3*	*4*
Education			
Less than high school (%)	7 (5.4)	51 (6.0)	58 (5.9)
High school graduate (%)	31 (23.8)	187 (21.9)	218 (22.2)
Some college (%)	36 (27.7)	224 (26.2)	260 (26.4)
Baccalaureate or higher (%)	56 (43.1)	392 (45.9)	448 (45.5)
Unknown	*2*	*5*	*7*
Residence			
Metro counties (Clackamas, Multnomah, Washington) (%)	64 (49.2)	361 (42.3)	425 (43.2)
Coastal counties (%)	7 (5.4)	63 (7.4)	70 (7.1)
Other western counties (%)	48 (36.9)	365 (42.7)	413 (42.0)
East of the Cascades (%)	11 (8.5)	65 (7.6)	76 (7.7)
Unknown	*2*	*5*	*7*
End of life care			
Hospice			
Enrolled (%)	118 (92.2)	747 (90.2)	865 (90.5)
Not enrolled (%)	10 (7.8)	81 (9.8)	91 (9.5)
Unknown	*4*	*31*	*35*
Insurance			
Private (alone or in combination) (%)	44 (36.7)	489 (60.2)	533 (57.2)
Medicare, Medicaid or other governmental (%)	75 (62.5)	311 (38.3)	386 (41.4)
None (%)	1 (0.8)	12 (1.5)	13 (1.4)
Unknown	*12*	*47*	*59*

TOFFLER EXHIBIT B

Characteristics	2015 (N=132)	1998-2014 (N=859)	Total (N=991)
Underlying illness			
Malignant neoplasms (%)	**95 (72.0)**	**667 (77.9)**	**762 (77.1)**
Lung and bronchus (%)	23 (17.4)	154 (18.0)	177 (17.9)
Breast (%)	9 (6.8)	64 (7.5)	73 (7.4)
Colon (%)	7 (5.3)	54 (6.3)	61 (6.2)
Pancreas (%)	7 (5.3)	56 (6.5)	63 (6.4)
Prostate (%)	5 (3.8)	35 (4.1)	40 (4.0)
Ovary (%)	3 (2.3)	33 (3.9)	36 (3.6)
Other (%)	41 (31.1)	271 (31.7)	312 (31.6)
Amyotrophic lateral sclerosis (%)	**8 (6.1)**	**71 (8.3)**	**79 (8.0)**
Chronic lower respiratory disease (%)	**6 (4.5)**	**38 (4.4)**	**44 (4.5)**
Heart disease (%)	**9 (6.8)**	**17 (2.0)**	**26 (2.6)**
HIV/AIDS (%)	**0 (0.0)**	**9 (1.1)**	**9 (0.9)**
Other illnesses (%)[2]	**14 (10.6)**	**54 (6.3)**	**68 (6.9)**
Unknown	***0***	***3***	***3***
DWDA process			
Referred for psychiatric evaluation (%)	5 (3.8)	47 (5.5)	52 (5.3)
Patient informed family of decision (%)[3]	126 (95.5)	729 (93.2)	855 (93.5)
Patient died at			
Home (patient, family or friend) (%)	118 (90.1)	810 (94.6)	928 (94.0)
Long term care, assisted living or foster care facility (%)	9 (6.9)	37 (4.3)	46 (4.7)
Hospital (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	4 (3.1)	8 (0.9)	12 (1.2)
Unknown	*1*	*3*	*4*
Lethal medication			
Secobarbital (%)	114 (86.4)	466 (54.2)	580 (58.5)
Pentobarbital (%)	1 (0.8)	385 (44.8)	386 (39.0)
Phenobarbital/chloral hydrate/morphine sulfate mix (%)	16 (12.1)	0 (0.0)	16 (1.6)
Other (combination of above and/or morphine) (%)	1 (0.8)	8 (0.9)	9 (0.9)
End of life concerns	**(N=132)**	**(N=859)**	**(N=991)**
Less able to engage in activities making life enjoyable (%)	127 (96.2)	758 (88.7)	885 (89.7)
Losing autonomy (%)	121 (92.4)	782 (91.5)	903 (91.6)
Loss of dignity (%)[5]	98 (75.4)	579 (79.3)	677 (78.7)
Losing control of bodily functions (%)	46 (35.7)	428 (50.1)	474 (48.2)
Burden on family, friends/caregivers (%)	63 (48.1)	342 (40.0)	405 (41.1)
Inadequate pain control or concern about it (%)	37 (28.7)	211 (24.7)	248 (25.2)
Financial implications of treatment (%)	3 (2.3)	27 (3.2)	30 (3.1)
Healthcare provider present (collected 2001-present)	**(N=132)**	**(N=789)**	**(N=921)**
When medication was ingested[6]			
Prescribing physician	15	133	148
Other provider, prescribing physician not present	13	243	256
No provider	6	81	87
Unknown	*98*	*332*	*430*
At time of death			
Prescribing physician (%)	14 (10.8)	121 (15.7)	135 (15.0)
Other provider, prescribing physician not present (%)	13 (10.0)	268 (34.7)	281 (31.2)
No provider (%)	103 (79.2)	383 (49.6)	486 (53.9)
Unknown	*2*	*17*	*19*

TOFFLER EXHIBIT B

Characteristics	2015 (N=132)	1998-2014 (N=859)	Total (N=991)
Complications[1]	(N=132)	(N=859)	(N=991)
Regurgitated	2	22	24
Other	2	1	3
None	23	506	529
Unknown	*105*	*330*	*435*
Other outcomes			
Regained consciousness after ingesting DWDA medications[7]	0	6	6
Timing of DWDA event			
Duration (weeks) of patient-physician relationship			
Median	9	13	12
Range	1-1004	0-1905	0-1905
Number of patients with information available	*132*	*857*	*989*
Number of patients with information unknown	*0*	*2*	*2*
Duration (days) between 1st request and death			
Median	45	47	46
Range	15-517	15-1009	15-1009
Number of patients with information available	*131*	*859*	*990*
Number of patients with information unknown	*1*	*0*	*1*
Minutes between ingestion and unconsciousness[6]			
Median	5	5	5
Range	2-15	1-38	1-38
Number of patients with information available	*25*	*506*	*531*
Number of patients with information unknown	*107*	*353*	*460*
Minutes between ingestion and death[6]			
Median	25	25	25
Range (minutes - hours)	5mins-34hrs	1min-104hrs	1min-104hrs
Number of patients with information available	*25*	*511*	*536*
Number of patients with information unknown	*107*	*348*	*455*

1 Unknowns are excluded when calculating percentages.

2 Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease.

3 First recorded beginning in 2001. Since then, 40 patients (4.4%) have chosen not to inform their families, and 19 patients (2.1%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and 3 in 2013.

4 Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

5 First asked in 2003. Data available for 130 patients in 2015, 730 patients between 1998-2014, and 860 patients for all years.

6 A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.

7 Six patients have regained consciousness after ingesting prescribed medications, and are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (http://www.healthoregon.org/dwd) for more detail on these deaths.

diazepam

TOFFLER EXHIBIT B

A-35

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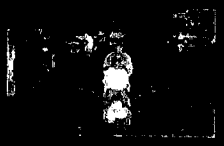
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By JESSICA FIRGER CBS NEWS *April 17, 2014, 5:00 AM*

12 million Americans misdiagnosed each year

17 Comments Share Tweet Stumble Email

Each year in the U.S., approximately 12 million adults who seek outpatient medical care are misdiagnosed, according to a new study published in the journal BMJ Quality & Safety. This figure amounts to 1 out of 20 adult patients, and researchers say in half of those cases, the misdiagnosis has the potential to result in severe harm.

Previous studies examining the rates of medical misdiagnosis have focused primarily on patients in hospital settings. But this paper suggests a vast number of patients are being misdiagnosed in outpatient clinics and doctors' offices.

"It's very serious," says CBS News chief medical correspondent Dr. Jon LaPook. "When you have numbers like 12 million Americans, it sounds like a lot -- and it is a lot. It represents about 5 percent of the outpatient encounters."

Getting 95 percent right be good on a school history test, he notes, "but it's not good enough for medicine, especially when lives are at stake."

→ More from Morning Rounds with Dr. LaPook

For the paper, the researchers analyzed data from three prior studies related to diagnosis and follow-up visits. One of the studies examined the rates of misdiagnosis in primary care settings, while two of the studies looked at the rates of colorectal and lung cancer screenings and subsequent diagnoses.

To estimate the annual frequency of misdiagnosis, the authors used a mathematical formula and applied the proportion of diagnostic errors detected in the data to the number of all outpatients in the U.S. adult population. They calculated the overall annual rate of misdiagnoses to be 5.08 percent.

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CANADA **C O U R S U P É R I E U R E**

PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

c.

PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF JOHN NORTON IN OPPOSITION TO ASSISTED SUICIDE AND EUTHANASIA

THE UNDERSIGNED, being first duly sworn on oath, STATES:

1. I live in Florence Massachusetts USA. When I was eighteen years old and in my first year of college, I was diagnosed with Amyotrophic Lateral Sclerosis (ALS) by the University of Iowa Medical School. ALS is commonly referred to as Lou Gehrig's disease. I was told that I would get progressively worse (be paralyzed) and die in three to five years.

2. I was a very physical person. The diagnosis was devastating to me. I had played football in high school and was extremely active riding bicycles. I also performed heavy labor including road construction and farm work. I prided myself for my physical strength, especially in my hands.

3. The ALS diagnosis was confirmed by the Mayo Clinic in Rochester Minnesota. I was eighteen or nineteen years old at the

time. By then, I had twitching in both hands, which were also getting weaker. At some point, I lost the ability to grip in my hands. I became depressed and was treated for my depression. If instead, I had been told that my depression was rational and that I should take an easy way out with a doctor's prescription and support, I would have taken that opportunity.

4. Six years after my initial diagnosis, the disease progression stopped. Today, my condition is about the same. I still can't grip with my hands. Sometimes I need special help. But, I have a wonderful life. I am married to Susan. We have three children and one grandchild. I have a degree in Psychology and one year of graduate school. I am a retired bus driver (no gripping required). Prior to driving bus, I worked as a parole and probation officer. When I was much younger, I drove a school bus. We have wonderful friends. I enjoy singing tenor in amateur choruses. I help other people by working as a volunteer driver.

5. I will be 75 years old this coming September. If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come. I hope that Canada does not legalize these practices.

SWORN BEFORE ME at
MASSACHUSETTS, USA
on, August 1st, 2012

NAME: Heidi Pruzynski

A notary in and for the
State of ~~Washington~~ Massachusetts

ADDRESS: 85 Main St
Florence MA 01062

EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:

HEIDI PRUZYNSKI
MY COMMISSION EXPIRES
JUNE 22, 2018
COMMONWEALTH OF MASSACHUSETTS
NOTARY PUBLIC

JOHN NORTON

CANADA

C O U R S U P É R I E U R E

PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse
c.
PROCUREUR GÉNÉRAL DU CANADA,
défendeur
et
PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF KENNETH R. STEVENS, JR., MD

THE UNDERSIGNED, being duly sworn under oath, states:

1. I am a doctor in Oregon USA where physician-assisted suicide is legal. I am also a Professor Emeritus and a former Chair of the Department of Radiation Oncology, Oregon Health & Science University, Portland, Oregon. I have treated thousands of patients with cancer.

2. In Oregon, our assisted suicide law applies to patients predicted to have less than six months to live. I write to clarify for the court that this does not necessarily mean that patients are dying.

3. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live, which was based on her not being treated for cancer. I understand that he had referred her to me.

4. At our first meeting, Jeanette told me plainly that she did not want to be treated and that was going to "do" our law, *i.e.*, kill herself with a lethal dose of barbiturates. It was very much a settled decision.

5. I, personally, did not and do not believe in assisted suicide. I also believed that her cancer was treatable and that her prospects were good. She was not, however, interested in treatment. She had made up her mind, but she continued to see me.

6. On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated and she is still alive today. Indeed, she is thrilled to be alive. It's been twelve years.

7. For Jeanette, the mere presence of legal assisted suicide had steered her to suicide.

8. Today, for patients under the Oregon Health Plan (Medicaid), there is also a financial incentive to commit suicide: The Plan covers the cost. The Plan's "Statements of Intent for the April 1, 2012 Prioritized List of Health Services," states:

> It is the intent of the [Oregon Health Services] Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services.

Attached hereto at page SI-1.

9. Under the Oregon Health Plan, there is also a financial incentive towards suicide because the Plan will not necessarily pay for a patient's treatment. For example, patients with cancer are denied treatment if they have a "less than 24 months median survival with treatment" and fit other criteria. This is the Plan's "Guideline Note 12." (Attached hereto at page GN-4).

10. The term, "less than 24 months median survival with treatment," means that statistically half the patients receiving treatment will live less than 24 months (two years) and the other half will live longer than two years.

11. Some of the patients living longer than two years will likely live far longer than two years, as much as five, ten or twenty years depending on the type of cancer. This is because there are always some people who beat the odds.

12. All such persons who fit within "Guideline Note 12" will nonetheless be denied treatment. Their suicides under Oregon's assisted suicide act will be covered.

13. I also write to clarify a difference between physician-assisted suicide and end-of-life palliative care in which dying patients receive medication for the intended purpose of relieving pain, which may incidentally hasten death. This is the principle of double effect. This is not physician-assisted suicide in which death is intended for patients who may or may not be dying anytime soon.

14. The Oregon Health Plan is a government health plan administered by the State of Oregon. If assisted suicide is legalized in Canada, your government health plan could follow a similar pattern. If so, the plan will pay for a patient to die, but not to live.

SWORN BEFORE ME at Sherwood
Oregon, USA
on September 18, 2012

NAME: Jessica Borgo

A notary in and for the
State of Oregon

ADDRESS: 16100 SW Tualatin-Sherwood Rd

EXPIRY OF COMMISSION: Aug, 30, 2015

PLACE SEAL HERE: Jessica Borgo

Ken Stevens MD
Ken Stevens, MD

OFFICIAL SEAL
JESSICA R BORGO
NOTARY PUBLIC - OREGON
COMMISSION NO. 461438
MY COMMISSION EXPIRES AUGUST 30, 2015

STATEMENT OF INTENT 1: PALLIATIVE CARE

It is the intent of the Commission that palliative care services be covered for patients with a life-threatening illness or severe advanced illness expected to progress toward dying, regardless of the goals for medical treatment and with services available according to the patient's expected length of life (see examples below).

Palliative care is comprehensive, specialized care ideally provided by an interdisciplinary team (which may include but is not limited to physicians, nurses, social workers, etc.) where care is particularly focused on alleviating suffering and promoting quality of life. Such interdisciplinary care should include assessment, care planning, and care coordination, emotional and psychosocial counseling for patients and families, assistance accessing services from other needed community resources, and should reflect the patient and family's values and goals.

Some examples of palliative care services that should be available to patients with a life-threatening/limiting illness,

A) without regard to a patient's expected length of life:
   - Inpatient palliative care consultation; and,
   - Outpatient palliative care consultation, office visits.

B) with an expected median survival of less than one year, as supported by the best available published evidence:
   - Home-based palliative care services (to be defined by DMAP), with the expectation that the patient will move to home hospice care.

C) with an expected median survival of six months or less, as supported by peer-reviewed literature:
   - Home hospice care, where the primary goal of care is quality of life (hospice services to be defined by DMAP).

It is the intent of the Commission that certain palliative care treatments be covered when these treatments carry the primary goal to alleviate symptoms and improve quality of life, without intending to alter the trajectory of the underlying disease.

Some examples of covered palliative care treatments include:

A) Radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life.
B) Surgical decompression for malignant bowel obstruction.
C) Medication therapy such as chemotherapy with low toxicity/low side effect agents with the goal to decrease pain from bulky disease or other identified complications. Cost of chemotherapy and alternative medication(s) should also be considered.
D) Medical equipment and supplies (such as non-motorized wheelchairs, walkers, bandages, and catheters) determined to be medically appropriate for completion of basic activities of daily living, for management of symptomatic complications or as required for symptom control.
E) Acupuncture with intent to relieve nausea.

Cancer treatment with intent to palliate is not a covered service when the same palliation can be achieved with pain medications or other non-chemotherapy agents.

It is NOT the intent of the Commission that coverage for palliative care encompasses those treatments that seek to prolong life despite substantial burdens of treatment and limited chance of benefit. See Guideline Note 12: TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE.

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

It is the intent of the Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services. Such services include but are not limited to attending physician visits, consulting physician confirmation, mental health evaluation and counseling, and prescription medications.

STATEMENT OF INTENT 3: INTEGRATED CARE

Recognizing that many individuals with mental health disorders receive care predominantly from mental health care providers, and recognizing that integrating mental and physical health services for such individuals promotes patient-centered care, the Health Evidence Review Commission endorses the incorporation of chronic disease health management support within mental health service systems. Although such supports are not part of the mental health benefit package, mental health organizations (MHOs) that elect to provide these services may report them using psychiatric rehabilitation codes which pair with mental health diagnoses. If MHOs choose to provide tobacco cessation supports, they should report these services using 99407 for individual counseling and S9453 for classes.

GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY (CONT'D)

b) Suspected Crohn's disease: upper and lower endoscopy, small bowel follow through
2) Radiological evidence of lack of stricture
3) Only covered once during any episode of illness
4) FDA approved devices must be used
5) Patency capsule should not be used prior to procedure

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

Central serous retinopathy (362.41) is included on this line only for treatment when the condition has been present for 3 months or longer. Pars planitis (363.21) should only be treated in patients with 20/40 or worse vision..

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES

Lines 79,102,103,105,123-125,131,144,159,165,166,168,170,181,197,198,206-208,218,220,221,228,229,231,243,249,252,275-278,280,287,292,310-312,314,320,339-341,356,459,622

A) CSF are not indicated for primary prophylaxis of febrile neutropenia unless the primary chemotherapeutic regimen is known to produce febrile neutropenia at least 20% of the time. CSF should be considered when the primary chemotherapeutic regimen is known to produce febrile neutropenia 10-20% of the time; however, if the risk is due to the chemotherapy regimen, other alternatives such as the use of less myelosuppressive chemotherapy or dose reduction should be explored in this situation.
B) For secondary prophylaxis, dose reduction should be considered the primary therapeutic option after an episode of severe or febrile neutropenia except in the setting of curable tumors (e.g., germ cell), as no disease free or overall survival benefits have been documented using dose maintenance and CSF.
C) CSF are not indicated in patients who are acutely neutropenic but afebrile.
D) CSF are not indicated in the treatment of febrile neutropenia except in patients who received prophylactic filgrastim or sargramostim or in high risk patients who did not receive prophylactic CSF. High risk patients include those age >65 years or with sepsis, severe neutropenia with absolute neutrophil count <100/mcl, neutropenia expected to be more than 10 days in duration, pneumonia, invasive fungal infection, other clinically documented infections, hospitalization at time of fever, or prior episode of febrile neutropenia.
E) CSF are not indicated to increase chemotherapy dose-intensity or schedule, except in cases where improved outcome from such increased intensity has been documented in a clinical trial.
F) CSF (other than pegfilgrastrim) are indicated in the setting of autologous progenitor cell transplantation, to mobilize peripheral blood progenitor cells, and after their infusion.
G) CSF are NOT indicated in patients receiving concomitant chemotherapy and radiation therapy.
H) There is no evidence of clinical benefit in the routine, continuous use of CSF in myelodysplastic syndromes. CSF may be indicated for some patients with severe neutropenia and recurrent infections, but should be used only if significant response is documented.
I) CSF is indicated for treatment of cyclic, congenital and idiopathic neutropenia.

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE

Lines 102,103,123-125,144,159,165,166,170,181,197,198,207,208,218,220,221,228,229,231,243,249,252,275-278,280,287,292,310-312,320,339-341,356,459,586,622

This guideline only applies to patients with advanced cancer who have less than 24 months median survival with treatment.

All patients receiving end of life care, either with the intent to prolong survival or with the intent to palliate symptoms, should have/be engaged with palliative care providers (for example, have a palliative care consult or be enrolled in a palliative care program).

Treatment with intent to prolong survival is not a covered service for patients with any of the following:

- Median survival of less than 6 months with or without treatment, as supported by the best available published evidence
- Median survival with treatment of 6-12 months when the treatment is expected to improve median survival by less than 50%, as supported by the best available published evidence
- Median survival with treatment of more than 12 months when the treatment is expected to improve median survival by less than 30%, as supported by the best available published evidence
- Poor prognosis with treatment, due to limited physical reserve or the ability to withstand treatment regimen, as indicated by low performance status.

Unpublished evidence may be taken into consideration in the case of rare cancers which are universally fatal within six months without treatment.

The Health Evidence Review Commission is reluctant to place a strict $/QALY (quality adjusted life-year) or $/LYS (life-year saved) requirement on end-of-life treatments, as such measurements are only approximations and cannot take into account all of the merits of an individual case. However, cost must be taken into consideration when considering treatment options near the end of life. For example, in no instance can it be justified to spend $100,000 in public resources to increase an individual's expected survival by three months when hundreds of thousands of Oregonians are without any form of health insurance.

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE (CONT'D)

Treatment with the goal to palliate is addressed in Statement of Intent 1, Palliative Care.

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76,195

Minimally invasive coronary artery bypass surgery indicated only for single vessel disease.

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

Lines 79,103,105,125,131,166,170,198,206,231,280,314

Second bone marrow transplants are not covered except for tandem autologous transplants for multiple myeloma.

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89,384

Radiation treatment is indicated only in those at high risk of heterotopic bone formation: those with a history of prior heterotopic bone formation, ankylosing spondylitis or hypertrophic osteoarthritis.

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1,3,4

Cystic fibrosis carrier testing is covered for 1) non-pregnant adults if indicated in the genetic testing algorithm or 2) pregnant women.

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

Dental cleaning and fluoride treatments are limited to once per 12 months for adults and twice per 12 months for children up to age 19 (D1110, D1120, D1203, D1204, D1206). More frequent dental cleanings and/or fluoride treatments may be required for certain higher risk populations.

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 108,279

Ventricular assist devices are covered only in the following circumstances:

A) as a bridge to cardiac transplant;
B) as treatment for pulmonary hypertension when pulmonary hypertension is the only contraindication to cardiac transplant and the anticipated outcome is cardiac transplant; or,
C) as a bridge to recovery.

Ventricular assist devices are not covered for destination therapy.

Ventricular assist devices are covered for cardiomyopathy only when the intention is bridge to cardiac transplant.

GUIDELINE NOTE 19, PET SCAN GUIDELINES

Lines 125,144,165,166,170,182,207,208,220,221,243,276,278,292,312,339

PET Scans are covered for diagnosis of the following cancers only:

- Solitary pulmonary nodules and non-small cell lung cancer
- Evaluation of cervical lymph node metastases when CT or MRI do not demonstrate an obvious primary tumor.

For diagnosis, PET is covered only when it will avoid an invasive diagnostic procedure, or will assist in determining the optimal anatomic location to perform an invasive diagnostic procedure.

PET scans are covered for the initial staging of the following cancers:

- Cervical cancer only when initial MRI or CT is negative for extra-pelvic metastasis
- Head and neck cancer when initial MRI or CT is equivocal

DECLARATION OF JEANETTE HALL

I, JEANETTE HALL, declare as follows:

1. I live in Oregon where assisted suicide is legal. Our law was enacted in 1997 via a ballot measure that I voted for.

2. In 2000, I was diagnosed with cancer and told that I had 6 months to a year to live. I knew that our law had passed, but I didn't know exactly how to go about doing it. I tried to ask my doctor, Kenneth Stevens MD, but he didn't really answer me. In hindsight, he was stalling me.

3. I did not want to suffer. I wanted to do our law and I wanted Dr. Stevens to help me. Instead, he encouraged me to not give up and ultimately I decided to fight the cancer. I had both chemotherapy and radiation. I am so happy to be alive!

4. This July, it will be 16 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

Dated this 30 day of June 2016

Jeanette Hall

Jeanette Hall

E:\ASE 2016 +\Colorado Initiative\Jeanette Hall Declaration.wpd

WESTLAW

West's Hawai'i Revised Statutes Annotated
Division 4. Courts and Judicial Proceedings
Title 36. Civil Remedies and Defenses and Special Proceedings

§ 671-3. Informed consent
West's Hawai'i Revised Statutes Annotated Division 4. Courts and Judicial Proceedings *(Approx. 2 pages)*

HRS § 671-3

§ 671-3. Informed consent

Currentness

(a) The Hawaii medical board may establish standards for health care providers to follow in giving information to a patient, or to a patient's guardian or legal surrogate if the patient lacks the capacity to give an informed consent, to ensure that the patient's consent to treatment is an informed consent. The standards shall be consistent with subsection (b) and may include:

(1) The substantive content of the information to be given;

(2) The manner in which the information is to be given by the health care provider; and

(3) The manner in which consent is to be given by the patient or the patient's guardian or legal surrogate.

(b) The following information shall be supplied to the patient or the patient's guardian or legal surrogate prior to obtaining consent to a proposed medical or surgical treatment or a diagnostic or therapeutic procedure:

(1) The condition to be treated;

(2) A description of the proposed treatment or procedure;

(3) The intended and anticipated results of the proposed treatment or procedure;

(4) The recognized alternative treatments or procedures, including the option of not providing these treatments or procedures;

(5) The recognized material risks of serious complications or mortality associated with:

(A) The proposed treatment or procedure;

(B) The recognized alternative treatments or procedures; and

(C) Not undergoing any treatment or procedure; and

(6) The recognized benefits of the recognized alternative treatments or procedures.

(c) On or before January 1, 1984, the Hawaii medical board shall establish standards for health care providers to follow in giving information to a patient or a patient's guardian, to ensure that the patient's consent to the performance of a mastectomy is an informed consent. The standards shall include the substantive content of the information to be given, the manner in which the information is to be given by the health care provider and the manner in which consent is to be given by the patient or the patient's guardian. The substantive content of the information to be given shall include information on the recognized alternative forms of treatment.

(d) Nothing in this section shall require informed consent from a patient or a patient's guardian or legal surrogate when emergency treatment or an emergency procedure is rendered by a health care provider and the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of the patient's health.

(e) For purposes of this section, "legal surrogate" means an agent designated in a power of attorney for health care or surrogate designated or selected in accordance with chapter 327E.

Credits

Laws 1976, ch. 219, § 2; Laws 1982, ch. 95, § 1; Laws 1983, ch. 223, § 2; Laws 1983, ch. 284, § 1; Laws 2003, ch. 114, § 2; Laws 2008, ch. 9, § 3, eff. April 11, 2008.

NOTES OF DECISIONS (97)

Breach of duty to inform
Consent forms
Consulting and referring physicians
Contributory negligence
Duty to inform patient
Elements and standards of informed consent
Full disclosure
Incompetent persons
Informed consent, generally
Instructions
Preservation of issues
Presumptions and burden of proof
Review
Risks to patient and alternatives
Testimony of experts
Therapeutic privilege exception
Verdicts
Waiver
Weight and sufficiency of evidence

BEFORE THE LEGISLATURE OF THE STATE OF NEW YORK

IN RE NEW YORK BILLS	**DECLARATION OF KENNETH STEVENS, MD**

I, Kenneth Stevens, declare the following under penalty of perjury.

1. I am a doctor in Oregon where physician-assisted suicide is legal. I am also a Professor Emeritus and a former Chair of the Department of Radiation Oncology, Oregon Health & Science University, Portland, Oregon. I have published articles in medical journals and written chapters for books on medical topics. This has been for both a national and international audience. I work in both hospital and clinical settings. I have treated thousands of patients with cancer.

2. In Oregon, our assisted suicide law applies to patients predicted to have less than six months to live. I write to clarify that this does not necessarily mean that patients are dying.

3. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live, which was based on her not being treated for

cancer. I understand that he had referred her to me.

4. At our first meeting, Jeanette told me plainly that she did not want to be treated and that was going to "do" our law, *i.e.*, kill herself with a lethal dose of barbiturates. It was very much a settled decision.

5. I, personally, did not and do not believe in assisted suicide. I also believed that her cancer was treatable and that her prospects were good. She was not, however, interested in treatment. She had made up her mind, but she continued to see me.

6. On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated and she is still alive today. Indeed, she is thrilled to be alive. It's been fifteen years.

7. For Jeanette, the mere presence of legal assisted suicide had steered her to suicide.

8. I also write to clarify a difference between physician-assisted suicide and end-of-life palliative care in which dying patients receive medication for the intended purpose of relieving pain, which may incidentally hasten death. This is the principle of double effect. This is not physician-assisted suicide in which death is intended for patients who may or may not be dying anytime soon.

9. Finally, I have been asked to comment on generally accepted medical practice regarding the administration of prescription drugs to a patient.

10. Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer prescription drugs to a patient. Common examples of persons acting under the direction of a doctor, include: nurses and other healthcare professionals who act under the direction of a doctor to administer drugs to a patient in a hospital setting; parents who act under the direction of a doctor to administer drugs to their children in a home setting; and adult children who act under the direction of a doctor to administer drugs to their parents in a home setting.

Signed under penalty of perjury, this 6th day of January, 2016.

Kenneth Stevens Jr. MD

Kenneth Stevens, Jr., MD
Sherwood, Oregon

Adult Asthma Symptoms?
Get Info On An Asthma Control Treatment For Adults Here.
www.Asthma-Control-Treatment.com

lethal injection

noun

the act or instance of injecting a drug for purposes of capital punishment or euthanasia

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Examples from the Web for lethal injection

Contemporary Examples

Rangers caught the dingo and put it down with *lethal injection*.

(http://www.thedailybeast.com/? Pets or Predators? 10 Things About Australia's Famous Dog, the Dingo (http://www.thedailybeast.com/articles/2012/06/13/pets-or-predators-10-things-on-australia-s-famous-dog-the-dingo.html?source=dictionary)
source=dictionary)
Meredith Kaufman (http://www.thedailybeast.com/contributors/meredith-kaufman.html?source=dictionary)
June 12, 2012

lethal injection is allowed as a form of execution in all thirty-two states that have the death penalty.

(http://www.thedailybeast.com/? Arizona Botches Execution (http://www.thedailybeast.com/articles/2014/07/23/arizona-botches-execution.html?source=dictionary)
source=dictionary)
Ben Jacobs (http://www.thedailybeast.com/contributors/ben-jacobs.html?source=dictionary)
July 22, 2014

Death by pills or *lethal injection* might be unnatural, but she believes that declining nourishment and medications is not.

(http://www.thedailybeast.com/? The Nurse Coaching People Through Death by Starvation (http://www.thedailybeast.com/articles/2014/11/17/the-nurse-coaching-people-through-suicide-by-starvation.html?source=dictionary)
source=dictionary)
Nick Tabor (http://www.thedailybeast.com/contributors/nick-tabor.html?source=dictionary)

awesome insults (http://www.dictionary.com/slideshows/12-insults-we-should-bring-back/?src=dcom-serp-tab)

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mercy killing

Also found in: **Thesaurus, Medical, Legal, Acronyms, Encyclopedia, Wikipedia.**

mercy killing

n.

Euthanasia.

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mercy killing

n

(Medicine) another term for **euthanasia**

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eu•tha•na•sia (ˌyu θəˈneɪ ʒə, -ʒi ə, -zi ə)

n.

Also called **mercy killing.** the act of putting to death painlessly or allowing to die, as by withholding medical measures from a person or animal suffering from an incurable, esp. a painful, disease or condition.

[1640–50; < New Latin < Greek *euthanasía* easy death]

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Thesaurus

Legend: = Synonyms ↔ Related Words ≠ Antonyms

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Noun 1. mercy killing - the act of killing someone painlessly (especially someone suffering from an incurable illness)

= **euthanasia**

↔ **kill, putting to death, killing** - the act of terminating a life

A-53

Google in accordance definition

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ac·cord·ance
/əˈkôrdns/

noun
noun: accordance

in a manner conforming with.
"the product is disposed of in accordance with federal regulations"
synonyms: in agreement with, in conformity with, in line with, true to, in the spirit of, observing, **following**, heeding
"a ballot held **in accordance with** union rules"

"in the spirit of"

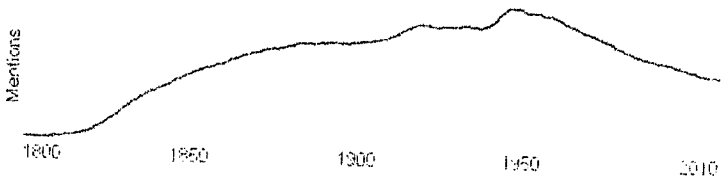
Origin

OLD FRENCH acorder — Bring to an Agreement
OLD FRENCH acordance
ENGLISH accord
accordance — Middle English

Middle English: from Old French *acordance*, from *acorder* 'bring to an agreement' (see accord).

Translate accordance to Choose language

Use over time for: accordance



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in (or in the) spirit

phrase of spirit

1. in thought or intention though not physically.
   "he couldn't be here in person, but he is with us in spirit"

"he couldn't be here in person, but he is with us in spirit"

Translate in the spirit to Choose language

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Feedback

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english.stackexchange.com/questions/165465/whats-the-meaning-of-in-the-**spirit-of**
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In the spirit - definition of in the spirit by The Free Dictionary
www.thefreedictionary.com/in+the+**spirit**
A force or principle believed to animate living beings. b. A force or principle believed to animate humans and often to endure after departing from the body of a person at death; the soul. 2. **Spirit** The Holy **Spirit**.

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www.merriam-webster.com/dictionary/**spirit** Merriam-Webster
1 : an animating or vital principle held to give life to physical organisms. 2 : a supernatural being or essence: asa capitalized : holy **spirit**b : soul 2ac : an often malevolent being that is bodiless but can become visible; specifically : ghost 2d : a malevolent being that enters and possesses a human being.

Spirit Definition and Meaning - Bible Dictionary - Bible study
www.biblestudytools.com/dictionary/**spirit**/ Crosswalk: Bible Study Tools
What is **Spirit**? **Definition** and meaning:**SPIRIT** spir'-it (ruach; pneuma; Latin, spiritus): 1.

SPIRIT - Definition from the KJV Dictionary - AV1611.COM
av1611.com/kjbp/kjv-dictionary/**spirit**.html
KJV Dictionary **Definition: spirit**. spirit. SPIR'IT, n. L. spiritus, from spiro, to breathe, to blow. The primary sense is to rush or drive. 1. Primarily, wind; air in motion; ...

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Washington State Department of Health

Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys: Compliance with the Death with Dignity Act

Washington's Death with Dignity Act (RCW 70.245) states that "...the patient's death certificate...shall list the underlying terminal disease as the cause of death." The act also states that, "Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law."

If you know the decedent used the Death with Dignity Act, you must comply with the strict requirements of the law when completing the death record:

1. The underlying terminal disease must be listed as the cause of death.
2. The manner of death must be marked as "Natural."
3. The cause of death section may not contain any language that indicates that the Death with Dignity Act was used, such as:
    a. Suicide
    b. Assisted suicide
    c. Physician-assisted suicide
    d. Death with Dignity
    e. I-1000
    f. Mercy killing
    g. Euthanasia
    h. Secobarbital or Seconal
    i. Pentobarbital or Nembutal

The Washington State Registrar will reject any death certificate that does not properly adhere to the requirements of the Death with Dignity Act.[1] If a death certificate contains any reference to actions that might indicate use of the act, the Local Registrar and Funeral Director will be instructed, under RCW 70.58.030, to obtain a correction from the medical certifier before a permit to proceed with disposition will be issued.

Call the Department of Health's Center for Health Statistics (360-236-4307) for guidance on how to proceed if you have any questions regarding compliance with cause of death reporting under the Death with Dignity Act.

---

[1] Under state law, the State Registrar of Vital Statistics "shall prepare and issue such detailed instruction as may be required to secure the uniform observance of its provisions and the maintenance of a perfect system of registration. ... The State Registrar shall carefully examine the certificates received monthly from the local registrars, county auditors, and clerks of the court and, if any are incomplete or unsatisfactory, the State Registrar shall require such further information to be furnished as may be necessary to make the record complete and satisfactory." RCW 43.70.160.

DECLARATION OF TESTIMONY

I, Isaac Jackson, declare under penalty of perjury the following:

1. I am a lawyer licensed to practice law in the State of Oregon, USA. I am in private practice with my own law firm specializing injury claims, including wrongful death cases. I previously served as a Law Clerk to Judge Charles Carlson of the Lane County Circuit Court. I was also an associate lawyer with a firm that specializes in insurance defense and civil litigation.

2. I write to inform the court regarding a lack of transparency under Oregon's assisted suicide act. Even law enforcement is denied access to information collected by the State of Oregon. Moreover, according to the current Oregon State website, this lack of access is official Oregon State Policy.

3. In 2010, I was retained by a client whose father had apparently died under Oregon's law. The client wanted to know whether that was true. I therefore made inquiry on his behalf. However and unlike other deaths I have investigated, it was difficult to get information.

4. I wrote Dr. Hedberg, the State epidemiologist. Attached hereto as Exhibit 1 is a true and correct copy of a letter I received back from the Office of the Attorney General of Oregon dated November 3, 2010. The letter describes that the Oregon Health Authority is only allowed to release annual statistical information about assisted suicide deaths. The letter states:

> ORS [Oregon Revised Statutes] 127.865 prevents OHA [Oregon Health Authority] from releasing any information to you or your client. OHA may only make public annual statistical information.

5. I also wrote the Oregon Medical Board. Attached hereto as Exhibit 2 is a true and correct redacted copy of a letter I received back, dated November 29, 2010, which states in part:

> While sympathetic to [your client's] concerns about the circumstances of his father's death, the Board is not able to provide the information requested. The Board does not possess the requested documents nor does the Board routinely receive these documents. Under Oregon law the Oregon Department of Health collects these documents for their purposes. Further, if the Board did have the documents as a part of an investigation, the Board would be prevented from releasing them by ORS 676.175. *See* Exhibit 2.

6. I also received a copy of the decedent's death certificate, which is the official death record in Oregon. A true and correct, but redacted copy, is attached hereto as Exhibit 3. The "immediate cause of death" is listed as "cancer." The "manner of death" is listed as "Natural."

///

7. Per my request, a police officer was assigned to the case. Per the officer's confidential report, he did not interview my client, but he did interview people who had witnessed the decedent's death.

8. The officer's report describes how he determined that the death was under Oregon's assisted suicide law act due to records other than from the State of Oregon. The officer's report also describes that he was unable to get this information from the Oregon Health Authority, which was not willing to confirm or deny whether the deceased had used the act. The officer closed the case.

9. Attached hereto as Exhibit 4 is a true and correct copy of the Oregon Health Authority's data release policy, as of September 18, 2012, which states in part:

> The Death with Dignity Act requires that the Oregon Health Authority collect information pertaining to compliance (ORS 127.865 (2)) and to make available to the public an annual statistical report (ORS 127.865 (3)).
>
> The Oregon Health Authority's role is limited to collecting information so that we can monitor compliance and provide a report regarding the effects of this legislation. Confidentiality is critical and the Act specifically states that information collected is not a public record and is not available for inspection by the public (ORS 127.865 (2)). The protection of confidentiality conferred by the Death with Dignity Act precludes the Oregon Health Authority from releasing information that identifies patients or participants, to the public, media, researchers, students, advocates, or other interested parties.
>
> The Oregon Health Authority will NOT confirm on a case-by-case basis whether an individual has used, or a provider has been involved with, Death with Dignity. We will not release a report when the first case occurs and we will not respond to questions regarding number of cases within a specific time period. (Emphasis in original).

Pursuant to Oregon Rules of Civil Procedure 1E, I hereby declare that the above statement is true to the best of my knowledge and belief, and that I understand it is made for use as evidence in court and is subject to penalty for perjury.

Dated Sept. 18 2012

Isaac Jackson, OSB 055494
Jackson Law Office, LLC

Post Office Box 41240
Eugene, OR 97404
541.225.5061
Jackson@irjlaw.com

JOHN R. KROGER
Attorney General

MARY H. WILLIAMS
Deputy Attorney General

DEPARTMENT OF JUSTICE
GENERAL COUNSEL DIVISION

RECEIVED
11/4/10

November 3, 2010

Isaac Jackson
Jackson Law Office, LLC
P.O. Box 279
Eugene, OR 97440

Re: Death with Dignity Act Records Request

Dear Mr. Jackson:

Dr. Hedberg, the state epidemiologist, received your letter dated October 27, 2010, requesting certain Death with Dignity Act records that may have been filed under OAR 333-009-0010. If records cannot be provided, you also ask Dr. Hedberg to investigate the existence of the documents and report findings to you, or lastly, to at least verify whether the Oregon Health Authority (OHA) has any record of contact with your client's deceased father. In sum, your client would like any information that might shed light on his father's death.

While Dr. Hedberg understands the difficult time your client must be going through, ORS 127.865 prevents OHA from releasing any information to you or your client. OHA may only make public annual statistical information. Please be assured that if irregularities are found on paperwork submitted to the OHA under OAR 333-009-0010, OHA can and has reported information to the Oregon Medical Board who can then investigate the matter.

I understand that you are in the process of getting the death certificate for your client's father and that may shed some light on the matter for your client. If your client believes that some nefarious actions have taken place he certainly could contact law enforcement.

Please contact me if you have additional questions.

Sincerely,

Shannon K. O'Fallon
Senior Assistant Attorney General
Health and Human Services Section

SKO:vdc/Justice# 2345752
cc: Katrina Hedberg, M.D, DHS

1515 SW Fifth Ave, Suite 410, Portland, OR 97201
Telephone: (971) 673-1880 Fax: (971) 673-18868 TTY: (503) 378-5938 www.doj.state.or.us

11/29/10

Oregon

Theodore R. Kulongoski, Governor

RECEIVED
12-6-10

Medical Board
1500 SW 1st Ave Ste 620
Portland, OR 97201-5847
(971) 673-2700
FAX (971) 673-2670
www.oregon.gov/omb

November 29, 2010

Isaac Jackson
Jackson Law Office
PO Box 279
Eugene, OR 97440

Dear Mr. Jackson:

The Oregon Medical Board has received your letter regarding .... and his death, apparently under the Oregon Death with Dignity Act. In order for the Board to proceed with a formal investigation, a medical and/or legal basis must exist to support an allegation that a physician licensed by the Board may have violated Oregon law. In our review of the information that you presented we did not find a physician identified nor was there a specific allegation of misconduct on the part of a physician. As such, the board is not able to initiate a formal investigation.

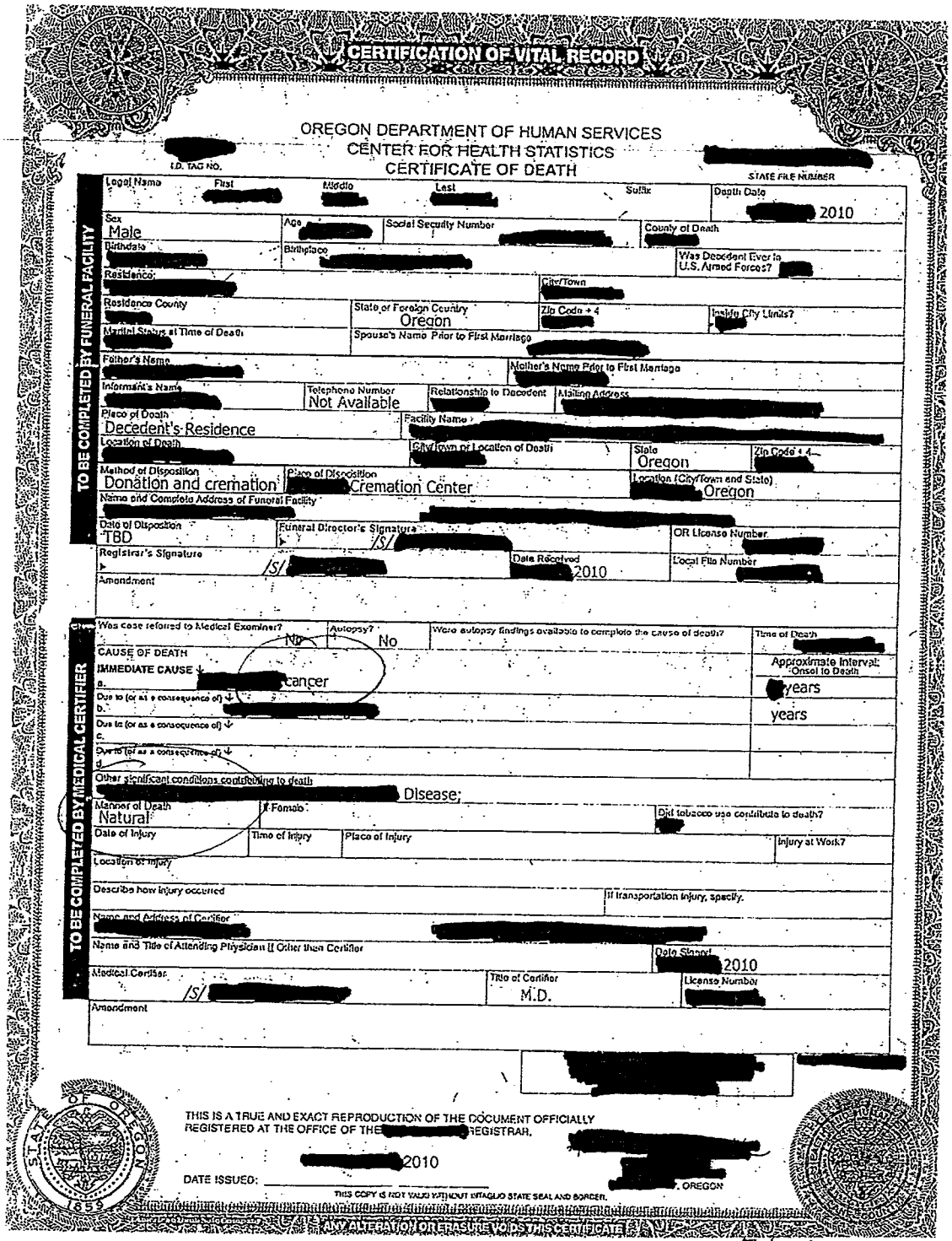
While sympathetic to concerns about the circumstances of his father's death, the Board is not able to provide the information requested. The Board does not possess the requested documents nor does the Board routinely receive these documents. Under Oregon law the Oregon Department of Human Services collects these documents for their purposes. Further, if the Board did have the documents as a part of an investigation, the Board would be prevented from releasing them by ORS 676.175.

Thank you for bringing your concerns to the attention of the Oregon Medical Board. If you have any further questions regarding this matter, you may contact me at 971-673-2702.

Sincerely,

Randy H. Day
Complaint Resource Officer
Investigations/Compliance Unit

Exhibit 2



CERTIFICATION OF VITAL RECORD

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

I.D. TAG NO. [redacted]

STATE FILE NUMBER [redacted]

TO BE COMPLETED BY FUNERAL FACILITY

Legal Name: First [redacted]	Middle [redacted]	Last [redacted]	Suffix	Death Date: [redacted] 2010
Sex: Male	Age: [redacted]	Social Security Number: [redacted]	County of Death: [redacted]	
Birthdate: [redacted]	Birthplace: [redacted]		Was Decedent Ever in U.S. Armed Forces? [redacted]	
Residence: [redacted]		City/Town: [redacted]		
Residence County: [redacted]	State or Foreign Country: Oregon	Zip Code + 4: [redacted]	Inside City Limits? [redacted]	
Marital Status at Time of Death: [redacted]	Spouse's Name Prior to First Marriage: [redacted]			
Father's Name: [redacted]		Mother's Name Prior to First Marriage: [redacted]		
Informant's Name: [redacted]	Telephone Number: Not Available	Relationship to Decedent: [redacted]	Mailing Address: [redacted]	
Place of Death: Decedent's Residence	Facility Name: [redacted]			
Location of Death: [redacted]	City/Town of Location of Death: [redacted]		State: Oregon	Zip Code + 4: [redacted]
Method of Disposition: Donation and cremation	Place of Disposition: [redacted] Cremation Center		Location (City/Town and State): [redacted] Oregon	
Name and Complete Address of Funeral Facility: [redacted]				
Date of Disposition: TBD	Funeral Director's Signature: /S/ [redacted]		OR License Number: [redacted]	
Registrar's Signature: /S/ [redacted]		Date Received: [redacted] 2010	Local File Number: [redacted]	
Amendment				

TO BE COMPLETED BY MEDICAL CERTIFIER

Was case referred to Medical Examiner? No	Autopsy? No	Were autopsy findings available to complete the cause of death?	Time of Death: [redacted]
CAUSE OF DEATH			Approximate Interval: Onset to Death
IMMEDIATE CAUSE a. [redacted] cancer			[redacted] years
Due to (or as a consequence of) b. [redacted]			years
Due to (or as a consequence of) c.			
Due to (or as a consequence of) d.			
Other significant conditions contributing to death: [redacted] Disease;			
Manner of Death: Natural	If Female:		Did tobacco use contribute to death? [redacted]
Date of Injury	Time of Injury	Place of Injury	Injury at Work?
Location of Injury			
Describe how injury occurred			If transportation injury, specify.
Name and Address of Certifier: [redacted]			
Name and Title of Attending Physician if Other than Certifier			Date Signed: [redacted] 2010
Medical Certifier: /S/ [redacted]	Title of Certifier: M.D.		License Number: [redacted]
Amendment			

[redacted]

THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY REGISTERED AT THE OFFICE OF THE [redacted] REGISTRAR.

DATE ISSUED: [redacted] 2010

[redacted], OREGON

THIS COPY IS NOT VALID WITHOUT INTAGLIO STATE SEAL AND BORDER.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

Exhibit 3

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Learn about air quality and health issues related to the 2012 Oregon wildfires.

Oregon Health

Data Release Policy

Release of Information Regarding the Death with Dignity Act

The Death with Dignity Act requires that the Oregon Health Authority collect information pertaining to compliance (ORS 127.865 (2)) and to make available to the public an annual statistical report (ORS 127.865 (3)).

The Oregon Health Authority's role is limited to collecting information so that we can monitor compliance and provide a report regarding the effects of this legislation.

Confidentiality is critical and the Act specifically states that information collected is not a public record and is not available for inspection by the public (ORS 127.865 (2)). The protection of confidentiality conferred by the Death with Dignity Act precludes the Oregon Health Authority from releasing information that identifies patients or participants, to the public, media, researchers, students, advocates, or other interested parties.

The Oregon Health Authority will **NOT** confirm on a case-by-case basis whether an individual has used, or a provider has been involved with, Death with Dignity. We will not release a report when the first case occurs and we will not respond to questions regarding number of cases within a specific time period.

Within the principles of confidentiality, the Oregon Health Authority will publish an annual report which will include information on how many prescriptions are written, and how many people actually take the prescribed medication. The specificity of any data released will depend upon whether we can ensure that confidentiality will not be breached.

To reiterate, the Oregon Health Authority's role in reporting on the Death with Dignity Act is similar to other public health data we collect. The data are population-based and our charge is to maintain surveillance of the overall effect of the Act. The data are to be presented in an annual report, but the information collected is required to be confidential. Therefore, case-by-case information will not be provided, and specificity of data released will depend on having adequate numbers to ensure that confidentiality will be maintained.

Frequently Asked Questions Related to Additional Data Requests

Exhibit 4

Margaret K. Dore

Margaret Dore <margaretdore@margaretdore.com>

RE: Death with Dignity Act

1 message

Parkman Alicia A <alicia.a.parkman@state.or.us>
To: Margaret Dore <margaretdore@margaretdore.com>
Cc: BURKOVSKAIA Tamara V <tamara.v.burkovskaia@state.or.us>

Wed, Jan 4, 2012 at 7:57 AM

Thank you for your email regarding Oregon's Death with Dignity Act. For all of your questions, the answer is no. Since our office is charged with maintaining absolute confidentiality, our policy is to never release identifying information. We can neither confirm nor deny participation of any individual patient or physician. We have been contacted by law enforcement and legal representatives in the past, but have not provided identfying information of any type. To ensure confidentiality, our office does not maintain source documentation on participants.

Please let me know if you have further questions.

Thank you,

Alicia

Alicia Parkman

Mortality Research Analyst

Center for Health Statistics

Oregon Health Authority

Ph: 971-673-1150

Fax: 971-673-1201

From: Margaret Dore [mailto:margaretdore@margaretdore.com]
Sent: Monday, January 02, 2012 5:48 PM
To: alicia.a.parkman@state.or.us
Subject: Death with Dignity Act

Thank you for answering my prior questions about Oregon's death with dignity act.

I have these follow up questions:

1. Would your office release copies of completed reporting forms, e.g., a doctor's completed "Oregon Death with Dignity Act Attending Physician Follow-up Form," in response to a civil subpoena?

X 2. Would your office release copies of completed reporting forms in answer to a request by law enforcement?

X 3. Would your office confirm to law enforcement whether a person had in fact died under Oregon's Death with Dignity Act?

Margaret Dore
Law Offices of Margaret K. Dore, P.S.
www.margaretdore.com
1001 4th Avenue, 44th Floor
Seattle, WA 98154
206 389 1754

Margaret K. Dore

Margaret Dore <margaretdore@margaretdor

Re: Record Retention Policy

1 message

DWDA INFO <dwda.info@state.or.us>
To: Margaret Dore <margaretdore@margaretdore.com>
Mon, Jun 27, 2011 at 4:18 PM

Hello Ms. Dore,

Thank you for your email regarding Oregon's Death with Dignity Act (DWDA). To answer your question, no, we would not have that information on file. Because the DWDA forms and data are not public records, they do not fall under the retention schedule. We (the Public Health Division) compile the data we need for our reports and then destroy all source documentation after one year.

More information can be found in our "Frequently Asked Questions" document, available on our website (http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/faqs.pdf).

The FAQ does contain a question specific to how data are collected, used and maintained by the agency:

Q: Are participating patients reported to the State of Oregon by name?

A: The State does collect the names of patients in order to cross-check death certificates. However, the law guarantees the confidentiality of all participating patients (as well as physicians) and the Department of Human Services does not release this information to the public or media. The identity of participating physicians is coded, but the identity of individual patients is not recorded in any manner. Approximately one year from the publication of the Annual Report, all source documentation is destroyed.

Please let me know if you have further questions.

Thank you,

Alicia

Alicia Parkman
Mortality Research Analyst
Center for Health Statistics
Oregon Health Authority
971-673-1150
alicia.a.parkman@state.or.us

>>> "Margaret Dore" <margaretdore@margaretdore.com> 6/25/2011 11:04 AM >>>

Hi. I am an attorney in Washington State.

I would like to know what is Oregon's document retention policy regarding DWDA reporting.

For example, if there were a question about a death occurring five years ago, would the original doctor after-death report still be on file with your office?

Thanks.

Margaret Dore
Law Offices of Margaret K. Dore, P.S.
www.margaretdore.com
1001 4th Avenue, 44th Floor
Seattle, WA 98154
206 389 1754

There is no state "program" for participation in the Act. People do not "make application" to the State of Oregon or the Oregon Health Authority. It is up to qualified patients and licensed physicians to implement the Act on an individual basis. The Act requires the Oregon Health Authority to collect information about patients who participate each year and to issue an annual report.

Q: Are there any other states that have similar legislation?

A: Yes. The Death with Dignity National Center, which advocates for the passage of death with dignity laws, tracks the status of these laws around the country (see: https://www.deathwithdignity.org/take-action).

Q: Who can participate in the Act?

A: The law states that, in order to participate, a patient must be: 1) 18 years of age or older, 2) a resident of Oregon, 3) capable of making and communicating health care decisions for him/herself, and 4) diagnosed with a terminal illness that will lead to death within six (6) months. It is up to the attending physician to determine whether these criteria have been met.

Q: Can someone who doesn't live in Oregon participate in the Act?

A: No. Only patients who establish that they are residents of Oregon can participate if they meet certain criteria.

Q: How does a patient demonstrate residency?

A: A patient must provide adequate documentation to the attending physician to verify that s/he is a current resident of Oregon. Factors demonstrating residency include, but are not limited to: an Oregon Driver License, a lease agreement or property ownership document showing that the patient rents or owns property in Oregon, an Oregon voter registration, a recent Oregon tax return, etc. It is up to the attending physician to determine whether or not the patient has adequately established residency.

Q: How long does someone have to be a resident of Oregon to participate in the Act?

A: There is no minimum residency requirement. A patient must be able to establish that s/he is currently a resident of Oregon.

Q: Can a non-resident move to Oregon in order to participate in the Act?

A: There is nothing in the law that prevents someone from doing this. However, the patient must be able to prove to the attending doctor that s/he is currently a resident of Oregon.

Q: Are participating patients reported to the State of Oregon by name?

A: The State does collect the names of patients in order to cross-check death certificates. However, the law guarantees the confidentiality of all participating patients (as well as physicians) and the Oregon Health Authority does not release this information to the public or media. The identity of participating physicians is coded, but the identity of individual patients is not recorded in any manner. Approximately one year from the publication of the Annual Report, all source documentation is destroyed.

Q: Who can give a patient a prescription under the Act?

A: Patients who meet certain criteria can request a prescription for lethal medication from a licensed Oregon physician. The physician must be a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) licensed to practice medicine by the Board of Medical Examiners for the State of Oregon. The physician must also be willing to participate in the Act. Physicians are not required to provide prescriptions to patients and participation is voluntary. Additionally, some health care systems (for example, a Catholic hospital or the Veterans Administration) have prohibitions against practicing the Act that physicians must abide by as terms of their employment.

Q: If a patient's doctor does not participate in the Act, how can s/he get a prescription?

A: The patient must find another M.D. or D.O. licensed to practice medicine in Oregon who is willing to participate. The Oregon Health Authority does not recommend doctors, nor can we provide the names of participating physicians or patients due to the need to protect confidentiality.

Q: If a patient's primary care doctor is located in another state, can that doctor write a prescription for the patient?

A: No. Only M.D.s or D.O.s licensed to practice medicine by the Board of Medical Examiners for the State of Oregon can write a valid prescription for lethal medication under the Act.

Q: How does a patient get a prescription from a participating physician?

A: The patient must meet certain criteria to be able to request to participate in the Act. Then, the following steps must be fulfilled:

1. The patient must make two oral requests to the attending physician, separated by at least 15 days;
2. The patient must provide a written request to the attending physician, signed in the presence of two witnesses, at least one of whom is not related to the patient;
3. The attending physician and a consulting physician must confirm the patient's diagnosis and prognosis;
4. The attending physician and a consulting physician must determine whether the patient is capable of making and communicating health care decisions for him/herself;
5. If either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder (such as depression), the patient must be referred for a psychological examination;
6. The attending physician must inform the patient of feasible alternatives to the Act including comfort care, hospice care, and pain control;
7. The attending physician must request, but may not require, the patient to notify their next-of-kin of the prescription request. A patient can rescind a request at any time and in any manner. The attending physician

Confidentiality of Death Certificates

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION

(503) 731-4412
FAX (503) 731-4084
TDD-Nonvoice (503) 731-4031

Center for Health Statistics
P.O. Box 14050
Portland, OR 97293-0050

December 12, 1997

TO: County Vital Records Registrars and Deputies
FROM: Sharon Rice, Manager, Registration Unit Center for Health Statistics

SUBJECT: CONFIDENTIALITY—DEATH WITH DIGNITY

This memo is to insure your continued support of the Vital Records strict code of confidentiality on all birth and death certificates.

You received a memo dated November 18, 1997 from Edward Johnson, II, State Registrar. In this memo he discussed the necessity of protecting the privacy of all parties when a death occurs by means of Oregon's death with dignity law.

I have received several calls from different counties asking for more information. After discussing these concerns with the Registrar and physicians within the Health Division the following rules will apply to all physician assisted deaths.

You will neither confirm nor deny if a death has occurred in your county. If this question is asked by employees within your own Health Department, those calls should be referred to Edward Johnson, II, State Registrar (503) 731-4109 or Katrina Hedberg, M.D. (503) 731-4024. If you are asked for information from any other source on this specific topic, those callers will be referred to Katrina Hedberg, M.D., Oregon Health Division, (503) 731-4024. Do not refer callers to me as I am not at liberty to discuss this topic, and I would only have to refer the caller again.

We will begin asking funeral directors to direct report all physicians assisted death certificates to this office thus eliminating the registration through the county office. This will assist in maintaining the confidentiality in your office. Only limited staff in records will be aware of this type of death, as these records will not be handled through regular channels. We will also be controlling the issuance of certified copies making sure the family is aware of the new abbreviated copies and recommending they receive this type of certified copy.

If the funeral home chooses to forward the death record to your office, you may forward it to this office for registration. You should not maintain a white copy of the death record for six months nor should you issue certified copies.

If you do register the death locally then you may not maintain a six-month copy of the death record. Before issuing any certified copies of the death record you will need to contact this office for special permission to do so. There are three people in this office that can grant that permission:

Edward Johnson, II—State Registrar (503) 731-4109
Carol Sanders, Manager, Certification Unit 731-4416
Sharon Rice, Manager, Registration Unit 731-4412

Since we do not anticipate a large number of these cases, the different rules for the handling, these deaths should not adversely affect your work. You may never have this type of death occur within your county.

If you haven't by now determined the seriousness of this, let me add one additional statement so you will know how seriously this matter is being taken by the State Health Division. Any staff within the Center for Health Statistics that reveals any information they are not authorized to release, will immediately be terminated. Any county vital records staff, releasing information will have their registrar-deputy registrar commissions immediately revoked, thus eliminating you from having any contact with vital records within your county.

Remember if you are asked if any physician assisted deaths have occurred in your county you may neither confirm nor deny their occurrence. This may put you in a difficult position if you are being asked from Personnel within your own health department. Again, you will need to explain that you have been told you are not to discuss this topic with anyone, and refer the caller as mentioned earlier in this memo.

The Oregon Death with Dignity Act:

A Guidebook for Health Care Professionals

Developed by
The Task Force to Improve the Care of Terminally-Ill Oregonians

Convened by
The Center for Ethics in Health Care, Oregon Health & Science University

Patrick Dunn, M.D., Task Force Chair and Co-Editor
Bonnie Reagan, M.D., R.N., Co-Editor
Susan W. Tolle, M.D., Reviewer and Major Contributor
Sarah Foreman, Manuscript Preparation

Initial writing of the Guidebook was supported in part by
The Greenwall Foundation

First Edition (print): March 1998

Current Edition (2008): Published on this website
Updated as information becomes available

Registrar, Center for Health Statistics, 800 NE Oregon St., Suite 205, Portland, OR 97232; or by facsimile to (971) 673-1201. Information to be reported to the Department shall include: (a) Patient's name and date of birth; (b) Prescribing physician's name and phone number; (c) Dispensing health care provider's name, address and phone number; (d) Medication dispensed and quantity; (e) Date the prescription was written; and (f) Date the medication was dispensed.

Attending physicians are encouraged to inform patients of the requirement that the Department of Human Services have access to data regarding implementation of the Oregon Act. They may wish to have the patient's written request for enacting the provisions of the statute include a statement of consent for release of medical records to the Department of Human Services. The patient and attending physician should discuss post-death arrangements as part of the overall plans. As discussed in the chapter, *Attending Physician and Consulting Physician*, the attending physician may want to be present at the time of death or make arrangements to be notified by the family immediately following the death. The attending physician could then notify the funeral home that this is an expected death and that he/she will be signing the death certificate. The death certificate will then be filed and processed according to routine procedures and the death will not go into the medical examiner's system. The Medical Examiner is required to investigate any death that is suspicious (i.e., not natural or expected).[6] In addition, if Emergency Medical Services (EMS) are present at the time of death the Medical Examiner will be called. Because medical examiner investigations allow for limited public disclosure,[7] the confidentiality of the patient cannot be assured in these instances. Additionally, family members may be questioned regarding the circumstances surrounding these deaths.

The death certificate originates in the mortician's office, and is sent to the physician to complete the cause of death information. The death certificate is then sent back to the mortician's office, which files it with the local health department. Finally, the death certificate is forwarded to the Department of Human Services, State Registrar for Vital Records. While the confidentiality of the death certificate can be assured once it has reached the local health department and the Department of Human Services, physicians must ensure confidentiality in the clinical setting. Because death certificates have multiple purposes, including settling the estate as well as for public health information, the Department of Human Services suggests physicians record the underlying terminal conditions as the cause of death and mark the manner of death "natural", rather than recording that the patient ingested a lethal dose of medication prescribed under the Oregon Death with Dignity Act. Death certificates should not be left on desktops or at nurses' stations. Health care professionals and institutions might consider implementing a policy of keeping all death certificates in envelopes marked "confidential" until they are formally filed.

Confidentiality is of paramount importance in ensuring compliance with this Oregon Act. The Oregon Act ensures that "information collected shall not be a public record and may not be made available for inspection by the public" (see *Liability and Negligence*). Thus, information regarding the identity of patients, health care professionals, and health care facilities obtained by the Department of Human Services with respect to compliance with the Oregon Act shall be confidential. Summary information released in Department of Human Services' annual reports will be aggregated to prevent identification of individuals, physicians, or health care professionals complying with the Oregon Act. Death certificates are also confidential: OAR 333-11-096 (1) states that the Department of Human Services "... shall not permit inspection of, or

Don't follow Oregon's lead: Say no to assisted suicide

Dear Editor:

I am an internal medicine doctor, practicing in Oregon where assisted suicide is legal. I write in support of Margaret Dore's article, Aid in Dying: Not Legal in Idaho; Not About Choice. I would also like to share a story about one of my patients.

I was caring for a 76 year-old man who came in with a sore on his arm. The sore was ultimately diagnosed as a malignant melanoma, and I referred him to two cancer specialists for evaluation and therapy. I had known this patient and his wife for over a decade. He was an avid hiker, a popular hobby here in Oregon. As he went through his therapy, he became less able to do this activity, becoming depressed, which was documented in his chart.

During this time, my patient expressed a wish for doctor-assisted suicide to one of the cancer specialists. Rather than taking the time and effort to address the question of depression, or ask me to talk with him as his primary care physician and as someone who knew him, the specialist called me and asked me to be the "second opinion" for his suicide. She told me that barbiturate overdoses "work very well" for patients like this, and that she had done this many times before.

I told her that assisted-suicide was not appropriate for this patient and that I did NOT concur. I was very concerned about my patient's mental state, and I told her that addressing his underlying issues would be better than simply giving him a lethal prescription. Unfortunately, my concerns were ignored, and approximately two weeks later my patient was dead from an overdose prescribed by this doctor. His death certificate, filled out by this doctor, listed the cause of death as melanoma.

The public record is not accurate. My patient did not die from his cancer, but at the hands of a once-trusted colleague. This experience has affected me, my practice, and my understanding of what it means to be a physician.

What happened to this patient, who was weak and vulnerable, raises several important questions that I have had to answer, and that the citizens of Idaho should also consider:

- If assisted suicide is made legal in Idaho, will you be able to trust your doctors, insurers and HMOs to give you and your family members the best care? I referred my patient to specialty care, to a doctor I trusted, and the outcome turned out to be fatal.
- How will financial issues affect your choices? In Oregon, patients under the Oregon Health Plan have been denied coverage for treatment and offered coverage for suicide instead. See e.g. KATU TV story and video at http://www.katu.com/home/video/26119539.html (about Barbara Wagner). Do you want this to be your choice?
- If your doctor and/or HMO favors assisted suicide, will they let you know about all possible options or will they simply encourage you to kill yourself? The latter option will often involve often less actual work for the doctor and save the HMO money.

In most states, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient received was a lethal prescription, intended to kill him.

Is this where you want to go? Please learn the real lesson from Oregon.

Despite all of the so-called safeguards in our assisted suicide law, numerous instances of coercion, inappropriate selection, botched attempts, and active euthanasia have been documented in the public record.

Protect yourselves and your families. Don't let legalized assisted suicide come to Idaho.

Charles J. Bentz MD
Oregon Health & Sciences University
Portland, OR

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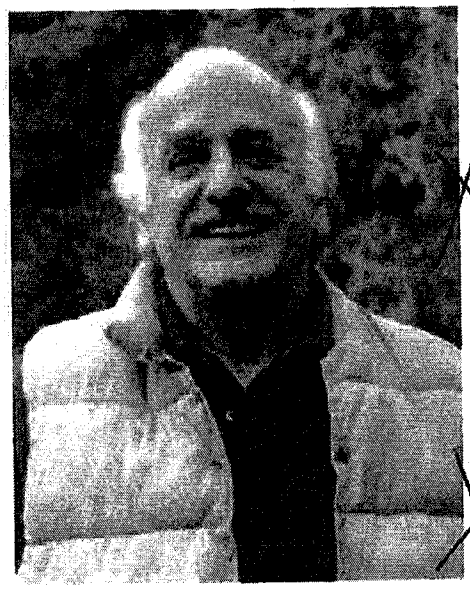
Derek Humphry to be Keynote Speaker at 2011 Annual Meeting



This year our keynote speaker will be Derek Humphry, the author of *Final Exit* and the founder of the Hemlock Society USA in 1980. Derek is generally considered to be the father of the modern movement for choice at the end of life in America.

Save the Date!
Sat., October 22, 2011, 1-3 p.m.
University Unitarian Church
6556 35th Ave NE
Seattle, WA 98115-7393

Derek is a British journalist and author who has lived in the United States since 1978, the same year he published the book *Jean's Way* describing his first wife's final years of suffering from cancer and his part in helping her to die peacefully. The public response to the book caused him to start the Hemlock Society USA in 1980 from his garage in Santa Monica. Years later, the Hemlock Society would become End of Life Choices and then merge with Compassion In Dying to become Compassion & Choices.

In 1991 he published *Final Exit*. Much to his surprise, it became the national #1 bestseller within six months. Since then it has been translated into 12 languages and is now in its fourth edition.

Although not affiliated with – and sometimes even at odds with – Compassion & Choices, Derek is still actively involved in the movement. Always interesting and sometimes controversial, Derek will provide our supporters and their guests with his perspective about the evolution of the movement for choice at the end of life in A

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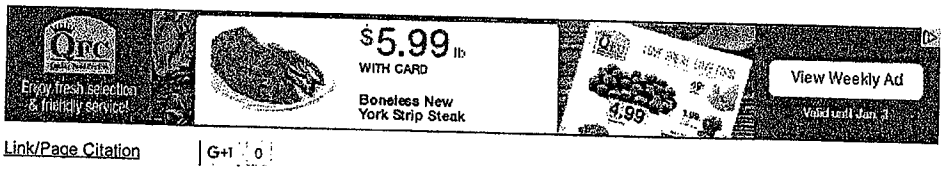
Police kick in door in confusion over suicide kit.



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Byline: Jack Moran The Register-Guard

SPRINGFIELD - The teletype message came Tuesday from the FBI, and it sounded urgent: A Springfield man had purchased a mail-order suicide kit and could be in danger.

Springfield police responded immediately to the man's Harlow Road home. They spoke with the condominium complex's manager, who told officers that he had seen the man carry a bag into his house earlier in the day, police Sgt. Richard Jones said.

Officers knocked on the man's front door, but received no response. After conferring with a police captain who urged them to force their way into the home in case the man needed immediate help, officers kicked in the front door, Jones said.

They soon learned the man was not home.

He was at work - in The Register-Guard's newsroom. And he said he's not at all suicidal.

Furthermore, he's not angry at Springfield police for kicking in his front door and damaging an interior door that had been shut.

"I'm going to put it all down as a misunderstanding," he said. "I thanked (the police officer who spoke with me on the phone about the incident) for taking it seriously and making sure that I was OK."

The Register-Guard employee - who said the complex manager must have seen him toting his gym bag home on Tuesday - agreed to be interviewed on the condition that his name not be used, citing privacy concerns. He said he purchased by mail a helium-hood suicide kit in February from a Southern California company that is now the focus of an ongoing FBI investigation.

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He didn't buy the kit for personal reasons. He mailed a check to The Gladd Group in order to get a suicide kit for reporter Randi Bjornstad, who at the time was researching the sale of the suicide kits for a story that was published March 20.

Bjornstad said she asked her colleague to order one of the kits by following instructions on a website maintained by Derek Humphry, a longtime Junction City resident and pro-suicide advocate whom she had interviewed as part of her research.

Although he claims complete separation from The Gladd Group, which manufactured and sold the devices until the FBI raided the business in late May, Humphry was the sole source, via his books, blog and online videos, for the company's address and the instructions for using the kit to commit suicide.

Bjornstad said she didn't want to raise any red flags that could prevent her from obtaining a kit if someone with The Gladd Group identified her as a reporter who had been researching the device.

The FBI's investigation involving The Gladd Group is ongoing. Since the May raid on the home of the company's owner, 91-year-old Sharlotte Hydorn, the FBI has asked local law enforcement agencies throughout the country to carry out "welfare checks" on people whose names are apparently listed on client lists gleaned from Hydorn's computers.

Jones, the Springfield police sergeant, said the FBI teletype his office received on Tuesday did not state when the Springfield man purchased the suicide kit.

"Nowhere in this teletype does it say that this happened (seven) months ago," Jones said. "It was interpreted by us that they're suggesting that we need to go out now and conduct a welfare assessment."

While Jones said he hopes to follow up with the FBI to ask why they didn't share more detailed information with police, he realizes that many of The Gladd Group's customers have probably bought the kits while contemplating end-of-life decisions.

"Most of them aren't going to be newspaper reporters looking to buy one for a story," Jones said.

In response to the same teletype, a Lane County sheriff's sergeant contacted a local woman who had purchased a kit from Hydorn's company.

"She advised that she bought it as an option in the future, but had no immediate plans" of suicide, sheriff's Lt. Byron Trapp said. He did not know when she bought the kit.

quote →

The sheriff's office will notify the FBI that they spoke with the woman about her purchase, Trapp said.

Responding Tuesday to a Register-Guard reporter's questions about the situation involving the Springfield Register-Guard employee, FBI Special Agent Darrell Foxworth, who works in the agency's San Diego office, issued a brief statement in which he said "that when the FBI receives information that a person may cause harm to themselves or others, we appropriate agency so that agency, at their discretion, and within their own guidelines, may take whatever action they deem appropriate. The FBI does this out of an abundance of caution for the safety of the individual and the public."

A spotlight was cast on the mail-order suicide kit business after a 29-year-old Eugene man committed suicide in December using a helium hood kit. The Register-Guard traced the $60 kit to Hydom, who has no website and does no advertising; clients find her address through the writings of Humphry.

State lawmakers this year approved a bill that makes it a felony to sell suicide kits to Oregonians. Gov. John Kitzhaber signed the bill into law in July.

The Register-Guard employee who purchased the kit in February said that Springfield police apologized and assured him that they would pay for damages to his home. He said the kit is no longer at his residence. Rather, the newspaper has it.

He also pointed out that officers could have simply opened the front door, had they checked underneath his door mat and seen the house key that he had left there earlier in the day for his wife, who had forgotten hers when she went to town.

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Article Details

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Title Annotation: Local News; The FBI message to police about the purchase of the gear failed to mention it was bought seven months ago
Publication: The Register-Guard (Eugene, OR)
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Words: 936
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Next Article: Local man pleads guilty to federal gun charge.
Topics: Suicide

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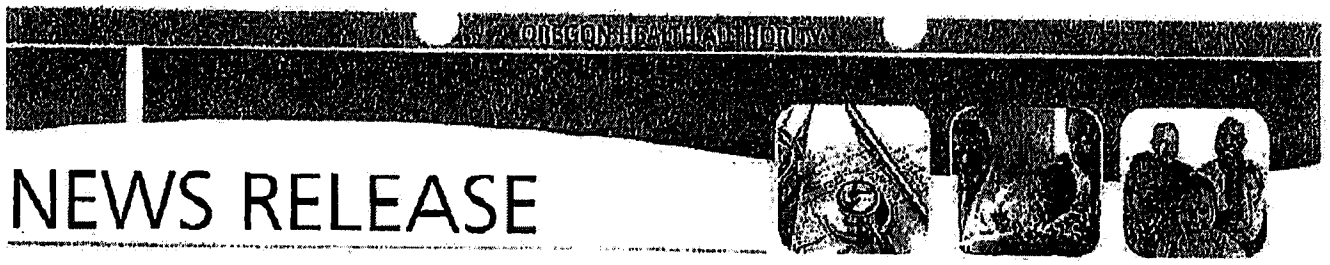


NEWS RELEASE

Date: Sept. 9, 2010

Contact: Christine Stone, Oregon Public Health Information Officer; 971-673-1282, desk; 503-602-8027, cell; christine.l.stone@state.or.us.

Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

Oregon's suicide rate is 35 percent higher than the national average. The rate is 15.2 suicides per 100,000 people compared to the national rate of 11.3 per 100,000. (for 2007)

After decreasing in the 1990s, suicide rates have been increasing significantly since 2000, according to a new report, "Suicides in Oregon: Trends and Risk Factors," from Oregon Public Health. The report also details recommendations to prevent the number of suicides in Oregon.

"Suicide is one of the most persistent yet preventable public health problems. It is the leading cause of death from injuries – more than even from car crashes. Each year 550 people in Oregon die from suicide and 1,800 people are hospitalized for non-fatal attempts," said Lisa Millet, MPH, principal investigator, and manager of the Injury Prevention and Epidemiology Section, Oregon Public Health.

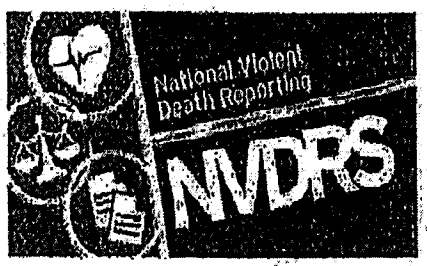
There are likely many reasons for the state's rising suicide rate, according to Millet. The single most identifiable risk factor associated with suicide is depression. Many people can manage their depression; however, stress and crisis can overwhelm their ability to cope successfully.

Stresses such as from job loss, loss of home, loss of family and friends, life transitions and also the stress veterans can experience returning home from deployment – all increase the likelihood of suicide among those who are already at risk.

"Many people often keep their depression a secret for fear of discrimination. Unfortunately, families, communities, businesses, schools and other institutions often discriminate against people with depression or other mental illness. These people will continue to die needlessly unless they have support and effective community-based mental health care," said Millet.

The report also included the following findings:

- There was a marked increase in suicides among middle-aged women. The number of women between 45 and 64 years of age who died from suicide rose 55 percent between 2000 and 2006 — from 8.2 per 100,000 to 12.8 per 100,000 respectively.
-



OREGON

Public Health Division

Suicides in Oregon: Trends and Risk Factors

-2012 Report-

Oregon Violent Death Reporting System

Injury and Violence Prevention Program

Center for Prevention and Health Promotion

Oregon Health Authority

Excerpt
Printed
2/9/14

Executive Summary

Suicide is one of Oregon's most persistent yet largely preventable public health problems. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all Oregonians in 2010. The financial and emotional impacts of suicide on family members and the broader community are devastating and long lasting. This report provides the most current suicide statistics in Oregon that can inform prevention programs, policy, and planning. We analyzed mortality data from 1981 to 2010 and 2003 to 2010 data of the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

Key Findings

In 2010, the age-adjusted suicide rate among Oregonians of 17.1 per 100,000 was 41 percent higher than the national average.

The rate of suicide among Oregonians has been increasing since 2000.

Suicide rates among adults ages 45-64 rose approximately 50 percent from 18.1 per 100,000 in 2000 to 27.1 per 100,000 in 2010. The rate increased more among women ages 45-64 than among men of the same age during the past 10 years.

Suicide rates among men ages 65 and older decreased approximately 15 percent from nearly 50 per 100,000 in 2000 to 43 per 100,000 in 2010.

Men were 3.7 times more likely to die by suicide than women. The highest suicide rate occurred among men ages 85 and over (76.1 per 100,000). Non-Hispanic white males had the highest suicide rate among all races / ethnicity (27.1 per 100,000). Firearms were the dominant mechanism of injury among men who died by suicide (62%).

Approximately 26 percent of suicides occurred among veterans. Male veterans had a higher suicide rate than non-veteran males (44.6 vs. 31.5 per 100,000). Significantly higher suicide rates were identified among male veterans ages 18-24, 35-44 and 45-54 when compared to non-veteran males. Veteran suicide victims were reported to have more physical health problems than non-veteran males.

Psychological, behavioral, and health problems co-occur and are known to increase suicide risk. Approximately 70 percent of suicide victims had a diagnosed mental disorder, alcohol and /or substance use problems, or depressed mood at time of death. Despite the high prevalence of mental health problems, less than one third of male victims and about 60 percent of female victims were receiving treatment for mental health problems at the time of death.

Eviction/loss of home was a factor associated with 75 deaths by suicide in 2009-2010.

Introduction

Suicide is an important public health problem in Oregon. Health surveys conducted in 2008 and 2009 show that approximately 15 percent of teens and four percent of adults ages 18 and older had serious thoughts of suicide during the past year; and about five percent of teens and 0.4 percent of adults made a suicide attempt in the past year[1,2]. In 2010, there were 685 Oregonians who died by suicide and more than 2,000 hospitalizations due to suicide attempts[3,4]. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all ages in Oregon[3]. The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars [3,4,5]. The loss to families and communities broadens the impact of each death.

The cost $

"Suicide is a multidimensional, multi-determined, and multi-factorial behavior. The risk factors associated with suicidal behaviors include biological, psychological, and social factors"[6]. This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2010 and 2003 to 2010 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

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[1] Oregon Healthy Teens 2009 -11th Grade Results, http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/2009/11/Documents/mental11.pdf

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[4] Wright D., Millet L., et al, Oregon Injury and Violence Prevention Program Report for 2011 Data year. Oregon Heath Authority.

[5] Corso P.S., Mercy J.A., Simon T.R., et al, Medical Costs and Productivity Losses Due to Interpersonal and Self-Directed Violence in the United States. Am J Prev Med. 2007;32(6):474–482.

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Original article

Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide

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Depression

ABSTRACT

Background: Despite continuing political, legal and moral debate on the subject, assisted suicide is permitted in only a few countries worldwide. However, few studies have examined the impact that witnessing assisted suicide has on the mental health of family members or close friends.
Methods: A cross-sectional survey of 85 family members or close friends who were present at an assisted suicide was conducted in December 2007. Full or partial Post-Traumatic Distress Disorder (PTSD; Impact of Event Scale–Revised), depression and anxiety symptoms (Brief Symptom Inventory) and complicated grief (Inventory of Complicated Grief) were assessed at 14 to 24 months post-loss.
Results: Of the 85 participants, 13% met the criteria for full PTSD (cut-off ≥ 35), 6.5% met the criteria for subthreshold PTSD (cut-off ≥ 25), and 4.9% met the criteria for complicated grief. The prevalence of depression was 16%; the prevalence of anxiety was 6%.
Conclusion: A higher prevalence of PTSD and depression was found in the present sample than has been reported for the Swiss population in general. However, the prevalence of complicated grief in the sample was comparable to that reported for the general Swiss population. Therefore, although there seemed to be no complications in the grief process, about 20% of respondents experienced full or subthreshold PTSD related to the loss of a close person through assisted suicide.
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1. Introduction

Assisted suicide and euthanasia for terminally ill patients are punishable by law almost everywhere except Switzerland, the Netherlands, Belgium and the U.S. states of Oregon and Washington. Assisted suicide is generally defined as the prescribing or supplying of drugs with the explicit intention of enabling the patient to end his or her own life. In euthanasia, in contrast, it is the physician who administers the lethal drug. In the Netherlands and Belgium, physician-assisted euthanasia is legally permitted, meaning that physicians are allowed to administer drugs to end a patient's life at his or her request. In Switzerland, in contrast, euthanasia is punishable by imprisonment (Article 114 of the Swiss penal code). It is only in the absence of self-serving motives that assisting another person's suicide is permissible. Physicians in Switzerland are therefore allowed to prescribe or supply a lethal dose of barbiturates with the explicit intention of enabling a patient they have examined to end his or her own life. However, most assisted suicides in Switzerland are conducted with the assistance of non-profit organisations [23]. These right-to-die organisations offer personal guidance to members suffering diseases with "poor outcome" or experiencing "unbearable suffering" who wish to die.

The two largest right-to-die organisations in Switzerland are Exit Deutsche Schweiz and Dignitas. Membership of Exit Deutsche Schweiz is available only for people living in Switzerland, whereas Dignitas is also open to people from abroad. Exit Deutsche Schweiz has about 50000 members, and between 100 and 150 people die each year with the organisation's assistance. In comparison, Dignitas has about 6000 members, most of whom live abroad. A member who decides to die must first undergo a medical examination. The physician then prescribes a lethal dose of barbiturates, and the drugs are stored at the Exit headquarters until the day of use. Usually, the suicide takes place at the patient's home. On the day the member decides to die, an Exit volunteer collects the medication and takes it to the patient's home. There, he or she hands the patient the fluid to swallow. If the patient is incapable of swallowing the barbiturate, it can be self-administered by gastrostomy or intravenously [4]. After the patient has died, the Exit volunteer notifies the police. All assisted suicides are reported to the authorities. Deaths through assisted suicide are recorded as unnatural deaths and investigated by the Institute of Legal Medicine.

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THE SENATE
TWENTY-NINTH LEGISLATURE, 2017
STATE OF HAWAII

S.B. NO. 1129 S.D. 2

A BILL FOR AN ACT

RELATING TO HEALTH.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that some states have enacted laws that establish a regulated process to allow their mentally competent adult residents who have a terminal illness with a confirmed prognosis of six or fewer months to live to voluntarily request and receive a prescription medication for self-administration so that they can die in a peaceful, humane manner. These laws, with labels such as "medical aid in dying" laws, "death with dignity" laws, or "end-of-life-options" laws, are based on the concept that the terminally ill person should have the ability to make reasoned end-of-life decisions and choose to end life in a peaceful, humane, and dignified manner or determine how much pain and suffering to endure.

The legislature also finds that Oregon's death with dignity act has been in effect since 1997. Similar laws are also in effect in California, Colorado, Vermont, and Washington. This act is modeled on the Oregon statute and includes safeguards to protect patients. These safeguards include confirmation by two

providers of the patient's diagnosis, prognosis, mental competence, and voluntariness of the request; multiple requests by the patient: an oral request followed by a signed written request that is witnessed by two people, one of whom must be unrelated to the patient, and a subsequent oral restatement of the request; and two waiting periods between the requests and the writing of the prescription. At all times the patient retains the right to rescind the request and is under no obligation to fill the prescription or ingest the medication.

The legislature concludes that terminally ill residents of the State should be able to determine their own medical treatment at the end of their lives.

The purpose of this Act is to enact a medical aid in dying act.

SECTION 2. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately designated and to read as follows:

"CHAPTER

MEDICAL AID IN DYING ACT

§ -1 Definitions. The following terms shall mean as follows:

"Adult" means an individual who is eighteen years of age or older.

"Attending provider" means a physician licensed pursuant to chapter 453 or an advanced practice registered nurse licensed pursuant to chapter 457 who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

"Capable" means that in the opinion of a court or in the opinion of the patient's attending provider or consulting provider, psychiatrist, or psychologist, a patient has the ability to make and communicate health care decisions to health care providers.

"Consulting provider" means a physician licensed pursuant to chapter 453 who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease, but who has not previously assumed responsibility for the care of the patient with the attending provider.

"Counseling" means one or more consultations as necessary between a state-licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is

capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

"Department" means the department of health.

"Health care facility" shall have the same meaning as in section 323D-2.

"Health care provider" means a person licensed, certified, or otherwise authorized or permitted by the law of this State to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

"Informed decision" means a decision by a qualified patient to request and obtain a prescription, which the qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending provider of:

(1) The medical diagnosis;

(2) The prognosis;

(3) The potential risks associated with taking the medication to be prescribed;

(4) The probable result of taking the medication to be prescribed; and

(5) The feasible alternatives, including but not limited to comfort care, hospice care, and pain control.

"Medically confirmed" means the medical opinion of the attending provider has been confirmed by a consulting provider who has examined the patient and the patient's relevant medical records.

"Patient" means a person who is under the care of a physician.

"Physician" means a doctor of medicine or osteopathy licensed to practice medicine pursuant to chapter 453 by the Hawaii medical board.

"Qualified patient" means a capable adult who is a resident of the State and has satisfied the requirements of this chapter in order to obtain a prescription for medication that the qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner.

"Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

§ -2 **Written request for medication; initiated.** (a) An adult who is capable, is a resident of the State, and has been determined by the attending provider and consulting provider to be suffering from a terminal disease, and who has voluntarily expressed the adult's wish to die, may make a written request for medication that the adult may self-administer for the purpose of ending the adult's life in a humane and dignified manner in accordance with this chapter.

(b) No person shall qualify under this chapter solely because of age or disability.

§ -3 **Form of the written request.** (a) A valid request for medication under this chapter shall be in substantially the form described in section -23, signed and dated by the qualified patient and witnessed by at least two individuals who, in the presence of the qualified patient, attest that to the best of their knowledge and belief the qualified patient is of sound mind, acting voluntarily, and is not being coerced to sign the request.

(b) One of the witnesses shall be a person who is not:

(1) A relative of the patient by blood, marriage, or adoption;

(2) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will, trust, or other legal instrument, or by operation of law; or

(3) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(c) The qualified patient's attending provider at the time the request is signed shall not be a witness.

(d) If the qualified patient is a patient in a long-term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility who has qualifications specified by the department of health by rule.

§ -4 **Attending provider responsibilities.** (a) The attending provider shall:

(1) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily; regarding request, not administration

(2) Request that the patient demonstrate residency pursuant to section -13;

(3) To ensure that the patient is making an informed decision, inform the patient of:

(A) The medical diagnosis;

(B) The prognosis;

(C) The potential risks associated with taking the medication to be prescribed;

(D) The probable result of taking the medication to be prescribed; and

(E) The feasible alternatives, including but not limited to comfort care, hospice care, and pain control;

(4) Refer the patient to a consulting provider for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(5) Refer the patient for counseling if appropriate;

(6) Recommend that the patient notify next of kin;

(7) Counsel the patient about the importance of having another person present when the qualified patient self-administers the medication prescribed pursuant to this chapter and of not self-administering the medication in a public place;

concerning the request for the lethal dose, not administration.

(8) Inform the patient that a qualified patient has an opportunity to rescind the request at any time and in any manner, and offer the qualified patient an opportunity to rescind at the time of the qualified patient's second oral request made pursuant to section -9;

(9) Verify, immediately prior to writing the prescription for medication under this chapter, that the qualified patient is making an informed decision;

(10) Fulfill the medical record documentation requirements of section -12;

(11) Ensure that all appropriate steps are carried out in accordance with this chapter prior to writing a prescription for medication to enable a qualified patient to end the qualified patient's life in a humane and dignified manner; and

(12) Either:

(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort; provided that the attending provider

is authorized to dispense controlled substances pursuant to chapter 329, has a current Drug Enforcement Administration certificate, and complies with any applicable administrative rule; or

(B) With the qualified patient's written consent:

(i) Contact a pharmacist of the qualified patient's choice and inform the pharmacist of the prescription; and

(ii) Transmit the written prescription personally, by mail, or electronically to the pharmacist, who will dispense the medications to either the qualified patient, the attending provider, or an expressly identified agent of the qualified patient.

(b) Notwithstanding any other provision of law, an attending provider may sign the qualified patient's death certificate. The death certificate shall list the terminal disease as the immediate cause of death.

§ -5 **Consulting provider confirmation.** Before a patient is qualified under this chapter, a consulting provider shall

examine the patient and the patient's relevant medical records and confirm, in writing, the attending provider's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily, and has made an informed decision.

concerning the request, not administration

§ -6 Counseling referral. If, in the opinion of either the attending provider or the consulting provider, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, the provider shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

§ -7 Informed decision. No qualified patient shall receive a prescription for medication to end the qualified patient's life in a humane and dignified manner unless the qualified patient has made an informed decision. Immediately prior to writing a prescription for medication under this chapter, the attending provider shall verify that the qualified patient is making an informed decision.

§ -8 **Family notification.** The attending provider shall recommend that the qualified patient notify the next of kin of the qualified patient's request for medication pursuant to this chapter. A qualified patient who declines or is unable to notify next of kin shall not have the qualified patient's request denied for that reason.

§ -9 **Written and oral requests.** To receive a prescription for medication that a qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to the qualified patient's attending provider not less than fifteen days after making the initial oral request. At the time the qualified patient makes the second oral request, the attending provider shall offer the qualified patient an opportunity to rescind the request.

§ -10 **Right to rescind request.** A qualified patient may rescind the request at any time and in any manner without regard to the qualified patient's mental state. No prescription for medication under this chapter may be made available pursuant to section -4(a)(12) without the attending provider having

offered the qualified patient an opportunity to rescind the request made pursuant to section -9.

§ -11 **Waiting periods.** Not less than fifteen days shall elapse between the qualified patient's initial oral request and the taking of steps to make available a prescription for medication pursuant to section -4(a)(12). Not less than forty-eight hours shall elapse between the qualified patient's written request and the taking of steps to make available a prescription for medication pursuant to section -4(a)(12).

§ -12 **Medical record; documentation requirements.** The following shall be documented or filed in a qualified patient's medical record:

(1) All oral requests by the qualified patient for medication to end the qualified patient's life in a humane and dignified manner;

(2) All written requests by the qualified patient for medication to end the qualified patient's life in a humane and dignified manner;

(3) The attending provider's diagnosis and prognosis and determination that the qualified patient is capable, acting voluntarily, and has made an informed decision regarding the request for the lethal dose, not administration

(4) The consulting provider's diagnosis and prognosis and verification that the qualified patient is capable, acting voluntarily, and has made an informed decision;

(5) A report of the outcome and determinations made during counseling, if performed;

(6) The attending provider's offer to the qualified patient to rescind the patient's request at the time of the qualified patient's second oral request made pursuant to section -9; and

(7) A note by the attending provider indicating that all requirements under this chapter have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

§ -13 **Residency requirement.** Only requests made by residents of this State under this chapter shall be granted. Factors demonstrating state residency include but are not limited to:

(1) Possession of a Hawaii driver's license or civil identification card;

(2) Registration to vote in Hawaii;

regarding request for lethal dose, not administration

(3) Evidence that the person owns or leases property in Hawaii; or

(4) Filing of a Hawaii tax return for the most recent tax year.

§ **-14 Reporting requirements.** (a) The department shall annually review a sample of records maintained pursuant to this chapter.

(b) The department shall require any health care provider, upon dispensing medication pursuant to this chapter, to file a copy of the dispensing record with the department.

(c) The department shall adopt rules to facilitate the collection of information regarding compliance with this chapter. Except as otherwise required by law, the information collected shall not be a public record and shall not be made available for inspection by the public. The department shall retain and exercise reasonable care in maintaining the information collected; provided that the information shall not be subject to any disposal or destruction of records requirements.

(d) The department shall generate and make available to the public an annual statistical report of information collected under subsection (c).

§ -15 **Disposal of unused medication.** A person who has custody or control of any unused medication dispensed under this chapter after the death of a qualified patient shall personally deliver the unused medication for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means.

§ -16 **Effect on construction of wills or contracts.** (a) No provision in a will or contract, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end the person's life in a humane and dignified manner, shall be valid.

(b) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end the person's life in a humane and dignified manner.

§ -17 **Insurance or annuity policies.** The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end the person's life in a humane and dignified manner. A qualified patient's act of ingesting medication to end the qualified patient's life in a humane and dignified manner shall have no effect upon a life, health, or accident insurance or annuity policy.

§ -18 **Construction of chapter.** Nothing in this chapter shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this chapter shall not, for any purpose, constitute suicide, assisted suicide, mercy killing, murder, manslaughter, negligent homicide, or any other criminal conduct under the law.

§ -19 **Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions.** (a) Except as provided in section -20:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating or acting in good faith compliance with this chapter, including being present when a qualified patient takes the prescribed medication to end the qualified patient's life in a humane and dignified manner;

(2) No professional organization or association or health care provider may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter;

(3) No request by a qualified patient for or provision by an attending provider of medication in good faith compliance with this chapter shall constitute neglect, harm, self-neglect, or abuse for any purpose of law or provide the sole basis for the appointment of a guardian or conservator;

(4) No health care provider shall be under any duty, whether by contract, by statute, or by any other legal

requirement, to participate in the provision to a qualified patient of medication to end the qualified patient's life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers the patient's care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider; and

(5) No health care facility shall be subject to civil or criminal liability for acting in good faith compliance with this chapter including but not limited to the designation of a witness for a qualified patient who makes a written request when residing in a long-term care facility pursuant to section -3(d).

(b) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider from participating in actions covered by this chapter on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider's

policy regarding participation in actions covered by this chapter. Nothing in this subsection shall prevent a health care provider from providing health care services to a patient that do not constitute participation in actions covered by this chapter.

(c) Subsection (a) notwithstanding, a health care provider may subject another health care provider to the following sanctions, if the sanctioning health care provider has notified the sanctioned health care provider prior to participation in actions covered by this chapter that it prohibits participation in actions covered by this chapter:

(1) Loss of privileges, loss of membership, or other sanction provided pursuant to the medical staff bylaws, policies, and procedures of the sanctioning health care provider if the sanctioned health care provider is a member of the sanctioning provider's medical staff and participates in actions covered by this chapter while on the health care facility premises of the sanctioning health care provider, but not including the private medical office of a physician or other health care provider;

(2) Termination of lease or other property contract or other nonmonetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned health care provider participates in actions covered by this chapter while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(3) Termination of contract or other nonmonetary remedies provided by contract if the sanctioned health care provider participates in actions covered by this chapter while acting in the course and scope of the sanctioned health care provider's capacity as an employee or independent contractor of the sanctioning health care provider; provided that nothing in this paragraph shall be construed to prevent:

(A) A health care provider from participating in actions covered by this chapter while acting outside the course and scope of the health care

provider's capacity as an employee or independent contractor; or

(B) A patient from contracting with the patient's attending provider and consulting provider to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(d) A health care provider that imposes sanctions pursuant to subsection (c) shall follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(e) For the purposes of this section:

"Notify" means a separate statement in writing to the health care provider specifically informing the health care provider prior to the health care provider's participation in actions covered by this chapter of the sanctioning health care provider's policy regarding participation in actions covered by this chapter.

"Participate in actions covered by this chapter" means to perform the duties of an attending provider pursuant to section

-4, the consulting provider function pursuant to section -5, or the counseling referral function pursuant to section -6. The term does not include:

(1) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(2) Providing information about this chapter to a patient upon the request of the patient;

(3) Providing a patient, upon the request of the patient, with a referral to another physician; or

(4) A patient contracting with the patient's attending provider and consulting provider to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(f) Action taken pursuant to sections -4 to -6 shall not be the sole basis for disciplinary action under section 453-8 or section 457-12.

(g) This chapter shall not be construed to allow a lower standard of care for patients in the community where the patient is treated or in a similar community.

§ **-20 Prohibited acts; penalties.** (a) A person who without the authorization of a qualified patient intentionally alters or forges a request for medication or conceals or destroys a rescission of that request to cause the patient's death shall be guilty of a class A felony.

(b) A person who coerces or exerts undue influence on a qualified patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of the request, shall be guilty of a class A felony.

(c) A person who, without authorization of a qualified patient, intentionally alters, forges, conceals, or destroys an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting a qualified patient's desires and interests, with the intent and effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition and hydration that hastens the death of the qualified patient, shall be guilty of a class A felony.

(d) Except as provided in subsection (c), it shall be a misdemeanor for a person without authorization of a qualified patient to intentionally alter, forge, conceal, or destroy an

instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the principal's desires and interests with the intent or effect of affecting a health care decision.

(e) Nothing in this section shall limit any liability for civil damages resulting from any negligent conduct or intentional misconduct by any person.

(f) The penalties in this chapter are cumulative and do not preclude criminal penalties pursuant to other applicable state law.

§ **-21 Claims by governmental entity for costs incurred.** Any government entity that incurs costs resulting from a person terminating the person's life pursuant to this chapter in a public place shall have a claim against the estate of the person to recover costs and reasonable attorneys' fees related to enforcing the claim.

§ **-22 Severability.** Any provision of this chapter that is held invalid as to any person or circumstance shall not affect the application of any other provision of this chapter that can be given full effect without the invalid section or application.

§ **-23 Form of the request.** A request for a medication as authorized by this chapter shall be in substantially the following form:

"REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

I am suffering from _____, which my attending provider has determined is a terminal disease and that has been medically confirmed by a consulting provider.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care, and pain control.

I request that my attending provider prescribe medication that I may self-administer to end my life in a humane and ~~dignified~~ manner.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my attending provider has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress or to have been induced by fraud, or subjected to undue influence when signing the request; and

(d) Is not a patient for whom either of us is the attending provider.

_____Witness 1 Date_____

_____Witness 2 Date_____

NOTE: One witness shall not be a relative (by blood, marriage, or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death, and shall not own, operate, or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a long-term care facility, one of the witnesses shall be an individual designated by the facility who has qualifications specified by the Department of Health by rule.""

SECTION 3. Section 327E-13, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) This chapter shall not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of this State[~~.~~]; provided that this subsection shall not apply to actions taken under chapter ."

One of two witnesses on the lethal dose request form is not allowed to be an heir who will financially benefit from the death. The other witness can be

SECTION 4. Section 327H-2, Hawaii Revised Statutes, is amended by amending subsection (b) to read as follows:

"(b) Nothing in this section shall be construed to:

(1) Expand the authorized scope of practice of any licensed physician;

(2) Limit any reporting or disciplinary provisions applicable to licensed physicians and surgeons who violate prescribing practices; and

(3) Prohibit the discipline or prosecution of a licensed physician for:

(A) Failing to maintain complete, accurate, and current records that document the physical examination and medical history of a patient, the basis for the clinical diagnosis of a patient, and the treatment plan for a patient;

(B) Writing false or fictitious prescriptions for controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 United States Code 801 et seq. or in chapter 329;

(C) Prescribing, administering, or dispensing pharmaceuticals in violation of the provisions of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 United States Code 801 et seq. or of chapter 329;

(D) Diverting medications prescribed for a patient to the licensed physician's own personal use; and

(E) Causing, or assisting in causing, the suicide, euthanasia, or mercy killing of any individual; provided that it is not "causing, or assisting in causing, the suicide, euthanasia, or mercy killing of any individual" to prescribe, dispense, or administer medical treatment for the purpose of treating severe acute pain or severe chronic pain, even if the medical treatment may increase the risk of death, so long as the medical treatment is not also furnished for the purpose of causing, or the purpose of assisting in causing, death for any reason[~~.~~]; provided that this subparagraph shall not apply to actions taken under chapter ____."

SECTION 5. Section 707-701.5, Hawaii Revised Statutes, is amended by amending subsection (1) to read as follows:

"(1) Except as provided in section 707-701, a person commits the offense of murder in the second degree if the person intentionally or knowingly causes the death of another person[~~.~~]; provided that this section shall not apply to actions taken under chapter ."

SECTION 6. Section 707-702, Hawaii Revised Statutes, is amended by amending subsection (1) to read as follows:

"(1) A person commits the offense of manslaughter if:

(a) The person recklessly causes the death of another person; or

(b) The person intentionally causes another person to commit suicide[~~.~~];

provided that this section shall not apply to actions taken under chapter ."

SECTION 7. The department of health shall submit a report that includes but is not limited to:

(1) An annual statistical report of the information collected pursuant to section -14(d), Hawaii Revised Statutes;

(2) An annual analysis of the implementation of the medical aid in dying act under chapter , Hawaii Revised Statutes, including any implementation problems; and

(3) Any proposed legislation,

to the legislature no later than twenty days prior to the convening of each regular session.

SECTION 8. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

SECTION 9. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 10. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 11. This Act shall take effect upon its approval.

Dear State of Hawaii, House of Representatives, Committee on Health. Chair, Vice Chair and Representatives:
Testimony in opposition to bill SB 1128, SD2

There is strong opposition against bill SB1129 SD2 from the physical health community, physicians, nurses and from the mental health community due to the bill in its current state is flawed because in part it does not address the root issue of the person who may be requesting the lethal dose of medication to end their life.

A few years ago when former speaker of the House Ms. Nancy Pelosi, declared from our Federal House of Representatives that "if we legislate it, it is moral". This brought government into a new slippery slope because most would interpret the above statement that government is our new god.

There is great concern that the government placing itself in the position as legislating death thru a prescribed method and procedure is not the position which government should take.

When Rosalyn H. Baker in her opening memo to the President of the Senate, Ronald D. Kouchi, that she could not note any abuses of the current Death with Dignity law of Oregon, it was true but is not the current situation in Oregon. As quoted below from Oregon:

“We are not given the resources to investigate [assisted-suicide cases] and not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves.” [1]
— Dr. Katrina Hedberg, Oregon Department of Human Services

Oregon discourages investigation of abuses of its death with dignity law and he physicians are discouraged from investigation therefore documentation from within the system of the abuses may not be available from within the system but the abuses are well known and my attachments to my testimony provide many examples.

Examples include
- Coercion
- Lethal medication given to wrong person
- Legal procedures not followed.
- Requirement of the person who receives the lethal dosage should have only 180 days to live, but there is documentation of a person who received the death dosages, lived over 1000 days.
- Pressure on families to allow premature death of loved ones due to outside of family and finances pressures.

One interesting item to note in the Oregon legislature and resultants is that pain is not mentioned.

When this current bill is marketed, in the minds eye of the people of the State of Hawaii, usually the picture is a person in dire need of relief from pain and a method to end life of unmanageable conditions, but that is not in this legislature, pain is not mentioned.

As in the Hawaii legislation, as what the resultants of Oregon are, a health person who may be diagnosed with a terminal condition can ask for lethal medication and receive it. Unfortunately it can be acquired from an "Attending Provider", and not the attending physician of the person. There is no qualification for the attending provider to be knowledgeable in the status of the condition of the person in order to make an informed decision to recommend ending life of the person who may be requesting the lethal medication.

This bill will create a new industry of the "Attending Provider" of a licensed physician or a registered nurse but there is no qualification of these persons to be skilled in the medical areas which the person requesting the medication may be requiring. This bill exempts those involved from legal prosecution which leaves the door open for abuse and the same resultants of the Oregon studies, which effectively sweeps fraud, waste and abuse under the carpet.

BELOW IS ANCILLARY RESEARCH DOCUMENTATION IN SUPPORT OF SJ MELENDREZ, DRSJMEL@GMAIL.COM TESTIMONY IN OPPOSITION TO BILL SB 1129, SD2, DEATH BILL

Some Oregon and Washington State Assisted Suicide Abuses and Complications

"We are not given the resources to investigate [assisted-suicide cases] and not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves." [1]
— Dr. Katrina Hedberg, Oregon Department of Human Services

Under Oregon and Washington State's lax oversight, these are some of the documented abuses and complications that have come to light. This list includes abuses and medical complications, as well as other incidents showing some of the harms and dangers that accompany assisted suicide laws.

Doctor Shopping Gets Around Any "Safeguards"

- **Kate Cheney,**[1] 85, died by assisted suicide under Oregon's law even though she had early dementia. Her physician had declined to provide the lethal prescription. Her managed care provider then found another physician to prescribe the lethal dose. The second physician ordered a psychiatric evaluation, which found that Cheney lacked "the very high level of capacity required to weigh options about assisted suicide." Cheney's request was denied, and her daughter "became angry." Another evaluation took place, this time with a psychologist who insisted on meeting Cheney alone. Disturbingly, the psychologist deemed Cheney competent while still noting that her "choices may be influenced by her family's wishes and her daughter, Erika, may be somewhat coercive." Cheney soon took the drugs and died, but only after spending a week in a nursing home.
- **The first known assisted suicide death** [2] under the Oregon law was that of a woman in her mid-eighties who had been battling breast cancer for twenty-two years. Initially, two doctors, including her own physician who believed that her request was due to depression, refused to prescribe lethal drugs. Compassion & Choices—then operating under the name Compassion in Dying, although originally called The Hemlock Society—became involved in the case and referred the woman to a doctor willing to write the prescription.

  Dr. Peter Goodwin, the group's former Medical Director, said that about 75 percent of those who died using Oregon's assisted suicide law through the end of 2002 did so with the organization's assistance.[3] In one example year, during 2003, the organization was involved in 79 percent of reported assisted suicide deaths. [4] According to Dr. Elizabeth Goy of Oregon Health and Science University, Compassion in Dying sees "almost 90 percent of requesting Oregonians…" [5] "In 2008 the proportion of C&C PAS deaths significantly increased to 88 percent (53/60) of all reported deaths."[6] And in 2009, 57 of the 59 assisted suicide deaths were Compassion & Choices clients. But then they ceased to provide further information.[7]

Depression and Psychiatric Disability

- **Michael Freeland,**[8] age 64, had a 43-year medical history of acute depression and suicide attempts. Yet when Freeland saw a doctor about arranging an assisted suicide, the physician said he didn't think that a psychiatric consultation was "necessary." But the law's supporters frequently insist that as a key safeguard, depressed people are ineligible. When Freeland chanced to find improved medical and suicide prevention services, he was able to reconcile with his estranged daughter and lived two years post-diagnosis. Oregon's statistics for the years 2011 – 2014 show that each year, only 3% of patients (or fewer) were referred for psychological evaluation or counseling before receiving their prescriptions for lethal drugs.[9] N. Gregory Hamilton, M.D., Distinguished Fellow of the American Psychiatric

Association, demonstrated how Oregon's flimsy safeguards do not protect people with psychiatric and other mental health disabilities.[10] Moreover, a majority of clinical and forensic psychiatrists believe "that the presence of major depressive disorder should result in an automatic finding of incompetence" to make decisions about assisted suicide.[11] And only six percent of Oregon psychiatrists are confident they can diagnose depression after one visit,[12] yet the Oregon and Washington State definitions of a psychiatric consultation permit one visit only.[13]

- **Absence of psychiatric consultation:** This case is about what can happen when competent psychiatric consultation is not provided. "[A] woman in her mid-fifties with severe heart disease . . . requested assisted suicide from her cardiologist, despite having little discomfort and good mobility. She was referred to another doctor, who in turn referred her to a physician willing to provide assisted suicide. That doctor determined that the woman had more than six months to live, according to his best estimate. She was eventually dismissed as ineligible. Rather than inquire further into possible causes of [her] suicidal despair [or refer her for psychiatric treatment], the physician apparently considered … his responsibility ended. … [H]e told her to go back and make yet another appointment with her original physician and dismissed her. She killed her self the next day."[14]

Economic Pressures and Coercion

- **Linda Fleming**, the first to use the WA state law, was divorced, had had financial problems, had been unable to work due to a disability, and was forced to declare bankruptcy. Yet the Director of Compassion & Choices of Washington said that her situation presented "none of the red flags" that might have given his group pause in supporting her request for death.[15] But we are told by proponents that financial pressures have never played a role.
- **Thomas Middleton** was diagnosed with Lou Gehrig's disease, moved into the home of Tami Sawyer in July 2008, and died by assisted suicide later that very month. Middleton had named Sawyer his estate trustee and put his home in her trust. Two days after Thomas Middleton died, Sawyer listed the property for sale and deposited $90,000 into her own account.[16] It took a federal investigation into real estate fraud to expose this abuse. Sawyer was indicted for first-degree criminal mistreatment and first-degree aggravated theft, partly over criminal mistreatment of Thomas Middleton. But the Oregon state agency responsible for the assisted suicide law never even noticed.

Self-Administration

- **Patrick Matheny**[17] received his assisted suicide prescription by Federal Express. He couldn't take the drugs by himself so his brother-in-law helped. Commenting on the Matheny case, Dr. Hedberg of Oregon Department of Human Services said that "we do not know exactly how he helped this person swallow, whether it was putting a feed tube down or whatever, but he was not prosecuted …" The state's official annual report on assisted suicide deaths did not take note of this violation of the Oregon law. Proponents regularly insist that the law's self-administration requirement is a key safeguard against abuse that is scrupulously followed, and that Oregon's reports have thoroughly reflected all key circumstances as the law has unfolded.
- **Another anonymous patient:** Dr. David Jeffrey wrote, "The question of administration is a delicate one, a patient even had a PEG feeding tube inserted solely to allow him to have PAS [physician assisted suicide]."[18] Concern about the fate of unused lethal barbiturates is compounded by the fact that the Oregon law does not necessarily require that the drugs be ingested by mouth. Barbara Glidewell, Patient Advocate at Oregon Health & Science University, said that patients who cannot swallow would "need to have an NG tube or G tube placement … [Then, they could] express the medication through a large bore syringe that would go into their G tube."[19] Kenneth R. Stevens, Jr. MD, former Chairman of Radiation Oncology at Oregon Health & Science University, observed that since the lethal agent can be administered to a willing person through a feeding tube, it is equally possible to administer it to an

unwilling person by the same means. Moreover, once injectable pentobarbital leaves the pharmacy, there is nothing to prevent it from being used through an intravenous (IV) line, or as a lethal injection. If a patient or someone assisting appears to have used a feeding tube or an injection, abuse is far more difficult to detect and prove.[20] Yet, supporters of the Oregon law allege that assisted suicide is totally voluntary by virtue of the fact that the individual alone must actually swallow the lethal agents.

Deadly Mix Between Our Broken Health Care System & Assisted Suicide

- **Barbara Wagner & Randy Stroup:** What happened to these patients underscores the danger of legalizing assisted suicide in the context of our broken U.S. health care system. **Wagner**, a 64-year-old great-grandmother, had recurring lung cancer. Her physician prescribed Tarceva to extend her life. Studies show the drug provides a 30 percent increased survival rate for patients with advanced lung cancer, and patients' one-year survival rate increased by more than 45 percent. But the Oregon Health Plan sent Wagner a letter saying the Plan would not cover the beneficial chemotherapy treatment "but … it would cover … [among other things,] physician-assisted suicide." **Stroup** was prescribed Mitoxantrone as chemotherapy for his prostate cancer. His oncologist said the medication's benefit has been shown to be "not huge, but measurable"; while the drug may not extend a patient's life by very long, it helps make those last months more bearable by decreasing pain.[21] Yet Stroup also received a letter saying that the state would not cover his treatment, but would pay for the cost of, among other things, his physician-assisted suicide.[22]

  These treatment denials were based on an Oregon Medicaid rule that denies surgery, radiotherapy, and chemotherapy for patients with a less than a five-percent expectation of five-year survival. H. Rex Greene, M.D., retired, former Medical Director of the Dorothy E. Schneider Cancer Center at Mills Health Center in San Mateo, CA and formerly a member of the AMA Ethics Council, called this rule "an extreme measure that would exclude most treatments for cancers such as lung, stomach, esophagus, and pancreas. Many important non-curative treatments would fail the five-percent/five-year criteria."[23] Though called free choice, when insurers won't pay, assisted suicide is a phony form of freedom.

Breakdown in Rules Attendant to Changing the Law

The following cases were caused be **legal erosion and the breakdown in rules and codes of conduct** associated with assisted suicide laws, rules and codes that elsewhere protect health care patients.

- **Wendy Melcher**[24] died in August 2005 after two Oregon nurses, Rebecca Cain and Diana Corson, gave her overdoses of morphine and phenobarbital. They claimed Melcher had requested an assisted suicide, but they administered the drugs without her doctor's knowledge, in clear violation of Oregon's law. No criminal charges have been filed against the two nurses. The case prompted one newspaper to write, "If nurses—or anyone else—are willing to go outside the law, then all the protections built into [Oregon's] Death with Dignity Act are for naught."[25]
- **Annie O. Jones, John Avery, and three other patients** were killed by illegal overdoses of medication given to them by a nurse, and none of these cases have been prosecuted in Oregon.[26]

Medical Complications

Assisted suicide proponents and medical personnel alike have established that taking lethal drugs by mouth is often ineffective in causing a quick and simple death. The body sometimes expels the drugs through vomiting, or the person falls into a lengthy state of unconsciousness rather than dying promptly, as assisted suicide advocates

wish. Such ineffective suicide attempts happen in a substantial percentage of cases—estimates range from 15 percent to 25 percent.[27]

- **Peaceful death?** Speaking at Portland Community College, pro-assisted-suicide attorney Cynthia Barrett[28] described one botched assisted suicide. "The man was at home. There was no doctor there" … . "After he took it [the lethal dose], he began to have … physical symptoms … that were hard for his wife to handle. Well, she called 911." He was taken to a local Portland hospital and revived, then to a local nursing facility. "I don't know if he went back home. He died shortly – some … period of time after that … ."

  Commenting on this botched assisted suicide case, The Oregonian editorial columnist David Reinhard observed, "The Health Division knows nothing [about this case], … through no fault of its own. Why? Because the doctor who wrote the prescription, the emergency medical technicians and the hospital reported nothing. Why? Because [the assisted-suicide law]reporting requirements are a sham."
- **David Prueitt**[29] took his prescribed lethal overdose in the presence of his family and members of the assisted-suicide advocacy group Compassion & Choices. After being unconscious for 65 hours, he awoke. His family leaked the failed assisted suicide to the media. Oregon DHS issued a release saying it "has no authority to investigate individual Death with Dignity cases."[30]

Impacts by Doctors and Their Quality of Care

- **Kathryn Judson** wrote of bringing her seriously ill husband to the doctor in Oregon. "I collapsed in a half-exhausted heap in a chair once I got him into the doctor's office, relieved that we were going to get badly needed help (or so I thought)," she wrote. "To my surprise and horror, during the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. 'Think of what it will spare your wife, we need to think of her' he said, as a clincher."[31] According to prescribing doctors, 40% of people who died by assisted suicide reported feeling like a burden on family and caregivers as a reason for requesting lethal drugs.[32]
- **By contrast: Jeanette Hall** of Oregon was diagnosed with cancer in 2000 and told she had six months to a year to live. She knew about the assisted suicide law, and asked her doctor about it, because she didn't want to suffer. Her doctor encouraged her not to give up, and she decided to fight the disease. She underwent chemotherapy and radiation. Eleven years later, she wrote, "I am so happy to be alive! If my doctor had believed in assisted suicide, I would be dead. … Assisted suicide should not be legal."[33] Unfortunately, not all doctors are like Jeanette Hall's.

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[3] *Transcript of tape of Peter Goodwin*, Oregon, January 11, 2003, Presentation at 13th National Hemlock Society Biennial Conference, "Charting a New Course, Building on a Solid Foundation, Imagining a Brighter Future for America's Terminally Ill," January 9 – 12, 2003, Bahia Resort Hotel, San Diego, California.

[4] Compassion in Dying of Oregon, *Summary of Hastened Deaths*, data attached to Compassion in Dying (now called Compassion and Choices) of Oregon's IRS Form 990 for 2003.

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[10] Hamilton, *op. cit*.

[11] Linda Ganzini, M.D., Gregory B. Leong, M.D., Darien S. Fenn, Ph.D., J. Arturo Silva, M.D., and Robert Weinstock, M.D., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, American Journal of Psychiatry, Vol. 157, April 2000, pp. 595 and 598.

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[14] N. Gregory Hamilton, *Oregon's Culture of Silence, in The Case against Assisted Suicide: For the Right to End-of-Life Care*, supra note 2, at 175, 188.

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[19] Letter from Barbara Glidewell, included in testimony transcript, House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]* Vol. II, p. 268, number 3; p. 270, question 623; p. 275, question 653.

[20] Kenneth R. Stevens, Jr., M.D., personal communication to Marilyn Golden, Disability Rights Education & Defense Fund, July 8, 2009; information on lethal drugs based on data taken from Oregon Public Health Division, Death with Dignity Act Annual Reports.

[21] Kenneth R. Stevens, Jr., M.D., *Oregon Rationing Cancer Treatment But Offering Assisted Suicide to Cancer Patients—Paying to Die But Not to Live* , Physicians for Compassionate Care Educational Foundation, June 6, 2008, (accessed July 9, 2009). Stevens is Professor Emeritus and former Chairman of Radiation Oncology at Oregon Health & Science University.

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[26] *Nursing Chaos – Is Oregon State Board of Nursing Protecting Nurses at the Expense of Public Safety*, Portland Tribune, May 7, 2006.

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[31] Kathryn Judson, *Assisted Suicide? "I was afraid to leave my husband alone again with doctors and nurses,"* Letter to the Editor, Hawai'I Free Press, February 15, 2011, accessed March 15, 2015,

[32] *Oregon Death with Dignity Act Annual Reports* , Oregon Health Authority Public Health Division.

[33] Jeanette Hall letter to the editor , Boston Globe, October 4, 2011, accessed June 1, 2012.

One of the most frequently repeated claims by proponents of assisted suicide laws is that there is "no evidence or data" to support any claim that these laws are subject to abuse, and that there has not been "a single documented case of abuse or misuse" in the 18 reported years.

These claims are demonstrably false.

Regarding documented cases, please refer to a compilation of individual cases and source materials pulled together by the Disability Rights Education and Defense Fund entitled Oregon and Washington State Abuses and Complications.

For an in-depth analysis of several cases by Dr. Herbert Hendin and Dr. Kathleen Foley, please read "Physician-Assisted Suicide in Oregon: A Medical Perspective."

The focus of the discussion below is the Oregon Health Division data. These reports are based on forms filed with the state by the physicians who prescribe lethal doses and the pharmacies that dispense the drugs. As the early state reports admitted:

"As best we could determine, all participating physicians complied with the provisions of the Act. . . . Under reporting and noncompliance is thus difficult to assess because of possible repercussions for noncompliant physicians reporting to the division."

Further emphasizing the serious limits on state oversight under the assisted suicide law, Oregon authorities also issued a release in 2005 clarifying that they have No authority to investigate a "Death with Dignity" case.

Nevertheless, contrary to popular belief and despite these extreme limitations, the Oregon state reports substantiate some of the problems and concerns raised by opponents of assisted suicide bills.

Non-Terminal Disabled Individuals Are Receiving Lethal Prescription In Oregon

The Oregon Health Division assisted suicide reports show that non-terminal people receive lethal prescriptions every year.

The prescribing physicians' reports to the state include the time between the request for assisted suicide and death for each person. However, the online state reports do not reveal how many people outlived the 180-day prediction. Instead, the reports give that year's median and range of the number of days between the request for a lethal prescription and death. This is on page 7 of the 2015 annual report.

In 2015, at least one person lived 517 days; across all years, the longest reported duration between the request for assisted suicide and death was 1,009 days. In every year except the first year, the reported upper range is significantly longer than 180 days.

The definition of "terminal" in the statute only requires that the doctor predict that the person will die within six months. There is no requirement that the doctor consider the likely impact of medical treatment in terms of survival, since people have the right to refuse treatment.

Unfortunately, while terminal predictions of some conditions, such as some cancers, are fairly well established, this is far less true six months out, as the bill provides, rather than one or two months before death, and is even less true for other diseases. Add the fact that many conditions will or may become terminal if certain medications or routine treatments are discontinued – e.g., insulin, blood thinners, pacemaker, CPAP [: Continuous Positive Airway Pressure]– and "terminal" becomes a very murky concept.

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The state report's footnote about "other" conditions found eligible for assisted suicide has grown over the years, to include:

". . . benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease."

Overall in 2015, 7% (68 individuals) had conditions classified as "other." In addition, it should be noted that the attending physician who determines terminal status and prescribes lethal drugs is not required to be an expert in the disease condition involved, nor is there any information about physician specialties in the state reports.

The Only Certifiers of Non-Coercion And Capability Need Not Know the Person

Four people are required to certify that the person is not being coerced to sign the assisted suicide request form, and appears capable: the prescribing doctor, second-opinion doctor, and two witnesses.

In most cases, the prescribing doctor is a doctor referred by assisted suicide proponent organizations. See, M. Golden, Why Assisted Suicide Must Not Be Legalized, section on "Doctor Shopping" and related citations.

The Oregon state reports say that the median duration of the physician patient relationship is 12 weeks. Thus, lack of coercion is not usually determined by a physician with a longstanding relationship with the patient. This is significant in light of well-documented elder abuse-identification and reporting problems among professionals in a society where an estimated one in ten elders is abused, mostly by family and caregivers. (Lachs, et al., New England Journal of Medicine, Elder Abuse.)

The witnesses on the request form need not know the person either. One of them may be an heir (which would not be acceptable for witnessing a property will), but neither of them needs actually know the person (the form says that if the person is not known to the witness, then the witness can confirm identity by checking the person's ID).

So neither doctors nor witnesses need know the person well enough to certify that they are not being coerced.

No Evidence of Consent or Self-Administration At Time of Death

In about half the reported cases, the Oregon Health Division reports also state that no health care provider was present at the time of ingestion of the lethal drugs or at the time of death. Footnote six clarifies:

"A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010."

While the only specific example mentioned is the "time of death," other "circumstances surrounding death" include whether the lethal dose was self-administered and consensual at the time of death. Therefore, although "self administration" is touted as one of the key "safeguards", in about half the cases, there is no evidence of consent or self-administration at the time of ingestion of the lethal drugs.

If the drugs were, in some cases, administered by others without consent, no one would know. The request form constitutes a virtual blanket of legal immunity covering all participants in the process.

Pain Is Not the Issue, Unaddressed Disability Concerns Are

The top five reasons doctors give for their patients' assisted suicide requests are not pain or fear of future pain, but psychological issues that are all-too-familiar to the disability community:

"loss of autonomy" (92%), "less able to engage in activities" (90%), "loss of dignity" (79%), "losing control of bodily functions" (48%), and "burden on others" (41%).

These reasons for requesting assisted suicide pertain to disability and indicate that over 90% of the reported individuals, possibly as many as 100%, are disabled.

Three of these reasons (loss of autonomy, loss of dignity, feelings of being a burden) could be addressed by consumer-directed in-home long-term care services, but no disclosures about or provision of such services is required. Some of the reported reasons are clearly psycho-social and could be addressed by disability-competent professional and peer counselors, but this is not required either. Moreover, only 5.3% of patients who request assisted suicide were referred for a psychiatric or psychological evaluation, despite studies showing the prevalence of depression in such patients.

Basically, the law operates as though the reasons don't matter, and nothing need be done to address them.

Conclusion

The Oregon assisted suicide data demonstrates that people who were not actually terminal received lethal prescriptions in all 18 reported years except the first, and that there is little or no substantive protection against coercion and abuse. Moreover, reasons for requesting assisted suicide that sound like a "cry for help" with disability-related concerns are apparently ignored. Thus, the data substantiates problems with the implementation of assisted suicide laws and validates the concern that the risks of mistake, coercion and abuse are too great.

Well-informed legislators on both sides of the aisle should vote against assisted suicide bills.

LifeNews Note: *Diane Coleman is an attorney and President of the disability rights group, Not Dead Yet*

THE SENATE
TWENTY-NINTH LEGISLATURE, 2017
STATE OF HAWAII

S.B. NO. 1129 S.D. 2

A BILL FOR AN ACT

RELATING TO HEALTH.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that some states have enacted laws that establish a regulated process to allow their mentally competent adult residents who have a terminal illness with a confirmed prognosis of six or fewer months to live to voluntarily request and receive a prescription medication for self-administration so that they can die in a peaceful, humane manner. These laws, with labels such as "medical aid in dying" laws, "death with dignity" laws, or "end-of-life-options" laws, are based on the concept that the terminally ill person should have the ability to make reasoned end-of-life decisions and choose to end life in a peaceful, humane, and dignified manner or determine how much pain and suffering to endure.

The legislature also finds that Oregon's death with dignity act has been in effect since 1997. Similar laws are also in effect in California, Colorado, Vermont, and Washington. This act is modeled on the Oregon statute and includes safeguards to protect patients. These safeguards include confirmation by two providers of the patient's diagnosis, prognosis, mental competence, and voluntariness of the request; multiple requests by the patient: an oral request followed by a signed written request that is witnessed by two people, one of whom must be unrelated to the patient, and a subsequent oral restatement of the request; and two waiting periods between the requests and the writing of the prescription.

At all times the patient retains the right to rescind the request and is under no obligation to fill the prescription or ingest the medication.

The legislature concludes that terminally ill residents of the State should be able to determine their own medical treatment at the end of their lives.

The purpose of this Act is to enact a medical aid in dying act.

SECTION 2. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately designated and to read as follows:

"CHAPTER

MEDICAL AID IN DYING ACT

§ -1 Definitions. The following terms shall mean as follows:

"Adult" means an individual who is eighteen years of age or older.

"Attending provider" means a physician licensed pursuant to chapter 453 or an advanced practice registered nurse licensed pursuant to chapter 457 who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

"Capable" means that in the opinion of a court or in the opinion of the patient's attending provider or consulting provider, psychiatrist, or psychologist, a patient has the ability to make and communicate health care decisions to health care providers.

"Consulting provider" means a physician licensed pursuant to chapter 453 who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease, but who has not previously assumed responsibility for the care of the patient with the attending provider.

"Counseling" means one or more consultations as necessary between a state-licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

"Department" means the department of health.

"Health care facility" shall have the same meaning as in section 323D-2.

"Health care provider" means a person licensed, certified, or otherwise authorized or permitted by the law of this State to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

"Informed decision" means a decision by a qualified patient to request and obtain a prescription, which the qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending provider of:

(1) The medical diagnosis;

(2) The prognosis;

(3) The potential risks associated with taking the medication to be prescribed;

(4) The probable result of taking the medication to be prescribed; and

(5) The feasible alternatives, including but not limited to comfort care, hospice care, and pain control.

"Medically confirmed" means the medical opinion of the attending provider has been confirmed by a consulting provider who has examined the patient and the patient's relevant medical records.

"Patient" means a person who is under the care of a physician.

"Physician" means a doctor of medicine or osteopathy licensed to practice medicine pursuant to chapter 453 by the Hawaii medical board.

"Qualified patient" means a capable adult who is a resident of the State and has satisfied the requirements of this chapter in order to obtain a prescription for medication that the qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner.

"Terminal disease" means an incurable and irreversible disease that

has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

§ -2 Written request for medication; initiated. (a) An adult who is capable, is a resident of the State, and has been determined by the attending provider and consulting provider to be suffering from a terminal disease, and who has voluntarily expressed the adult's wish to die, may make a written request for medication that the adult may self-administer for the purpose of ending the adult's life in a humane and dignified manner in accordance with this chapter.

(b) No person shall qualify under this chapter solely because of age or disability.

§ -3 Form of the written request. (a) A valid request for medication under this chapter shall be in substantially the form described in section -23, signed and dated by the qualified patient and witnessed by at least two individuals who, in the presence of the qualified patient, attest that to the best of their knowledge and belief the qualified patient is of sound mind, acting voluntarily, and is not being coerced to sign the request.

(b) One of the witnesses shall be a person who is not:

(1) A relative of the patient by blood, marriage, or adoption;

(2) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will, trust, or other legal instrument, or by operation of law; or

(3) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(c) The qualified patient's attending provider at the time the request is signed shall not be a witness.

(d) If the qualified patient is a patient in a long-term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility who has qualifications specified by the department of health by rule.

§ -4 Attending provider responsibilities. (a) The attending provider shall:

(1) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(2) Request that the patient demonstrate residency pursuant to section -13;

(3) To ensure that the patient is making an informed decision, inform the patient of:

(A) The medical diagnosis;

(B) The prognosis;

(C) The potential risks associated with taking the medication to be prescribed;

(D) The probable result of taking the medication to be prescribed; and

(E) The feasible alternatives, including but not limited to comfort care, hospice care, and pain control;

(4) Refer the patient to a consulting provider for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(5) Refer the patient for counseling if appropriate;

(6) Recommend that the patient notify next of kin;

(7) Counsel the patient about the importance of having another person present when the qualified patient self-administers the medication prescribed pursuant to this chapter and of not self-administering the medication in a public place;

(8) Inform the patient that a qualified patient has an opportunity to rescind the request at any time and in any manner, and offer the qualified patient an opportunity to rescind at the time of the qualified patient's second oral request made pursuant to section -9;

(9) Verify, immediately prior to writing the prescription for medication under this chapter, that the qualified patient is making an informed decision;

(10) Fulfill the medical record documentation requirements of section -12;

(11) Ensure that all appropriate steps are carried out in accordance with this chapter prior to writing a prescription for medication to enable a qualified patient to end the qualified patient's life in a humane and dignified manner; and

(12) Either:

(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort; provided that the attending provider is authorized to dispense controlled substances pursuant to chapter 329, has a current Drug Enforcement Administration certificate, and complies with any applicable administrative rule; or

(B) With the qualified patient's written consent:

(i) Contact a pharmacist of the qualified patient's choice and inform the pharmacist of the prescription; and

(ii) Transmit the written prescription personally, by mail, or electronically to the pharmacist, who will dispense the medications to either the qualified patient, the attending provider, or an expressly identified agent of the qualified patient.

(b) Notwithstanding any other provision of law, an attending provider may sign the qualified patient's death certificate. The death certificate shall list the terminal disease as the immediate cause of death. .LIE

§ **-5 Consulting provider confirmation.** Before a patient is qualified under this chapter, a consulting provider shall examine the patient and the patient's relevant medical records and confirm, in writing, the attending provider's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily, and has made an informed decision.

§ **-6 Counseling referral.** If, in the opinion of either the attending provider or the consulting provider, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, the provider shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that

the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

§ **-7 Informed decision.** No qualified patient shall receive a prescription for medication to end the qualified patient's life in a humane and dignified manner unless the qualified patient has made an informed decision. Immediately prior to writing a prescription for medication under this chapter, the attending provider shall verify that the qualified patient is making an informed decision.

§ **-8 Family notification.** The attending provider shall recommend that the qualified patient notify the next of kin of the qualified patient's request for medication pursuant to this chapter. A qualified patient who declines or is unable to notify next of kin shall not have the qualified patient's request denied for that reason.

§ **-9 Written and oral requests.** To receive a prescription for medication that a qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to the qualified patient's attending provider not less than fifteen days after making the initial oral request. At the time the qualified patient makes the second oral request, the attending provider shall offer the qualified patient an opportunity to rescind the request.

§ **-10 Right to rescind request.** A qualified patient may rescind the request at any time and in any manner without regard to the qualified patient's mental state. No prescription for medication under this chapter may be made available pursuant to section -4(a)(12) without the attending provider having offered the qualified patient an opportunity to rescind the request made pursuant to section -9.

§ **-11 Waiting periods.** Not less than fifteen days shall elapse between the qualified patient's initial oral request and the taking of

steps to make available a prescription for medication pursuant to section -4(a)(12). Not less than forty-eight hours shall elapse between the qualified patient's written request and the taking of steps to make available a prescription for medication pursuant to section -4(a)(12).

§ -12 **Medical record; documentation requirements.** The following shall be documented or filed in a qualified patient's medical record:

(1) All oral requests by the qualified patient for medication to end the qualified patient's life in a humane and dignified manner;

(2) All written requests by the qualified patient for medication to end the qualified patient's life in a humane and dignified manner;

(3) The attending provider's diagnosis and prognosis and determination that the qualified patient is capable, acting voluntarily, and has made an informed decision;

(4) The consulting provider's diagnosis and prognosis and verification that the qualified patient is capable, acting voluntarily, and has made an informed decision;

(5) A report of the outcome and determinations made during counseling, if performed;

(6) The attending provider's offer to the qualified patient to rescind the patient's request at the time of the qualified patient's second oral request made pursuant to section -9; and

(7) A note by the attending provider indicating that all requirements under this chapter have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

§ -13 **Residency requirement.** Only requests made by residents of this State under this chapter shall be granted. Factors demonstrating state residency include but are not limited to:

(1) Possession of a Hawaii driver's license or civil identification card;

(2) Registration to vote in Hawaii;

(3) Evidence that the person owns or leases property in Hawaii; or

(4) Filing of a Hawaii tax return for the most recent tax year.

§ -14 **Reporting requirements.** (a) The department shall annually review a sample of records maintained pursuant to this chapter.

(b) The department shall require any health care provider, upon dispensing medication pursuant to this chapter, to file a copy of the

dispensing record with the department.

(c) The department shall adopt rules to facilitate the collection of information regarding compliance with this chapter. Except as otherwise required by law, the information collected shall not be a public record and shall not be made available for inspection by the public. The department shall retain and exercise reasonable care in maintaining the information collected; provided that the information shall not be subject to any disposal or destruction of records requirements.

(d) The department shall generate and make available to the public an annual statistical report of information collected under subsection (c).

§ **-15 Disposal of unused medication.** A person who has custody or control of any unused medication dispensed under this chapter after the death of a qualified patient shall personally deliver the unused medication for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means.

§ **-16 Effect on construction of wills or contracts.** (a) No provision in a will or contract, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end the person's life in a humane and dignified manner, shall be valid.

(b) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end the person's life in a humane and dignified manner.

§ **-17 Insurance or annuity policies.** The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end the person's life in a humane and dignified manner. A qualified

patient's act of ingesting medication to end the qualified patient's life in a humane and dignified manner shall have no effect upon a life, health, or accident insurance or annuity policy.

§ **-18 Construction of chapter.** Nothing in this chapter shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this chapter shall not, for any purpose, constitute suicide, assisted suicide, mercy killing, murder, manslaughter, negligent homicide, or any other criminal conduct under the law.

§ **-19 Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions.** (a) Except as provided in section -20:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating or acting in good faith compliance with this chapter, including being present when a qualified patient takes the prescribed medication to end the qualified patient's life in a humane and dignified manner;

(2) No professional organization or association or health care provider may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter;

(3) No request by a qualified patient for or provision by an attending provider of medication in good faith compliance with this chapter shall constitute neglect, harm, self-neglect, or abuse for any purpose of law or provide the sole basis for the appointment of a guardian or conservator;

(4) No health care provider shall be under any duty, whether by contract, by statute, or by any other legal requirement, to participate in the provision to a qualified patient of medication to end the qualified patient's life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers the patient's care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider; and

(5) No health care facility shall be subject to civil or criminal liability for acting in good faith compliance with this chapter including but not limited to the designation of a witness for a qualified patient who makes a written request when residing in a long-term care facility pursuant to section -3(d).

(b) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider from participating in actions covered by this chapter on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the

prohibiting provider's policy regarding participation in actions covered by this chapter. Nothing in this subsection shall prevent a health care provider from providing health care services to a patient that do not constitute participation in actions covered by this chapter.

(c) Subsection (a) notwithstanding, a health care provider may subject another health care provider to the following sanctions, if the sanctioning health care provider has notified the sanctioned health care provider prior to participation in actions covered by this chapter that it prohibits participation in actions covered by this chapter:

(1) Loss of privileges, loss of membership, or other sanction provided pursuant to the medical staff bylaws, policies, and procedures of the sanctioning health care provider if the sanctioned health care provider is a member of the sanctioning provider's medical staff and participates in actions covered by this chapter while on the health care facility premises of the sanctioning health care provider, but not including the private medical office of a physician or other health care provider;

(2) Termination of lease or other property contract or other nonmonetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned health care provider participates in actions covered by this chapter while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(3) Termination of contract or other nonmonetary remedies provided by contract if the sanctioned health care provider participates in actions covered by this chapter while acting in the course and scope of the sanctioned health care provider's capacity as an employee or independent contractor of the sanctioning health care provider; provided that nothing in this paragraph shall be construed to prevent:

(A) A health care provider from participating in actions covered by this chapter while acting outside the course and scope of the health care provider's capacity as an employee or independent contractor; or

(B) A patient from contracting with the patient's attending provider and consulting provider to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(d) A health care provider that imposes sanctions pursuant to

subsection (c) shall follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(e) For the purposes of this section:

"Notify" means a separate statement in writing to the health care provider specifically informing the health care provider prior to the health care provider's participation in actions covered by this chapter of the sanctioning health care provider's policy regarding participation in actions covered by this chapter.

"Participate in actions covered by this chapter" means to perform the duties of an attending provider pursuant to section -4, the consulting provider function pursuant to section -5, or the counseling referral function pursuant to section -6. The term does not include:

(1) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(2) Providing information about this chapter to a patient upon the request of the patient;

(3) Providing a patient, upon the request of the patient, with a referral to another physician; or

(4) A patient contracting with the patient's attending provider and consulting provider to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(f) Action taken pursuant to sections -4 to -6 shall not be the sole basis for disciplinary action under section 453-8 or section 457-12.

(g) This chapter shall not be construed to allow a lower standard of care for patients in the community where the patient is treated or in a similar community.

§ -20 Prohibited acts; penalties. (a) A person who without the authorization of a qualified patient intentionally alters or forges a request for medication or conceals or destroys a rescission of that request to cause the patient's death shall be guilty of a class A felony.

(b) A person who coerces or exerts undue influence on a qualified patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of the request, shall be guilty of a class A felony.

(c) A person who, without authorization of a qualified patient, intentionally alters, forges, conceals, or destroys an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting a qualified patient's desires and interests, with the intent and effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition and hydration that hastens the death of the qualified patient, shall be guilty of a class A felony.

(d) Except as provided in subsection (c), it shall be a misdemeanor for a person without authorization of a qualified patient to intentionally alter, forge, conceal, or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the principal's desires and interests with the intent or effect of affecting a health care decision.

(e) Nothing in this section shall limit any liability for civil damages resulting from any negligent conduct or intentional misconduct by any person.

(f) The penalties in this chapter are cumulative and do not preclude criminal penalties pursuant to other applicable state law.

§ -21 Claims by governmental entity for costs incurred. Any government entity that incurs costs resulting from a person terminating the person's life pursuant to this chapter in a public place shall have a claim against the estate of the person to recover costs and reasonable attorneys' fees related to enforcing the claim.

§ -22 Severability. Any provision of this chapter that is held invalid as to any person or circumstance shall not affect the application

of any other provision of this chapter that can be given full effect without the invalid section or application.

§ -23 Form of the request. A request for a medication as authorized by this chapter shall be in substantially the following form:

"REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

I am suffering from _____, which my attending provider has determined is a terminal disease and that has been medically confirmed by a consulting provider.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care, and pain control.

I request that my attending provider prescribe medication that I may self-administer to end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my attending provider has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress or to have been induced by fraud, or subjected to undue influence when signing the request; and

(d) Is not a patient for whom either of us is the attending provider.

_____Witness 1 Date_____

_____Witness 2 Date_____

NOTE: One witness shall not be a relative (by blood, marriage, or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate, or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a long-term care facility, one of the witnesses shall be an individual designated by the facility who has qualifications specified by the Department of Health by rule.""

SECTION 3. Section 327E-13, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) This chapter shall not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of this State[~~.~~]; provided that this subsection shall not apply to actions taken under chapter ."

SECTION 4. Section 327H-2, Hawaii Revised Statutes, is amended by amending subsection (b) to read as follows:

"(b) Nothing in this section shall be construed to:

(1) Expand the authorized scope of practice of any licensed physician;

(2) Limit any reporting or disciplinary provisions applicable to licensed physicians and surgeons who violate prescribing practices; and

(3) Prohibit the discipline or prosecution of a licensed physician for:

(A) Failing to maintain complete, accurate, and current records that document the physical examination and medical history of a patient, the basis for the clinical diagnosis of a patient, and the treatment plan for a patient;

(B) Writing false or fictitious prescriptions for controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 United States Code 801 et seq. or in chapter 329;

(C) Prescribing, administering, or dispensing pharmaceuticals in violation of the provisions of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 United States Code 801 et seq. or of chapter 329;

(D) Diverting medications prescribed for a patient to the licensed physician's own personal use; and

(E) Causing, or assisting in causing, the suicide, euthanasia, or mercy killing of any individual; provided that it is not "causing, or assisting in causing, the suicide, euthanasia, or mercy killing of any individual" to prescribe, dispense, or administer medical treatment for the purpose of treating severe acute pain or severe chronic pain, even if the medical treatment may increase the risk of death, so long as the medical treatment is not also furnished for the purpose of causing, or the purpose of assisting in causing, death for any reason[~~.~~]; provided that this subparagraph shall not apply to actions taken under chapter .".

SECTION 5. Section 707-701.5, Hawaii Revised Statutes, is amended by amending subsection (1) to read as follows:

"(1) Except as provided in section 707-701, a person commits the offense of murder in the second degree if the person intentionally or knowingly causes the death of another person[~~.~~]; provided that this section

shall not apply to actions taken under chapter ."

SECTION 6. Section 707-702, Hawaii Revised Statutes, is amended by amending subsection (1) to read as follows:

"(1) A person commits the offense of manslaughter if:

(a) The person recklessly causes the death of another person; or

(b) The person intentionally causes another person to commit suicide[.];

provided that this section shall not apply to actions taken under chapter ."

SECTION 7. The department of health shall submit a report that includes but is not limited to:

(1) An annual statistical report of the information collected pursuant to section -14(d), Hawaii Revised Statutes;

(2) An annual analysis of the implementation of the medical aid in dying act under chapter , Hawaii Revised Statutes, including any implementation problems; and

(3) Any proposed legislation,

to the legislature no later than twenty days prior to the convening of each regular session.

SECTION 8. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

SECTION 9. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 10. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 11. This Act shall take effect upon its approval.

Report Title:
Health; Medical Aid in Dying

Description:
Establishes a medical aid in dying act that establishes a regulatory process under which an adult resident of the State with a medically confirmed terminal disease may obtain a prescription for medication to be self-administered to end the patient's life. (SD2)

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

Please read the attachments to this testimony which states the resultants of the Oregon Death with Dignity law because in it the professional analysis of the persons requesting the lethal medication is not a death wish but a cry for help.

Instead of this medical aid in dying bill, which is essentially a type of death with dignity, our state legislature should be supporting a "Life with Honor" bill.

This death bill will effect the most vulnerable in our society, the aged, infirmed, those in our society which due to economic or other attributes some may think of non-contributing to the society, therefore death is an option not because of the medical condition, (because our hospitals and physicians have excellent end of life care) but because of an attitude of some in the society that some persons life is not at the value of others lives. This is prejudice and discrimination in its ugliest form.

The resultants of the Oregon studies of the death with dignity law is not of a person desiring death but desiring life. The outstanding concurrent theme of the requesters of the lethal medication is a mental health condition which is brought about by depression, oppression or other external pressures and exuberated by a medical condition and as in Oregon once this bill is enacted there is no guarantees that the mental health conditions of the requester may be adequately addressed because of the time and expense factors, nor may they be addressed by the proper professionals.

Due to the persons attending physicians not being involved in the process, who would know the requesters mental and physical health better than a casual observer who is brought in to recommend lethal medication, there is a strong causes of abuse of this law if enacted.

It is obvious from the resultants of the studies of the Oregon death with dignity bill that those requesting lethal medication is faced with a mental health issue and may not be a near term medical condition.

Therefore instead of providing a death bill, our state legislature should support additional mental health assistance to the elderly, infirmed and those of the economic state which may cause depressions, to lift those up from the state that they are in by providing counseling, family intervention, community support and medical and economic assistance to improve the conditions of the requester.

In evaluation of this bill, it is not ready for publishing it is a combination of different organizations and persons thoughts and causes inconsistencies in the theme of what is presented and has many open holes which would permit legal challenges if enacted.

If enacted it is perceived that it will be challenged from the moral side, the churches, the insurance companies and health care providers due to the bill contents and context.

Our state legislature is entrusted with the trust of the people to provide laws which provide governance and are to the benefit of the well being of the people of Hawaii and to do no harm.

This legislature does not meet this criteria.

It is strongly recommended this bill die in committee and not be allowed to continue in the legislative process.

Thank you

SJ Melendrez
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