**DAVID Y. IGE**
GOVERNOR

**JOSH GREEN**
LT. GOVERNOR

**STATE OF HAWAII**
**OFFICE OF THE DIRECTOR**
**DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS**
335 MERCHANT STREET, ROOM 310
P.O. BOX 541
HONOLULU, HAWAII 96809
Phone Number: 586-2850
Fax Number: 586-2856
cca.hawaii.gov

**CATHERINE P. AWAKUNI COLÓN**
DIRECTOR

**JO ANN M. UCHIDA TAKEUCHI**
DEPUTY DIRECTOR

# Testimony of the Department of Commerce and Consumer Affairs

## Before the
## Senate Committee on Commerce, Consumer Protection, and Health
## Tuesday, February 4, 2020
## 9:30 a.m.
## State Capitol, Conference Room 229

## On the following measure:
## S.B. 3047, RELATING TO HEALTH

Chair Baker and Members of the Committee:

My name is Colin Hayashida, and I am the Insurance Commissioner of the Department of Commerce and Consumer Affairs' (Department) Insurance Division. The Department offers comments on this bill.

The purposes of this bill are to: (1) allow an advance directive to be a valid written request for a prescription to be self-administered for the purpose of ending an adult's life; (2) include advanced practice registered nurses under the definition of "attending provider"; (3) allow an attending provider to waive the counseling referral requirement; (4) allow an attending provider to perform duties through telehealth, under certain conditions; and (5) require health insurance policies and contracts issued after December 31, 2020, to provide coverage for services related to ending a patient's life.

Insofar as this bill requires coverage for services related to ending a patient's life (page 34, line 17 to page 35, line 6; page 36, line 8 to line 17; and page 38, line 3), this may be interpreted as establishing a new benefit mandate. The addition of new mandated coverage may trigger section 1311(d)(3) of the federal Patient Protection and Affordable Care Act (PPACA), which requires states to make payments to defray the costs of any benefits, in addition to the essential health benefits of the State's qualified health plan under the PPACA. 45 Code of Federal Regulations section 155.170(a)(2) also provides that "[a] benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, is considered in addition to the essential health benefits" (emphasis added).

The federal Department of Health and Human Services (HHS) recently proposed rulemaking to the PPACA to address states' defrayment and obligations. The HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans (HHS Notice)[1] states, in pertinent part: "At [45 CFR] § 156.111, we propose to require states to annually report to HHS . . . any state-required benefits applicable to the individual and/or small group market that are considered in addition to EHB[.]" HHS Notice at page 184. The HHS Notice further provides: "We are also proposing at [45 CFR] § 156.111(d)(2) to specify that if the state does not notify HHS of its required benefits considered to be in addition to EHB . . . HHS will determine which benefits are in addition to EHB for the state for the applicable plan year." HHS Notice at page 140.

Furthermore, pursuant to Hawaii Revised Statutes section 23-51, any proposed mandate providing coverage for care requires the passage of a concurrent resolution requesting the State Auditor to prepare and submit a report assessing the social and financial impacts of the proposed mandate.

Thank you for the opportunity to testify on this bill.

---

[1] This document is scheduled to be published on February 6, 2020. The unpublished PDF version is available at: https://www.federalregister.gov/documents/2020/02/06/2020-02021/benefit-and-payment-parameters-notice-requirement-for-non-federal-governmental-plans.

**TESTIMONY OF**
**THE DEPARTMENT OF THE ATTORNEY GENERAL**
**THIRTIETH LEGISLATURE, 2020**

LATE

**ON THE FOLLOWING MEASURE:**
S.B. NO. 3047, RELATING TO HEALTH.

**BEFORE THE:**

SENATE COMMITTEE ON COMMERCE, CONSUMER PROTECTION, AND HEALTH

**DATE:** Tuesday, February 4, 2020 **TIME:** 9:30 a.m.

**LOCATION:** State Capitol, Room 229

**TESTIFIER(S):** Clare E. Connors, Attorney General, or
Angela A. Tokuda, Deputy Attorney General

---

Chair Baker and Members of the Committee:

The Department of the Attorney General provides the following comments.

The purpose of this bill is to add a new section and amend chapter 327L, Hawaii Revised Statutes (HRS), to allow an advance directive pursuant to chapter 327E, HRS, to be treated as a valid written request for a prescription under 327L in lieu of a form of a written request, adds an advanced practice registered nurse with prescriptive authority under the definition of “attending provider,” allow an attending provider to perform duties through telehealth if the patient is unable to leave the patient’s residence, allow the attending provider to waive the counseling referral requirement, and require health insurance policies, contracts, and plans issued after December 31, 2020, to provide coverage for services under chapter 327L.

Allowing an advanced health-care directive to serve as a valid written request for a prescription under chapter 327L in lieu of a form of a written request conflicts with the capacity determination prerequisite and the process of receiving a written prescription under chapter 327L.

> 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 the attending provider's prognosis, and verify that the **patient is capable, is acting voluntarily, and has made an informed decision**.

HRS § 327L-5 (emphasis added). It is unclear how an advanced health-care directive could comply with the verification requirements.

An additional step is required before the qualified patient can receive a prescription - "[i]mmediately prior to writing a prescription under this chapter, the attending provider shall verify that the qualified patient is making an informed decision." HRS § 327L-7.

An advance health-care directive is effective "upon a determination that the principal lacks capacity." HRS § 327E-3(e). It is unclear whether an advance health-care directive could be a valid instrument to qualify a patient under chapter 327L, particularly if the patient lacks capacity and therefore is unable to make an informed decision in order to receive a written prescription.

Additionally, under section 1311(d)(3)(B) of the Affordable Care Act and 45 C.F.R. section 155.170, a state may only require a Qualified Health Plan to add benefits if the state defrays the cost of the additional benefits, unless the proposed new benefit is directly attributable to State compliance with Federal requirements to provide Essential Health Benefits after December 31, 2011.

This bill would require Qualified Health Plans to provide coverage for the cost of services related to ending a patient's life. Currently, Hawaii's benchmark plan does not include the coverage required by this bill. Accordingly, if these additional benefits are mandated, the State may be required to defray any related cost.

At this time, our department is unaware of a state that has been obligated to defray the cost for additional benefits. Therefore, there are no prior examples of how the State would meet its obligation and what specific procedures would be necessary to fulfill the obligation. Our department's best understanding is that after the Qualified Health Plan issuer submits the issuer's costs attributable to the additional mandate, the Legislature would need to appropriate the money during the following legislative session and propose a mechanism to distribute the money.

Thank you for the opportunity to testify.

# Testimony of the Board of Nursing

**Before the**
**Senate Committee on Commerce, Consumer Protection and Health**
**Tuesday, February 4, 2020**
**9:30 a.m.**
**State Capitol, Conference Room 229**

**On the following measure:**
**S.B. 3047, RELATING TO HEALTH**

Chair Baker and Members of the Committee:

My name is Lee Ann Teshima, and I am the Executive Officer of the Board of Nursing (Board). The Board will review this bill at its next publicly scheduled meeting on February 6, 2020.

The purposes of this bill are to: (1) allow an advance directive to be a valid written request for a prescription to be self-administered for the purpose of ending an adult’s life; (2) include advanced practice registered nurses under the definition of “attending provider”; (3) allow an attending provider to waive the counseling referral requirement; (4) allow an attending provider to perform duties through telehealth, under certain conditions; and (5) require health insurance policies and contracts issued after December 31, 2020, to provide coverage for services related to ending a patient’s life.

Thank you for the opportunity to testify on this bill.

**DAVID Y. IGE**
GOVERNOR OF HAWAII

**BRUCE S. ANDERSON, PHD**
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 SB3047
# RELATING TO HEALTH.

SENATOR ROSALYN H. BAKER, CHAIR
SENATE COMMITTEE ON COMMERCE, CONSUMER PROTECTION, AND HEALTH

Hearing Date: February 4, 2020 Room Number: 229

**Fiscal Implications:** N/A.

**Department Testimony:** The Department of Health (DOH) expresses reservations on SB3047 because some amendments are incocnsistent with consensus feedback from providers who have participated in medical aid in dying pursuant to chapter 327L, Hawaii Revised Statutes. The department acknowledges certain patients and families are unable to benefit from chapter 327L due to degraded mental capacity but more community discussion and deliberation is urged. DOH prefers SB2582 RELATING TO HEALTH, for which amendments were vetted by a summit of provider stakeholders in October 2019.

From January 1, 2019 through December 26, 2019, to date, there were a total of 27 qualified patients who received aid-in-dying prescriptions. Of those 27, 19 patients expired and of that cohort 15 patients suffered from some form of cancer, 14 ingested aid in dying medications, and 5 did not ingest the aid-in-dying medication. All nineteen patients who expired had private insurance and/or Medicare.

DDMP2 was the most commonly prescribed medication with 13 scripts written; DDMA was prescribed only 6 times. Twelve attending physicians wrote prescriptions during this reporting period. Only one attending physician was located on the neighboring islands on the Big Island. There were no reported complications due to ingesting the medications.

The eligibility process from the first oral request to the date of receipt of the written prescription was approximately 34 days with the shortest period being 20 days.

Thank you for the opportunity to testify.

HAWAIʻI STATE CENTER FOR NURSING
Connecting Nurses. Transforming Healthcare.

**Written Testimony Presented Before the**
**Senate Committee on Commerce, Consumer Protection, and Health**
**Tuesday, February 4, 2020 at 9:30 a.m.**
**by**
**Laura Reichhardt, MS, AGNP-C, APRN**
**Director, Hawaiʻi State Center for Nursing**
**University of Hawaiʻi at Mānoa**

## WRITTEN COMMENTS on SB3047

Chair Baker, Vice Chair Chang, and members of the Committee on Commerce, Consumer Protection, and Health, thank you for hearing the measure, SB3047, which explicitly authorizes advanced practice registered nurses (APRNs) to practice medical aid in dying in accordance with their scope of practice and prescriptive authority. The Hawaiʻi State Center for Nursing provides written comments to section 3 of this measure.

APRNs in Hawaiʻi may care for people across the lifespan and wellness continuum, in accordance with their education, training, certification, and licensure. According to the functions specified in the **Hawaiʻi Administrative Rules Chapter 16-89-81 Practice Specialties**, the two types of APRNs most likely to meet the criteria of "Attending Provider", Nurse Practitioner and Clinical Nurse Specialist, may evaluate the physical and psychosocial health status of patients through a comprehensive health history and physical examination, or mental status examination and assess the normal and abnormal findings from the history, physical, and mental status examinations, and diagnostic reports.

Further, in order to maintain prescriptive authority, APRNs must maintain current national certification in the nursing practice specialty by a board-recognized national certifying body and maintain continuing education in pharmacotherapeutics. Currently, in our state, nearly 85% of APRNs maintain prescriptive authority, with over 90% of APRNs on Hawaiʻi, Maui, and Kauaʻi Counties holding this authority (HSCN nursing workforce supply data tables, 2019).

Should the Committee move this measure forward, the Center asks the Committee to consider amending the definition of 'Attending provider' to read **"Attending provider" means a physician licensed pursuant to chapter 453 <u>or an advanced practice registered nurse pursuant to chapter 457</u> who has responsibility for the care of the patient and treatment of the patient's terminal disease."**

Thank you for the opportunity to provide written comments related section 3 of this measure.

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

**SB-3047**
Submitted on: 2/2/2020 12:27:20 AM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Brett Kulbis | Testifying for Honolulu County Republican Party | Oppose | No |

Comments:

Honolulu County Republican Party opposes SB 3047.

This bill proposes to eliminate some of the safeguards originally put in place to prevent abuse of the “Our Care, Our Choice” assisted suicide law in Hawaii:

(1) Allows an advance directive to be a valid written request for a prescription to be self-administered for the purpose of ending an adult's life;

(2) includes advanced practice registered nurses under the definition of "attending provider";

(3) allows an attending provider to waive the counseling referral requirement;

(4) allows an attending provider to perform duties through telehealth, under certain conditions;

(5) requires health insurance policies and contracts issued after December 31, 2020, to provide coverage for services related to ending a patient's life.

Proponents want to circumvent the safeguard of a counselor, that would prevent the doctor from knowing the patient isn’t suffering from conditions that may interfere with decision-making, such as a lack of treatment of depression, by accepting an advance directive as a valid request. To make it easier to find a death-doctor, proponents are advocating for APRNs to be given the authority to approve these suicides. It is uncertain whether APRNs are willing to do this and what the outcome will be if there still is not enough medical professionals willing to participate. Keep in mind there are no states that allow APRNs to practice medical aid in dying. Proponents also want the provider the ability to waive counseling, circumventing another safeguard.

This is another attempt to make Hawaii a testing ground to see how far they can push the envelope. Will there be another bill next year removing more safe guards?

# UNIVERSITY OF HAWAIʻI SYSTEM
Legislative Testimony

LATE

---

Testimony Presented Before the
Senate Committee on Commerce, Consumer Protection & Health
Tuesday, February 4, 2020 at 9:30 a.m.
by
Mary G. Boland, DrPH, RN, Dean and Professor
School of Nursing and Dental Hygiene
University of Hawai'i at Mānoa
and
Michael Bruno, PhD
Provost
University of Hawaiʻi at Mānoa

## SB 3047 – RELATING TO HEALTH

Chair Baker, Vice Chair Chang, and members of the Committee on Commerce, Consumer Protection and Health:

Thank you for this opportunity to provide testimony in **strong support of SB 3047 with recommended amendments** as it relates to advanced practice registered nurses (APRN) participation in medical aid in dying in accordance with their scope of practice and prescriptive authority.

The Hawaiʻi Legislature recognizes that access to care is a significant problem statewide and in particular in rural island settings. The Hawaiʻi Legislature also recognizes the incredible opportunity for APRNS to contribute to the solution. You have enacted over 25 bills since 2009 enabling APRNs in Hawaiʻi to practice to the full extent of their education. Since then, the number of APRNs in the state has increased across all the islands including rural settings. Of APRNs in Hawaiʻi, Maui and Kauai counties, all work in HRSA defined medically underserved populations/areas, over 90% hold prescriptive authority and over 88% care for Medicare or Medicaid patients in a typical week.[1,2]

APRNs provide high quality safe care for people across the lifespan, in accordance with their education, training, national certification, and licensure. The patient-centered nature of the APRN role require a commitment to meeting the evolving needs of society and advances in health care science and a responsibility to the public and adaptable to the dynamic changes in health care.[3] In Hawaiʻi, 41% of APRNs work in ambulatory

---

[1] Hawaiʻi State Center for Nursing, (2017). 2017 Nursing Workforce Supply Survey Special Report: Employment Location of APRNS.

[2] Hawaiʻi State Center for Nursing, 2019 Nursing Workforce Report. Data provided through the voluntary nurse re-licensure survey of nurses.

[3] American Academy of Nurse Practitioners, (2019). Nurse Practitioner Scope of Practice.

settings, nearly 33% report working in family practice or adult-gerontology. Another 8.5% work in palliative care/hospice, nephrology, cardiology, and oncology; specialties where they care for people with terminal illnesses.[4] In addition, 7.4% of APRNs work in the psychiatric/mental health specialty with greater rates of APRNS in these specialties in neighbor islands than on Oahu.[4]

The University of Hawaiʻi at Mānoa and Hilo Doctor of Nursing (DNP) Programs educate family and adult gerontology primary care nurse practitioners, the most common type of APRN in our state. Our graduates meet both the national and Hawaiʻi Board of Nursing requirements for advanced pharmacological education, as well as education related to the assessment, diagnosis, and care planning that prepares them to care for patients across the continuum of life. Thus, their scope of practice and education prepares them to serve as both attending provider and consulting provider for persons suffering from a terminal disease. APRNs are recognized in Hawaiʻi and the nation for their high quality care, safe prescribing practices, and are trusted by the people and families under their care.

The University of Hawaiʻi prefers the language referring to APRNs found in SB 2582 which adds APRNs to the definitions of both attending and consulting provider. However, should the Committee move this measure forward, the University of Hawai'i asks the Committee to consider amending the following definitions:

- Page 3, lines 13-21
    - "Attending provider" means a physician licensed pursuant to chapter 453 or an advanced practice registered nurse pursuant to chapter 457 who has responsibility for the care of the patient and treatment of the patient's terminal disease."
- Add to this measure the definition of consulting provider:
    - "Consulting provider" means a physician licensed pursuant to chapter 453 or an advanced practice registered nurse pursuant to chapter 457 who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
- Add to this measure the definition of counseling:
    - "Counseling" means one or more consultations, which may be provided through telehealth, as necessary between a psychiatrist licensed under chapter 453, an advanced practice registered nurse pursuant to chapter 457, psychologist licensed under chapter 465, or clinical social worker licensed pursuant to chapter

---

[4] Hawaiʻi State Center for Nursing, 2019 Nursing Workforce Report. Data provided through the voluntary nurse re-licensure survey of nurses.

> 467E and a patient for the purpose of determining that the patient is capable, and that the patient does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with the patient's ability to make an informed decision pursuant to this chapter.

Thank you for the opportunity to provide testimony in **strong support of SB 3047 with amendments**.

hawaii family forum

LATE

Submitted Online: February 3, 2020

Hearing: February 4, 2020 @9:30 a.m.

TO: Senate Committee on Consumer Protection & Health
Sen. Rosalyn Baker, Chair
Sen. Stanley Chang, Vice Chair

FROM: Eva Andrade, President

RE: Opposition to SB3047 Relating to Health

Aloha and thank you for the opportunity to provide our testimony. Hawaii Family Forum is a non-profit, pro-family education organization committed to preserving and strengthening families in Hawaii, representing a network of various Christian Churches and denominations. We oppose this bill because it destroys the current foundational framework of advance care planning, undermines the safeguards that were put in place in the Our Care Our Choice law that was implemented only a year ago, and unfairly threatens the lives of those with advance-stage dementia.

***Adding advanced practice registered nurses under the definition of "attending provider" may harm patient safety.***

Providing a prognosis of 6 months or less is one of the most challenging tasks doctors face. Unless patients are within days or weeks of dying, it is often impossible to provide an accurate one. We believe that this issue will be compounded by placing life and death medical decision-making into the hands of nurses who have much less training. Any mistake to that end may very well result in the untimely death of patients who would have years, or even decades, of life ahead of them. In addition, the proposed legislation doesn't mention ongoing education and training for nurses, to assess patients for capacity, depression and other factors before giving them power to make irreversible decisions to end a patient's life.

***Allowing an attending provider to waive the counseling referral requirement may ignore signs of depression causing wrongful death.***

Oregon, Washington, California, District of Columbia and Colorado emphasize that no medication to end life shall be prescribed until a professional determines that the patient is not suffering from a disorder causing impaired judgment[i]. In fact, recent reports show that few patients have been referred for psychiatric assessment. Between 1998- 2016, a total of 57 patients (5.1%) out of 1127 who completed physician assisted death under the Death with Dignity Act were referred for psychiatric evaluation; in 2016, 5 patients (3.8%) out of 133 were referred for evaluation[ii]. This is unacceptable.

Page Two
Opposition to SB 3047 Relating to Health

Many physicians testified in 2018 that treating depression and pain often results in many of these patients electing NOT to request lethal suicide drugs. If we make the mistake of waiving the counseling referral requirement, some patients who may have opted NOT to go down the road of assisted suicide may not be given that chance. Far, far too *few* patients are referred for counseling based on the Oregon data[iii], so diminishing this requirement would be going in the wrong direction and condemning more patients to an unnecessary death. We should not fail to protect patients who are suffering from depression from finding the help they deserve.

***Allowing an attending provider to perform duties through telehealth, under certain conditions.***

Physicians who have long-term relationships with their patients know their patients better than anyone. These relationships provide them the wisdom to potentially recognize signs of depression. If patients shop for a new doctor because their regular doctor refuses to participate, there is no way to guarantee that signs of depression will be noted by either the new doctor of the nurse. Only trained psychologists and psychiatrists are able to make a true diagnosis regarding depression. Tele-health evaluations may not bring to light any signs of coercion, abuse or exploitation. Patient safety should remain a top priority.

***Mandating health insurance policies and contracts issued after December 31, 2020, to provide coverage for services related to ending a patient's life.***

This may open the state to lengthy lawsuits. Companies and employers in Hawaii that conscientiously object to assisted suicide may very well sue to prevent themselves from being forced to purchase an insurance product that uses their premium dollars to pay for assisted suicide. The insured who pay into their premiums will, likewise, not want to be forced to pay for lethal drugs for others. Finally, if insurance companies are required to cover assisted suicide drugs, which are cheaper than lifesaving treatments, it may give these companies another incentive to take the less expensive option.

Mahalo for the opportunity to submit our testimony in opposition.

---

[i] APA RESOURCE DOCUMENT ON PHYSICIAN ASSISTED DEATH (2017)

[ii] IBID

[iii] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf (accessed 02/02/20)

LATE

**SB-3047**
Submitted on: 2/3/2020 11:21:21 AM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Jacqueline Burnett | Testifying for Catholic Church | Oppose | No |

Comments:

Please vote NO on SB3047 and SB2582. The original law should not have been approved in the first place and to remove the safeguards is just not right.

LATE

**SB-3047**
Submitted on: 2/3/2020 2:37:53 PM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Michael Golojuch Jr | Testifying for LGBT Caucus of the Democratic Party of Hawaii | Support | No |

Comments:

Aloha Chair Baker, Vice Chair Chang and Committee Members,

The LGBT Caucus of the Democratic Party of Hawaiʻi stands in full support of the passage of Senate Bill 3047.

Allowing for advance directives for medical aid in dying is the right thing to do.

Mahalo for the opportunity to testify,

Michael Golojuch, Jr.
Chair
LGBT Caucus of the Democratic Party of Hawaiʻi

LATE

**SB-3047**
Submitted on: 2/3/2020 4:52:21 PM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Janet Hochberg | Testifying for Hawaii Life Alliance | Oppose | No |

Comments:

Aloha Chair Baker, Vice-Chair Chang & Members on the Commerce, Consumer Protection & Health Committee:

My name is Janet Hochberg, Executive Director of Hawaii Life Alliance.

Hawaii Life Alliance STRONGLY OPPOSES SB3047 for a number of reasons:

1. Hawaii's Assisted Suicide Law has been in effective for only one year. How can such a short timeline of the current law - which we were extremely concerned that safeguards would not work - this fast track legislation proves it -have **any solid reporting and/or data** to valdiate such heartbreaking new expansion to the existing law?

2. Allowing Advanced Directives to be a valid written request for a prescription to be self-administered is clearly taking advantage of the primary purpose of Advanced Directives and confusing the issue. This is a slippery slope, especially for those who may be diagnosed after the fact with chronic disease(s) such as Alzheimer's Disease or other related dementia(s), COPD, brain injury, etc. It's heartbreaking and unless someone is thoroughly educated on the issue, may be open to exploitation and coercion.

3. APRN's may be needed to write presciptions - which again is heartwrenching - because many of Hawaii's doctor's and pharmacists know assisted suicide is a slippery slope (why don't lawmakers care about this?) Why open this up to APRN's in such a short time to prescribe these drugs? Doesn't the law require a doctor to sign off on prescibing these legal drugs. We are extremely concerned and believe there's not enough data to constitute APRN's to have prescribing authority.

4. Waiving the counseling referral (mental health and at the very least depression) requirement -this is also heart wrenching! This is a requirement you and those in support promised would definately be needed in order for someone to qualify for the drugs. How can a person's life be so devalued? Do people cost to much to treat and be cared for?

5. Under certain conditions - allowing attending providers to perform services via telehealth and not require a physical visit with a patient who may be able to avail themself to this law. How can this be a legitimate process in such a critical decision? Again, we beleive so called safeguards don't work and we also believe the most vulnerable will be taken advantage of.

6. Requires health insurance policies and contracts after December 31, 2020 to provide services for someone who thinks they want to end their own life. We believe health

We rerspectuflly ask that this committe **OPPOSE** this bill, and give the current law more time to truly find out if these expansions are neccesary.

Sincerely & mahalo,

Janet Hochberg

COMMITTEE ON COMMERCE, CONSUMER PROTECTION AND HEALTH
SENATOR ROSALYN BAKER, CHAIR
SENATOR STANLEY CHANG, VICE CHAIR

Hearing: February 4, 2020; 9:30am; Conference Room 229
**Testimony COMMENTING on SB 3047 Relating to Health**

Chair Baker, Vice Chair Chang, and Members of the Committee:

Thank you for the opportunity to testify on this critically important issue. I wish to make comments and recommendations for one provision of SB 3047.

I am Dr. Linda Axtell-Thompson. I have a doctorate degree in bioethics, an interdisciplinary field concerned with the ethical questions that arise among the health-related life sciences, biotechnology, medicine, law, theology and philosophy, politics and policy. Over the past 20 years, I have been professionally and personally engaged with the ethical issues of end-of-life care, dementia, and aging.

By way of background, after nearly 30 years in healthcare planning and policy, I now teach at the university level in healthcare ethics, policy, and administration, and also "aging ethics". I am chair of the state's Policy Advisory Board for Elder Affairs, board member of Kokua Mau, participant in the original and current work groups for the dementia state plan, and member of a hospital clinical ethics committee and two university research ethics committees. I speak today as an individual, not representing any entity or agency.

Regarding the provision of SB 3047 that would "allow an advance directive to be a valid written request for a prescription to be self-administered for the purpose of ending an adult's life." I would recommend that this provision be removed from consideration during the current legislative session, and that a duly constituted task force thoroughly research, analyze, and debate the distinctive ethical concerns embedded in this issue, before any reconsideration in the future.

I urge caution regarding the proposal to allow an advance directive to substitute in place of the carefully designed process for Medical Aid In Dying (MAID). It is not simple or straightforward to expand advance directives to MAID, or MAID to dementia. It has ethical complexity beyond advance directives alone or MAID alone, and it will be compounded by administrative complexity in implementation.

No other state in the country has taken this step, so we have no domestic data or experience to rely on. Canada is just now deliberating the issue, and in fact has compiled a lengthy study that warrants our thoughtful reflection and discussion.[1] Key issues concern the uncertainties in interpreting and carrying out advance requests for MAID:

- Status of the patient: level of alignment between their current state, their current desire for MAID, and the conditions described in their AR for MAID.
- Clarity of communication: how well the patient described the circumstances that represent intolerable suffering to them in their AR for MAID, how often they discussed their wishes, and how consistent these wishes were.
- Strength of relationships: whether the patient had strong and open relationships with their healthcare practitioners and loved ones, and whether at least one trusted person was familiar with and supportive of their AR for MAID.[2]

Only Belgium, Colombia, Luxembourg, and the Netherlands permit some form of advance requests for MAID. But use is rare, reporting and analysis are inconsistent, and so possible guidance from these countries is limited.[3] Results from Dutch experiences include the following:

- In a new study of euthanasia and assisted suicide (EAS) of persons with dementia, advance request cases "were complicated by ambiguous directives, patients being unaware of the EAS procedures, and physicians' difficulty assessing 'unbearable suffering.'"[4]
- A recent study of physicians concluded euthanasia requests by patients with dementia "seem to place an ethically and emotionally heavy burden on Dutch general practitioners and elderly care physicians." Difficulties included "pressure from and expectations of relatives, society's negative view of dementia in combination with the 'right to die' view, interpretation of law and advanced euthanasia directives, ethical considerations, and communication with patients and relatives."[5]

I cannot do justice to these concerns in my short testimony, but I ask for adequate time and deliberation to properly address the complexities and nuances with a duly constituted task force of informed professionals and stakeholders. Should that occur, I would welcome the opportunity to participate. Thank you for considering my testimony.

Linda M. Axtell-Thompson, DBe, MBA
46-147 Hinapu Street
Kaneohe, HI 96744
linda.axtell1@gmail.com
808-226-6865

---

[1] Council of Canadian Academies, Dec 2018, The State of Knowledge on Advance Requests for Medical Assistance in Dying: the Expert Panel working Group of Advance Requests for MAID. https://cca-reports.ca/wp-content/uploads/2019/02/The-State-of-Knowledge-on-Advance-Requests-for-Medical-Assistance-in-Dying.pdf

[2] CCA, page 81.

[3] Noam Berlin, Zeeshan Ansari & Seema Marwaha, 02/07/19, Should Canada introduce advance requests for MAID? https://healthydebate.ca/2019/02/topic/advance-requests-for-maid

[4] Dominic R. Mangino et al., Euthanasia and Assisted Suicide of Persons With Dementia in the Netherlands, American Journal of Geriatric Psychiatry, Volume 0, Issue 0 (article in press) https://www.ajgponline.org/article/S1064-7481(19)30488-9/abstract

[5] Jaap Schuurmans et al. Euthanasia requests in dementia cases: what are experiences and needs of Dutch physicians? A qualitative interview study, BMC Medical Ethics (2019) 20:66 https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-019-0401-y

**SB-3047**
Submitted on: 2/3/2020 7:19:07 AM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Jackie | Individual | Oppose | Yes |

Comments:

Jackie Mishler RN BSN PCCN

It is too soon to change a bill that has been in effect less than a year.

The responsible course of action would be to set up a small commission of interested parties to see if the law is working as intended-- **we really have no idea if it is or isn't**.

**We are looking at anecdotal reports from the people who didn't want the safeguards in**

**the first place.**

This is especially true for a couple of reasons.

1. *This bill was touted to us by the legislature as having the strongest safeguards any bill of this kind had in the Nation. Now you are asking to weaken those safeguards without documented and validated evidence of necessity*. **This speaks to the integrity of the legislative body.**

2. The law just passed was very controversial, had significant opposition over a very long time (more than 20 years) for a variety of reasons. These proposed changes would trash a number of thoughtful and reasoned objections that are in the record- without speaking to the reasons for ignoring any of them.

3. In the long course of the ultimate passage of this law, there was considerable commentary about whether or not doctors had sufficient training to recognize

some of the inherent problems and risks with people who request assisted suicide. A year later proponents are recommending that the authorization to provide lethal drugs devolve to nurses, who likely have even less training than doctors about the problems and risks inherent in these requests. And, again we don't know if the original law is working as intended or not.

4. Finally, after passing a law touted for its safeguards, proponents are recommending lethal drugs be given to patients cutting through a number of those safeguards, without any screening, review, or accountability to the contravening of the safeguards in the original law, all because in one person's opinion the patient doesn't have as long to live as the waiting period requires. Anyone who has attended to this issue knows there is considerable testimony and considerable literature on the difficulty and the large number of failures in accurately predicting the date of a patient's demise. What is the reason for doing this? There is no rationale for why these changes are needed, let alone safe. Please do not allow this bill to move forward.

# TESTIMONY IN OPPOSITION TO SB 3047

Re: Opposition to SB 3047 Relating to Health

Dear members of the Senate Health Committee

I am testifying in opposition to SB 3047, specifically regarding the waiving of the requirement of the counseling referral requirement. I am a hospice and palliative care physician who has had intimate involvement with the assessment, care, and support of individuals who have requested Medical Aid in Dying. While the majority of the cases have gone very well including the few who have expired via ingestion of the lethal medication, it is clear that the protocol of the Act as it stands has served its purpose well.

The provisions of the “counseling referral” states: “shall be prescribed until the person performing the counseling determines that the patient is capable, and does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with the patient’s ability to make an informed decision pursuant to this chapter”.

The individuals who are faced with an advanced illness display a range of emotions from remarkable equanimity to utter despair. Furthermore, the very nature of someone with an advanced illness, affects that individual’s cognitive abilities such that the person may lose the capacity for understanding and sufficient insight “to make an informed decision pursuant to this chapter”.

I therefore strongly oppose the waiver of counseling referral requirement.

Craig Nakatsuka, MD

**SB-3047**
Submitted on: 2/2/2020 5:58:16 PM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Jerris Hedges | Individual | Support | No |

Comments:

Aloha Senators,

I wish to note my strong support for SB3047. This bill affords licensed APRNs the ability to serve as both attending provider and consulting provider for persons suffering from a terminal disease and wishing to take advantage of the Hawaii Medical Aid in Dying act. The APRNs licensed in Hawaii are trained and credentialed to serve in this capacity.

Jerris Hedges, MD

Dean, University of Hawaii John A. Burns, School of Medicine

**SB-3047**
Submitted on: 2/3/2020 7:55:18 AM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Dr Marion Ceruti | Individual | Oppose | No |

Comments:

This is yet another death bill has many objectionable provisions, but one of the worst is to require health-insurance policies and contracts issued after 31 Dec. 2020 to provide coverage for services related to ending a patient's life. What if the subscriber of a health-insurance policy does not want or need this coverage? This provision will increase the cost of health care for people who object on moral grounds to the idea that health-care professionals should help end a patient's life. Kill SB3047 by voting NO.

January 31, 2020

Honored Senate Commerce, Consumer Protection and Health Committee Members,

I have taught and practiced full-time palliative medicine in Hawaii for over 15 years and I am writing, as an individual, **in opposition to SB3047**.

With barely a year's experience with the Our Care, Our Choice Act, this bill would take Hawaii from the state that was touted as having the safest physician-assisted suicide legislation in the nation to the state most willing to sacrifice safety in the interests of "stream-lining" the process.

- APRN's are an essential component of any high quality palliative care team. Personally, I am blessed to work on a daily basis with the best pain management and palliative care APRN's in the state. However, no state allows APRN's to prescribe lethal drugs under their physician-assisted suicide law and none of the APRN's in Hawaii I have spoken with support this expansion.
- Medicare specifically <u>prohibits</u> APRN's from certifying 6-month prognosis for hospice (although they may serve as an attending). This certification of six-month prognosis is an <u>essential</u> role of the attending under OCOCA. Why would Hawaii consider it <u>scope of practice</u> for APRNs to certify terminal prognosis when the federal government does not? On what evidence is this based as being safe or appropriate care?
- The provision that permits an advance directive to serve as a valid request for a life-ending prescription is a giant leap down the slippery slope to involuntary euthanasia. The introduction of SB3047 states that safeguards are delaying the end of life process. "For example, patients with advanced dementia will not have the required decision—making capacity by the time they are terminally ill and are, therefore, denied the opportunity to choose their own medical treatment at the end of life." Allowing a request to be placed in an advance directive, potentially decades before a terminal illness strikes is clearly designed to facilitate use of death-hastening treatment for people that are incapable of completing a simple written statement. This is not in keeping with the intention of OCOCA to permit capacitated adults to self-determine their care. This back-door approach to euthanasia of those with dementia has also come to the Oregon legislature but, wisely, been turned down. It would be a tragedy to see vulnerable elders in Hawaii exposed to this risk.
- The inclusion of a required behavioral health evaluation, which can be performed via telehealth was one of the touted safeguards of the Our Care, Our Choice Act. We know that a vanishingly small number of patients are referred for behavioral health evaluations in other states with physician-assisted suicide despite the fact that mood and anxiety disorders have an extremely high prevalence among those living with life-limiting illness. Furthermore, physicians who are not behavioral health experts (i.e. psychiatrists) miss more cases of depression than they detect. What evidence other than, perhaps, anecdote do we have that the behavioral health evaluation is an unnecessary burden to people wishing to pursue the OCOCA? I have spoken with hospice colleagues who shared that the opportunity to review their motivations and feelings with a behavioral health expert was actually a positive experience for the patient.
- I have no objection to the element of SB 3047 that clarifies that telehealth can be used for all elements of the OCOCA. The OCOCA is actually silent on this, only stating that it is permissible for the behavioral health evaluation to occur by telehealth. The OCOCA does not specifically exclude telehealth for other OCOCA encounters. However, I would recommend clarification that the telehealth encounter is only permissible for patients that are known to the attending

physician. Current telehealth law in Hawaii appropriately prevents telehealth from being used to establish a clinical relationship for the prescribing of controlled substances. The current four-drug compounded mixture used in physician-assisted suicide in Hawaii includes a one thousand-fold over-dose of the controlled substance morphine.

Thank you for your thoughtful consideration as you weigh this serious matter, attempting to find the best balance of avoiding unnecessary suffering for the less than 0.5% of people that typically access physician-assisted suicide laws and the safety of the 100% of us that will face the end of life.

Respectfully,

Daniel Fischberg, MD, PhD, FAAHPM
Kailua, HI

**SB-3047**
Submitted on: 2/3/2020 9:04:51 AM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Monika Tomita | Individual | Oppose | No |

Comments:

LATE

**SB-3047**
Submitted on: 2/3/2020 9:39:01 AM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Patricia Bilyk | Individual | Support | No |

Comments:

LATE

**SB-3047**
Submitted on: 2/3/2020 9:33:14 AM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Alfred Hagen | Individual | Oppose | No |

Comments:

Dear Senators,

I was opposed to the original bill and subsequent law. What these proposed amendments are doing is removing safeguards that were built into the original law. These safeguards represent the assurances that you made to those who opposed the original bill and now it seems if these amendments are passed you will be reneging on your original assurances. These amendments should be summarily voted down.

Please accept my testimony on SB 3047 as follows:

1) Advanced directive to end one's life - So, a person who develops dementia can be put to death? Where's the physical suffering? So, an elderly mother/father who forgets her/his son's name can be put to death?

2) Advanced practice registered nurses will now also be the "attending provider?" Have you asked the question why so may doctors and pharmacists refuse to participate? What happens when registered nurses refuse? Go the next level(s) down: LPNs, CNAs, caregivers, family members?

3) Waive the counseling referral requirement? Why? What's the hurry? What if the person is mentally unstable unbeknownst to the attending provider? Open to abuse.

4) Performs duties through telehealth? How do we know the practitioner is who they say they are? Who gives the lethal doses? Will this person be sitting in an office on the mainland? What if something goes wrong? As wrong as this all is, How more impersonal and cold can this get? Open to abuse.

5) Health insurance will be required to cover assisted suicide? Do you mean "will be mandated." And, once it's covered don't you think that insurance companies will be subtly promoting assisted suicide instead of paying for "traditional" medical treatment? It puts the insurance industry in the position of aiding and abetting assisted suicide.

Please vote "NO!"

Respectfully submitted,

Alfred Hagen

LATE

**SB-3047**
Submitted on: 2/3/2020 9:58:37 AM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Shawna Chong-Ishii | Individual | Oppose | No |

Comments:

An advance healthcare directive is often done many years in advance of any chronic or end of life issue and people can change their mind or have different views on life in that span of time. Using an advance healthcare directive as direction for medical aid and dying when the patient is not able to make their own decisions when situations/life events may have changed their mind is not prudent. Everyone is not able to revise their directive so easily and having the ability to change ones' mind is at the core of autonomy. How one feels when they first make the directive may be different when actually faced with life and death. The directive is a values based form giving providers insight into ones' values and wishes. There is so much gray area and specific situations that one may find themself in at the end of life that there needs to be conversations surrounding end of life rather than edicts.

LATE

**SB-3047**
Submitted on: 2/3/2020 12:56:15 PM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Kathleen Yokouchi | Individual | Support | No |

Comments:

LATE

**SB-3047**
Submitted on: 2/3/2020 1:02:56 PM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Susan Lee | Individual | Support | No |

Comments:

LATE

**SB-3047**
Submitted on: 2/3/2020 1:44:00 PM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Dara Carlin, M.A. | Individual | Oppose | No |

Comments:

**SB3047 is EXACTLY what was precautioned and warned about** when the Assisted Suicide bill was presented and passed two years ago!!! "Allows an attending provider to ***waive*** the counseling referral **REQUIREMENT**"; do you not recall that this provision was specifically put in-place to SAFEGUARD any abuses of power from occurring against the dying? To assure that a proponent's intentions were indeed "compassionate" and free from malintent? Eroding any safeguards proves the MALINTENT of the proponents of such legislation. May God have mercy on those who willfully violate His Holy Laws.

LATE

**SB-3047**
Submitted on: 2/3/2020 2:21:06 PM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Dr. Guy Yatsushiro | Individual | Oppose | No |

Comments:

LATE

**SB-3047**
Submitted on: 2/4/2020 6:42:13 AM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Lynn Robinson-Onderko | Individual | Support | No |

Comments:

LATE

**SB-3047**
Submitted on: 2/3/2020 4:35:16 PM
Testimony for CPH on 2/4/2020 9:30:00 AM

| Submitted By | Organization | Testifier Position | Present at Hearing |
|---|---|---|---|
| Susan Pcola_Davis | Individual | Oppose | No |

Comments:

SB3047 testimony

**I am in strong opposition to this bill that**

- allows an advance directive to be a valid written request for a prescription to be self-administered for the purpose of ending an adult's life.
- Includes advanced practice registered nurses under the definition of "attending provider"
- Allows an attending provider to waive the counseling referral requirement.
- Allows an attending provider to perform duties through telehealth, under certain conditions.
- Requires health insurance policies and contracts issued after December 31, 2020, to provide coverage for services related to ending a patient's life.

**There is no reason for the Our Care, Our Choice law to be changed when it hasn't been even one year.**

Why is there a need to further streamline the process to provide MORE options for the "terminally ill" and "mentally capable" patients?

As for the use of advance health-care directives for end of life medical treatment decisions would allow an individual the opportunity to determine their own medical treatment as they near the end of life well in advance of losing their decision-making capacity. I have seen first hand where a hospitalist and an ER doctor bullied our family to change the AD from full code to DNR. Yet, now this bill is saying, "We wll support an AD that justifies suicide."

No definition of telehealth was provided. How do you document in a record teleheath for an AD? Why is this necessary? Increased access to a health care professional, is this like a "right to a speedy trial" except it is the "right to a speedy death?"

**Then you add in a handful of other things:**

(1) Include advance practice registered nurses under the definition of "attending provider";

(2) Allow an attending provider to waive the counseling referral requirement;

An APRN doesn't have this delineated in their Scope of Practice.

Why waive the counselling referral requirement? This was a built in safeguard. Let's remove more safeguards. No this is wrong.

**THIS IS SO AGAINST WHAT WAS PASSED LAST YEAR.**

**FURTHERMORE HAS ANY OF THIS REPORTING BEEN DONE? WHERE IS THE DATA TO SUPPORT ANY OF THIS? AND YET ALL OF THE FOLLOWING IS REQUIRED...**

**Annual report.** The department shall submit to the legislature an annual report no later than twenty days prior to the convening of each regular session. The report shall include but not be limited to:

(1) An annual analysis of the implementation of this chapter, including any implementation problems; and

(2) Any proposed legislation."

The department shall **annually collect and review** all information submitted pursuant to this chapter. The information collected shall be confidential and shall be collected in such a manner that protects the privacy of all qualified patients, the qualified patients' family, and any attending provider, consulting provider, or counselor involved with a qualified patient pursuant to this chapter. Information collected pursuant to this section by the department shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

On or before July , 9, and each year thereafter, the department shall create a report of information collected under subsection Cc) and vital statistics records maintained by the department and shall post the report on the department's Website. Information contained in the report shall only include:

(1) The number of qualified patients for whom a prescription was written pursuant to this chapter;

(2) The number of known qualified patients who died each year for whom a prescription was written pursuant to this chapter and the cause of death of those qualified patients;

(3) The total number of prescriptions written pursuant to this chapter for the year in which the report was created as well as cumulatively for all years beginning with 9;

(4) The total number of qualified patients who died while enrolled in hospice or other similar palliative care program;

(5) The number of known deaths in Hawaii from a prescription written pursuant to this chapter per five-thousand deaths in Hawaii;

(6) The number of attending providers who wrote prescriptions pursuant to this chapter; who died as a result of self-administering a prescription pursuant to this chapter,

•The individual's:

(A) Age at death;

(B) Education level;

(C) Race;

(D) Sex;

(E) Type of insurance, if any; and

(F) Underlying illness; and

(G) Any other data deemed appropriate by the department. Such as;

§ - 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 to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means.

§ - Effect on construction of wills or contracts.

(a) No provision in any 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 a prescription to end the person's life pursuant to this chapter, 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 a prescription to end the person's life pursuant to this chapter.

§ - 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 such policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for a prescription to end the person's life pursuant to this chapter. A qualified patient's act of using medication to end the qualified patient’s life pursuant to this chapter shall have no effect upon a life, health, or accident insurance or annuity policy.

LATE

**From:** Doreen Anderson
**To:** CPH Testimony
**Subject:** From: Doreen Anderson
**Date:** Monday, February 3, 2020 12:01:41 PM

---

From: Doreen Anderson
41-143 Makaainana St
Waimanalo, HI 96795
gookolina@gmail.com
(808) 375-5059

Submitted on February 3, 2020

Testimony in opposition to SB3047 and SB2582, Relating to Health
Date:  Tuesday, February 4, 2020
Time:  9:30AM
Place:  Conference Room 229

Submitted to: The Senate Committee on Consumer Protection and Health

Aloha Senator Rosalyn Bakern and members of the Committee,

I do no support SB3047. The Assisted Suicide law goes against all of my principles; I think that it is morally wrong. Both changing from doctors or adding nurses as ”attending providers” and the use of telehealthcare greatly lowers our medical standards and quality of care. Mandating insurance companies to financially cover these services is unjust and will increase the cost of medical insurance that is already too expensive.

Please vote “NO” on SB2582. This bill drastically reduces the safeguards stipulated in the bill that became law last year. Again, I am thoroughly against nurses practicing assisted suicide medical aid to the dying. I do not support reducing the mandatory waiting period between oral requests from twenty to fifteen days and waiving the mandatory waiting period for those terminally ill individuals not expected to survive the mandatory waiting period.

Mahalo,
Doreen Anderson

Sent from my iPhone

LATE

**From:** DIANE ROCHA-CARLOS
**To:** CPH Testimony
**Subject:** Opposition to bill SB3047 & SB2582
**Date:** Monday, February 3, 2020 12:03:59 PM

---

From: Diane Rocha-Carlos

Submitted on February 3, 2020

Testimony in opposition to SB3047, Relating to Heslth

Submitted to: The Senate Committee on Consumer Protection and Health

Aloha Senator Laura Thielen and members of the Committee,

I do no support SB3047. The Assisted Suicide law goes against all of my principles; I think that it is morally wrong. Both changing from doctors or adding nurses as ”attending providers” and the use of telehealthcare greatly lowers our medical standards and quality of care. Mandating insurance companies to financially cover these services is unjust and will increase the cost of medical insurance that is already too expensive.

Please vote “NO” on SB2582. This bill drastically reduces the safeguards stipulated in the bill that became law last year. Again, I am thoroughly against nurses practicing assisted suicide medical aid to the dying. I do not support reducing the mandatory waiting period between oral requests from twenty to fifteen days and waiving the mandatory waiting period for those terminally ill individuals not expected to survive the mandatory waiting period.

Sincerely,
Diane Rocha-Carlos
Ph. 259-6478

Sent from my T-Mobile 4G LTE Device