Testimony of the Board of Nursing

Before the
Senate Committee on Health
Wednesday, February 10, 2021
1:00 p.m.
Via Videoconference

On the following measure:
S.B. 839, RELATING TO HEALTH

Chair Keohokaloke and Members of the Committees:

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

The purposes of this bill are to: (1) authorize APRNs, in addition to physicians, to practice medical aid in dying in accordance with their scope of practice and prescribing authority; (2) authorize psychiatric mental health nurse practitioners, in addition to psychiatrists, psychologists, and clinical social workers, to provide counseling to a qualified patient; (3) reduce the mandatory waiting period between oral requests from 20 days to 15 days; and (4) waive the mandatory waiting period for those terminally ill individuals not expected to survive the mandatory waiting period.

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

This bill amends the definition of "counseling" to authorize a "psychiatric mental health nurse practitioner" to consult with a patient to determine whether the patient is capable of making an informed decision regarding ending the patient's life. The Board notes that there are four categories of APRNs (nurse practitioner, clinical nurse specialist, certified nurse midwife, and certified registered nurse anesthetist), and specifying that only a psychiatric mental health nurse practitioner, or nurse practitioner,

may provide services will exclude a clinical nurse specialist who specializes in adult psychiatric mental health from providing care.

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

Thank you for the opportunity to testify on this bill.

HAWAI'I STATE CENTER FOR NURSING
Connecting Nurses. Transforming Healthcare.

Written Testimony Presented Before the
COMMITTEE ON HEALTH
DATE: Wednesday, February 10, 2021
TIME: 1:00 p.m.
PLACE: VIA VIDEOCONFERENCE
By
Laura Reichhardt, APRN, AGPCNP-BC
Director, Hawai'i State Center for Nursing
University of Hawai'i at Mānoa

Comments on SB839

Chair Keohokalole, Vice Chair Baker, and members of the Senate Committee on Health, thank you for the opportunity for the Hawai'i State Center for Nursing to provide Comments on Section 2 of this measure which, if enacted, would enable Advanced Practice Registered Nurses (APRNs) to participate as an attending, consulting, and counseling provider in the Our Care, Our Choice Program.

Advanced Practice Registered Nurses have more than doubled in Hawai'i between 2005 and 2017 with continued growth since that period. At this time, nearly 1,300 licensed APRNs reside in Hawai'i. APRNs are noted in national research to be more likely to provide care to underserved people and communities including rural areas, urban areas, to women, and to Medicaid recipients or uninsured people (Buerhaus et al., 2014). Currently there are practicing APRNs in all regions of Hawai'i with more than 25% of Hawai'i's APRNs are working in rural areas (Hawai'i State Center for Nursing, 2017). Further, the majority of APRNs working in the Counties of Hawai'i, Maui, and Kaua'i work in federally designated medically underserved areas.

Hawai'i adopted the national best practices for APRN regulation, the APRN Consensus Model (2008), which states that licensure, accreditation, and certification combined provide guidance on an APRN's scope of practice. APRNs include Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists. APRNs are educated from accredited schools of nursing in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related, or psych/mental health. Upon achieving national certification in their educated role and population foci, only then may an APRN apply for licensure. Hawai'i law (§457-2.7) defines APRN scope of practice to include advanced assessment and the diagnosis, prescription, selection, and administration of therapeutic measures including over the counter drugs, legend drugs, and controlled substances within the advanced practice registered nurse's role and specialty-appropriate education and certification.

Hawai‘i’s laws for APRNs ensure public safety during patient care through authorized assessment, diagnosis, and prescriptive authority. APRNs have grown significantly in Hawai‘i with APRNs providing care in all regions in the state where people live.

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

The mission of the Hawai‘i 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 Hawai‘i.

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Testimony of Sam Trad, Hawai'i State Director, Compassion & Choices

Supportive Testimony Regarding SB839

Senate Health Committee

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

Thank you for passing the Our Care, Our Choice Act, which has provided peace of mind to the terminally ill over the last two years it has been in effect; and thank you for your consideration of **SB839**. We are here today and pleased to offer our support for these crucial amendments to the Our Care, Our Choice Act.

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

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[1] Report to the Thirtieth Legislature, An Analysis of the analysis of the Implementation of the Our Care, Our Choice Act, Available from: https://health.hawaii.gov/opppd/files/2020/06/2020-Annual-OCCOA-Report-1.pdf

[2] Why the Doctor Shortage Continues in Hawai'i, Big Island Now, June 5, 2019. Accessed at: https://bigislandnow.com/2019/06/05/why-the-doctor-shortage-continues-in-hawai'i/

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

[4] Hawai'i's doctor shortage is taking 'a troubling turn for the worse,' Hawai'i News Now, June 5, 2019. Accessed at: https://www.Hawai'inewsnow.com/2019/09/10/Hawai'is-doctor-shortage-is-taking-troubling-turn-worse/

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

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

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

Additionally, this bill seeks to reduce the current mandatory 20 day waiting period between oral requests to 15 days, further reducing the unnecessary burden on the terminally ill seeking this option.

Expediting the mandatory minimum waiting period as they now do in Oregon

The data and experience have long demonstrated that barriers exist throughout the nine other authorized jurisdictions, which have less restrictive measures in place than currently exist in Hawai'i. In response to the evidence compiled over the last 21 years of practice, the Oregon legislature passed an amendment to the law in an attempt to find a better balance between safeguards intended to protect patients and access to medical aid in dying in 2019. The amendment (SB579) gives doctors the ability to waive the current mandatory minimum 15-day waiting period between the two required oral requests and the 48-hour waiting period after the required written request before the prescription can be provided, if they determine and attest that the patient is likely to die while waiting.[6] The amendment was a direct result of evidence and data that clearly demonstrated the need for easier access for eligible terminally ill patients facing imminent death.[7]

Expanding the Definition of Provider to includeAdvanced Practice Registered Nurses with Prescriptive Authority (APRN Rx)

Hawai'i is one of 24 states that give advanced practice registered nurses (APRNs) authority to independently carry out all medical acts consistent with their education and training, including prescribing all forms of medication, including controlled substances.[8] However, by not including APRNs within the definition of "provider," the Our Care, Our Choice Act unnecessarily prohibits APRNs from providing high quality health care and support to patients who want the option of medical aid in dying.

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[6] Senate Bill 579, 80th Oregon Legislative Assembly--2019 Regular Session. Available from: https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB579/Enrolled

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

[8] American Association of Nurse Practitioners, "2021 Nurse Practitioner State Practice Environment" available from: https://storage.aanp.org/www/documents/advocacy/State-Practice-Environment.pdf.

Amending the law to explicitly allow APRNs to participate as providers under the Our Care, Our Choice Act is consistent with their scope of practice and would help address the disparity in access to participating providers, particularly in rural areas and neighboring islands. For example, Ron Meadow, who lived on the Big Island, was terminally ill and eligible for the Our Care, Our Choice Act, spent his final weeks searching for a physician who would support him in the option of medical aid in dying, so he could end his suffering. Sadly, by the time he found a physician it was too late and Ron died in pain in exactly the way he did not want. Allowing APRNs to support patients in medical aid in dying will provide patients, like Ron, with more options to access this compassionate option.

Reducing the 20 day waiting period to 15 days and allowing attending providers to waive the mandatory waiting period if the patient is unlikely to survive and meets all other qualifications.

Hawai'i currently has the longest mandatory waiting period (20 days) between the first and second oral requests for medical aid in dying, of the 10 authorized U.S. jurisdictions. Hawai'i physicians have said that their eligible terminally ill patients are suffering terribly at the end of life and are not surviving the 20-day mandatory waiting period between oral requests. The Hawai'i Department of Health's report on the first five months of the law showed "the eligibility process from the first oral request to the date of receipt of the written prescription was approximately 37 days" for the eight people who received them from four physicians.[9]

Sadly, this is not an uncommon occurrence, even in the other authorized states with a 15 day waiting period. This experience is why Oregon recently amended its Death with Dignity law to allow the attending provider to waive the mandatory waiting period entirely if the patient is unlikely to survive it.[10] Both reducing the waiting period and allowing it to be waived in such circumstances will better ensure that otherwise qualified terminally ill individuals are not deprived of the comfort and peace of mind they so desire at life's end simply for the sake of checking a regulatory box.

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

Sincerely,

Sam Trad

Sam Trad
Hawai'i State Director
Compassion & Choices

[9] Hawai'i Department of Health (DOH) 2019 Our Care Our Choice Annual Report, July 1, 2019. Accessed at: https://health.Hawai'i.gov/opppd/files/2019/06/2019-Annual-OCOCA-Report-062819.pdf

[10] New law shortens 'Death With Dignity' waiting period for some patients, The Oregonian, Jul 24, 2019. Accessed at: www.oregonlive.com/politics/2019/07/new-law-shortens-death-with-dignity-waiting-period-for-some-patients.html

SB-839
Submitted on: 2/9/2021 8:23:59 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Charles F Miller	Testifying for Hawaii Society of Clincal Oncology	Support	No

Comments:

Dear Senator Baker and other members of the Health Committee

I'm a medical oncologist as well as a constituent in your district, and I'm writing to you today to urge you to support SB839/HB487 which makes very necessary improvements to the Our Care, Our Choice Act.

I have been an active physician participant in The Our Care, Our Choice Act for over 2 years now. Yet many eligible terminally ill patients are having trouble accessing the law, causing needless suffering. In this month of January, 2021 I have received 10 referrals for medical aid in dying, yet 4 out of those ten patients died of their underlying medical conditions before the required 20 day waiting period. We know from Kaiser HI and Hawai'i Pacific Health, that at least 21 eligible patients died before they could get their medication. Providers should be allowed to waive the waiting period for their patients if the patient is unlikely to survive it and goes through all of the other steps to qualify for the law. This is inexcusable and one of the problems that these amendments will address.

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

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

Sincerely,

Charles F. Miller, MD, FACP

Member, Board of Directors, Hawaii Society of Clinical Oncology

Honolulu, HI

LATE

SB-839
Submitted on: 2/9/2021 4:33:40 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

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

Comments:

SB839 Testimony

I STRONGLY OPPOSE THIS BILL AND MY REASON FOLLOW.

1. Giving an Advanced Practice Registered Nurse (APRN) privileges only afforded to physicians. Increasing the Scope of Practice for APRNs is not a solution.
Examples of this are in the bill,

- assessment, **No**
- screening, **No**
- diagnosing, **No**
- ordering, **NO**
- utilizing, **NO**
- or to perform medical, therapeutic, preventive, or corrective measure, **NO**
- including prescribing medications. **ABSOLUTELY NO**

2. **DO NOT** amend the definition of “attending provider.” Amending the definition of "attending provider" to is a slap in the face of providers who spent many hours in medical school and investing large amounts of money to obtain their Medical Doctor (M.D.) designation.

3. The care and treatment of a patient who is presumed to have a terminal illness **must not reside with an APRN.**

4. **DO NOT** amend the definition of “consulting provider” to add “or an advanced practice registered nurse licensed pursuant to chapter 457, who is qualified by specialty or experience to diagnose and prescribe medication."

5. **DO NOT** amend the definition of “counseling” to add: or psychiatric mental health nurse practitioner leave this determination ONLY to a psychiatrist licensed under chapter 453, psychologist licensed under chapter 465, or clinical social worker licensed pursuant to chapter 467E 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."

6. **Oral and written requests for medication; initiated.**

This paragraph doesn’t include an APRN (yet an APRN is included in other portions of the bill, to determine whether an adult who is capable, is a resident of the State, and has been determined by "Attending provider" [means a physician licensed pursuant to chapter 453 and “Consulting Provider” means a physician licensed pursuant to chapter 453] to be suffering from a terminal disease, and who has voluntarily expressed the adult's wish to die, may, pursuant to section 327L-9, submit:

(1) Two oral requests, a minimum of [twenty] fifteen days apart; and

(2) One written request,

for a prescription that may be self-administered for the purpose of ending the adult's life in accordance with this chapter. "Attending provider" [means a physician licensed pursuant to chapter 453 and “Consulting Provider” means a physician licensed pursuant to chapter 453]. THE ATTENDING PROVIDER SHALL DIRECTLY, AND NOT THROUGH A DESIGNEE, RECEIVE ALL THREE REQUESTS REQUIRED PURSUANT TO THIS SECTION." NOT AN APRN.

7. DO NOT REDUCE THE NUMBER OF DAYS FROM 20 DAYS TO 15 DAYS. Nothing in the bill offers any data that indicates reducing the number of days will make any difference.

8. **DO NOT** REDUCE THE NUMBER OF DAYS FROM 20 DAYS TO 15 DAYS for Waiting Periods. There is no evidence supporting the reduction of days to make any difference.

9. If the terminally ill individual's "Attending provider" [means a physician licensed pursuant to chapter 453 and “Consulting Provider” means a physician licensed pursuant to chapter 453], attests that the individual will, within a reasonable medical judgment, die within fifteen days after making the initial oral request, the fifteen day waiting period shall be waived and the terminally ill individual may reiterate the oral request to the attending provider at any time after making the initial oral request."

Determining whether an ill patient is going to die within 15 days, and waiving those 15 days IS EUTHANASIA, MURDER, AND TO SEE IT IN WRITING IS APPALLING.

IN ADDITION;

This bill expands assisted suicide in Hawaii to include Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs).

Expanding Prescription Power for Lethal Drugs to Physician Assistants (PA's) and Advanced Practice Registered Nurses (APRN's) is **dangerously wrong**.

Physicians are notoriously inaccurate in predicting how long a patient has to live, finding that a significant number live many years beyond the supposed six-month window for eligibility for assisted suicide drugs. The natural tendency of physicians who favor assisted suicide is to paint a grim prognosis for the patients, making them feel obligated to choose lethal drugs or instilling a mindset of “there aren’t any more options.”

The problem is made worse by placing life and death medical decision-making into the hands of PA's and APRN's who have much less training and knowledge in assessing patients than physicians. This may well result in the untimely death of patients who would have years, or even decades, of life ahead of them.

The proposed expansion of assisted suicide law in Hawaii doesn’t even call for training PA's or APRN's, let alone doctors, to assess patients for capacity, depression and other factors before giving them power to make irreversible decisions to end a patient’s life. It is an **egregious violation of patient safety** to allow PA 's or APRN's to make this decision.

The Waiting Period:
State laws have waiting periods for much less serious actions than suicide prescriptions such as purchase of goods and services. Patients who are depressed or in need of medical treatment frequently change their minds about what they want.

Medications to treat depression take several weeks to take effect, and sometimes several medications need to be tried to find the right one for the patient. Eliminating a waiting period does not allow for effective treatment of depression.

A waiting period of 20 days not 15 days is the **MINIMUM** that a state should require before a patient is given suicide drugs.

Hawai'i Psychological Association

For a Healthy Hawai'i

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SENATE COMMITTEE ON HEALTH
Senator Jarrett Keohokalole, Chair,
Senator Rosalyn H. Baker, Vice Chair

DATE: February 10, 2021 1:00 P.M. - VIA VIDEO CONFERENCE

Testimony in Support on SB839 HEALTH

The Hawai'i Psychological Association (HPA) supports SB839, which would give advanced practice registered nurses (APRNs) and psychiatric mental health nurse practitioners the authority to engage in certain medical aid in dying services, as well as reduce the waiting time for patients to be eligible for the program.

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

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

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

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

Sincerely,

Alex Lichton, Ph.D.

Alex Lichton, Ph.D.
Chair, HPA Legislative Action Committee

Submitted Online: February 8, 2021

HEARING: Thursday, February 11, 2021

TO: SENATE COMMITTEE ON HEALTH
Senator Jarrett Keohokalole, Chair
Senator Rosalyn Baker, Vice Chair

FROM: Eva Andrade, President

RE: Opposition to SB 839 Relating to Health

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

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

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

An editorial we printed in February of 2020, in the Star Advertiser, articulated the concerns we still have to this day: "In some respects, the changes would push Hawaii into the forefront. Eight other states and the District of Columbia allow medical aid in dying, but Hawaii would be the first to allow APRNs as well as physicians to participate. And Oregon, which legalized aid-in-dying more than 20 years ago, is the only state with a law that allows physicians to waive the waiting period — a change it made just last July, so the full effects may not be known for some time. Is changing the law an act of compassion, making this legal right more accessible to suffering patients? Or could it make the option less safe for patients who might change their minds? Lawmakers, move with care.[ii]" (Emphasis mine).

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

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[i] https://www.capitol.hawaii.gov/session2018/bills/HB2739_HD1_.HTM
[ii] https://www.staradvertiser.com/2020/02/08/editorial/our-view/editorial-secrecy-in-police-reports/ (accessed 02/03/21)

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

SENATE COMMITTEE ON HEALTH
Senator Jarrett Keohokalole, Chair,
Senator Rosalyn H. Baker, Vice Chair

DATE: February 10, 2021 1:00 P.M. - VIA VIDEO CONFERENCE
Testimony in Strong Support with Comments on SB839 RELATING TO HEALTH

The Hawaiian Islands Association for Marriage and Family Therapy (HIAMFT) strongly supports SB839, which would give advanced practice registered nurses and psychiatric mental health nurse practitioners the authority to engage in certain medical aid in dying services. These services have been previously limited to physicians, psychiatrists, psychologists, and social workers.

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

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

Perhaps most germane to this measure, MFTs are specifically trained to attend to a patient's primary relationship networks that may become resources for well-being. With a relational and

systemic focus, MFTs use a perspective that considers the full context of a patient's situation. This perspective is particularly important when working with critically serious issues like the intentional ending of one's life.

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

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

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

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

Sincerely,

John Souza, LMFT, DMFT

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

Hawai'i Association of Professional Nurses (HAPN)

To: The Honorable Senator Jarrett Keohokalole, Chair of the Senate Committee on Health

From: Hawaii Association of Professional Nurses (HAPN)
Subject: SB839 – Relating to Health

Hearing: February 10, 2021, 1p.m.

Aloha Senator Keohokalole, Chair; Senator Baker, Vice Chair, and Committee Members

Thank you for the opportunity to submit testimony regarding SB839. HAPN is in **strong Support with Amendments** of placing choice in the hands of patients with whom we work every day, which includes patient choice in who their provider is when making a decision of this magnitude. We have reviewed the recommendations made by the Department of Health to include Advanced Practice Registered Nurses (APRN) to practice medical aid in dying in accordance with their scope of practice. We also support reducing the mandatory waiting period to 15 days and allowing the provider to waive this waiting period as they deem appropriate after evaluation and discussion with the patient about their options. We request that Section 2.4 be amended to state "…or psychiatric mental health advanced practice registered nurse…" as this is in line with the license we hold.

HAPN's mission, to be the voice of APRNs in Hawaii, has been the guiding force that propelled us to spearhead the advancement of patients' access to healthcare as well as supporting the recognition of the scope of practice for APRNs in Hawaii which led us to full practice authority. We have worked to improve the physical and mental health of our communities. As our ability to provide close care with our patients progressed, we also opened up our own clinics to provide the care our patients deserve. As a result, the current law requires that a patient remove themselves from the excellent care their APRN has provided them over the years to discuss this end-of-life option with physicians who may not have the same patient-provider relationship. APRNs have played an important role in the healthcare of our communities and we will continue to be by our patients' side as they make many different healthcare decisions throughout their lives. There have been clear indications that patients on our rural islands have been having difficulty finding healthcare professionals to support them in their legal right: https://www.hawaiitribune-herald.com/2020/11/15/opinion/aid-in-dying-shouldnt-be-this-difficult-in-east-hawaii/. We support the recommendations from our partners at the Department of Health in their assessment and evaluation of this issue.

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

Respectfully,
Dr. Jeremy Creekmore, APRN
HAPN President

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

Written Testimony Presented Before the Senate Committee on Health

Hearing: February 10, 2021, 1:00 PM Via Videoconference

By Hawai'i – American Nurses Association (Hawaii-ANA)

HAWAII AMERICAN NURSES ASSOCIATION

SB839 - RELATING TO HEALTH

Chair Jarrett Keohokalole, Vice Chair Rosalyn H. Baker, and members of the Senate Committee on Health, thank you for this opportunity to provide testimony **in support of SB839.**

This bill seeks to explicitly recognize advanced practice registered nurses (APRNs) as attending providers and consulting providers capable of performing all necessary duties under the Our Care, Our Choice Act in accordance with their scope of practice and prescribing authority. This bill also seeks to reduce the mandatory waiting period between oral requests made by a terminally ill individual from twenty to fifteen days, and to allow an attending provider to waive the waiting period for terminally ill individuals not expected to survive the mandatory waiting period.

We are members of the American Nurses Association in Hawai'i. Over 17,000 Registered Nurses in Hawai'i care for patients every day, throughout the lifespan, from birth through dying and death. We have supported the passing of bills to enact this measure in the past, in our interest to provide choices and options to patients addressing end-of-life issues. We continue to support the Act as an option for both patients and providers, to consider in meeting the personal needs of the individual patient.

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

Hawai'i-ANA respectfully requests that SB839 pass out of this committee. Thank you for your continued support for measures that address the healthcare needs of our community.

Contact information for Hawai'i – American Nurses Association

President: Katie Kemp, BAN, RN-BC president@hawaii-ana.org
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SB-839
Submitted on: 2/5/2021 3:01:37 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Caroline Kunitake	Individual	Support	No

Comments:

Dear Chair Keohokalole, Vice Chair Baker and Commitee on Health,

Please support SB839.

My elderly parents, who are in their 80s, live in Kona on the Big Island. There is a shortage of primary care physicians especially on the neighbor islands. If my parents ever need to use the Our Care, Our Choice Act, I want them to have the option of utilizing an advanced practice registered nurse to provide medical aid in dying. I don't want my parents to be forced to endure a 20 day mandatory waiting period, especially if they are suffering with excruciating physical and emotional pain. My parents have both told me that they would consider medical aid in dying if they were terminally ill.

I want this bill to pass to provide legal and humane end of life options for all people in Hawaii struggling with a terminal illness. Illness and death are a natural and unavoidable part of life. Improving the Our Care, Our Choice Act will ease unnecessary physical and psychological suffering for the dying patient and their loved ones.

People with religious beliefs that are not aligned with the Our Care, Our Choice Act do not need to use this law. Yet the Our Care, Our Choice Act empowers those who wish to have control over when and how they want to end their lives with dignity. The existance and improvement of the Our Care, Our Choice Act does not threaten the rights of those who wish to live with a terminal illness until their lives are ended by natural causes. Medical aid in dying is ultimately a private and individual matter that need not be decided by opponents who object to medical aid in dying.

Thank you so much for your time and attention to this bill. I appreciate the opportunity to provide testimony in support for SB839.

Mahalo,

Caroline Kunitake

SB-839
Submitted on: 2/5/2021 3:52:15 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
donald erway	Individual	Support	No

Comments:

This is inportant to death with dignitiy!

Mahalo,

Don

SB-839
Submitted on: 2/5/2021 4:10:07 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Alison Bhattacharyya	Individual	Support	No

Comments:

I support making access to end of life care available to all citizens in our state and using APRN physician extenders is one way to do this. If there is a shortage of physicians it is only fair for remote areas of the islands to receive the same care and choice as those on Oahu. Also, reducing the waiting time to match other states to 15 days and shorten the current waiting period by 5 days could be 5 days of less suffering. As a cancer survivor, I know how important it is to have the proper end of life care for patients whose suffering can only be alleviated by death.

SB-839
Submitted on: 2/5/2021 5:16:53 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
AUBREY HAWK	Individual	Support	No

Comments:

I strongly support SB839. As a Puna resident, I have seen first-hand how rural terminally ill patients are unable to access the Our Care, Our Choice Act as curerntly written, due to lack of providers and geographical isolation.

02/05/2021

To Hawaii Senate Health Committee 2021:
Chair Jarrett Keohokalole
Vice Chair Rosalyn Baker
Sharon Y. Moriwaki
Joy San Buenaventura
Kurt A. Favella

SB 839: Urging your strong support for removing barriers to access Hawaii's Our Care, Our Choice Act

Greetings Senate Health Committee Chair, Vice Chair, and Members:

I appreciated previous votes to pass the original "Our Choices, Our Care Act" and, building on that, your support this year for SB 839 aimed at removing barriers of access to the act is very important.

Data: Over 60 prescriptions have been written in Hawaii since the law went into effect. Staying in line with nearly 40 years of combined national data, there has not been a single incident of coercion or abuse in Hawaii or in any other states that have authorized medical aid in dying.

My Story: These revisions are so important to me. I was diagnosed in 2016 with an aggressive form of breast cancer. While my prognosis now looks good—it's been nearly five years since my diagnosis and treatment—I embrace that we will all have the comfort we need, knowing that these improvements to the Our Care, Our Choice Act is there, and that no-one will suffer needlessly at the end of our lives because we can access the supportive care we need.

First: Although the law is working, there remains a lack of doctors who are participating. Many who desire the medical aid in dying option cannot find doctors to support them and many do not survive the 20-day waiting period. This has led to exacerbating stress for the dying person at a time when comfort is needed most. It increases distress that challenges families at the very moment when they need to stay grounded and share their loving. Both Kaiser Permanente and Hawaii Pacific Health have set up streamlined processes to assist their patients in accessing medical aid in dying, but nearly a quarter of their eligible patients did not survive the waiting period and died in exactly the way they didn't want. Therefore, I appeal to our legislators to amend the Our Care, Our Choice Act to allow the 20-day waiting period to be waived if the eligible patient will not survive the waiting period, just as they already do in Oregon.

Second: The law can be especially difficult to access on our neighbor islands. That is why the Hawaii State Department of Health has recommended that qualified Advanced Practice Registered Nurses (APRNs) be able to fully support eligible patients in the option of medical aid in dying, including writing prescriptions for qualified patients. Moreover, it is extremely hard for terminally ill patients, if they are not part of Kaiser or Hawaii Pacific Health, to find doctors who are willing to write a prescription. APRNs already have prescriptive authority in our state, thanks to your leadership. And they should have the ability to serve as the attending physician, especially because of the doctor shortage across our state. With this amendment, APRNs will become qualified to serve as either the attending or consulting for the law. These amendments to the law just make sense, contributing to the well being of families across the state who have loved ones at the end of life.

The amendments in SB 839 were recommended by our Department of Health. When Senator Roz Baker and Representative Gregg Takayama sponsored legislation reflecting these amendments last year, the bill did pass out of the Senate and was heading to the House when, unfortunately, the pandemic brought everything to a halt.

It's time for Hawaii to approve the Hawaii State DOH improvements to the "Our Care, Our Choices Act" to increase access so that everyone who prefers this legal option has equal access to implement their choices for themselves at one of the most important moments of their lives.

Aloha,

Lynn B. Wilson, PhD
Waipahu, Hawaii 96797

Mary M. Uyeda, APRN

To the House of Senators – Committee on Heath – February 5, 2021

I support SB 839 with fewer barriers in the given very specific scenario, as an alternative if it fits, for a person's right to choose at the end of his or her life.

During my 30 years of bedside nursing in Intensive Care, I have personally witnessed a wide range of deaths ranging from peaceful to prolonged agony, often dependent on the physician and nurses in charge of their care. One incident needs mention, where a terminal cancer patient packed his own loaded gun, "to give myself the alternative - out" when doctors would not give him the choice. Of course, the police interrogation was an embarrassment to all.

Too 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. Lastly, it needs to be emphasized that "no treatment" does not translate to "no care".

Hawaii is far behind the Oregon law which has built-in safeguards that prevailed over the last 20+ years.

Help us support those very few candidates who fit this narrow scenario, with passage of SB 839.

SB-839
Submitted on: 2/6/2021 7:20:28 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Bob Grossmann, PhD	Individual	Support	No

Comments:

I reviewed all opposing testimony when the bill was first introduced into the legislature that included nurses in advanced practice in the definitions. None of the arguments for having removed the language was based on community health reasoning.

Striking APRNs limited nurses' scope of practice and greatly reduced options for those terminal and their families/friends (especially on the neighbor islands and with the increasing physician shortage).

Two non-compassionate alternatives are a horrible suicide and an undignified, prolonged painful death.

Please pass this measure.

Dear Members of these Senate Committee on Health

In opposition to SB 839

In the wake of a tripling of suicides during this COVID pandemic when suicide rates had been increasing in all age categories even before the pandemic, to talk about expansion of the original act is, to put it bluntly: “suicidal”.

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

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

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

Craig Nakatsuka, MD

SB-839
Submitted on: 2/6/2021 9:36:36 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
william metzger	Individual	Support	No

Comments:

IMPORTANT TO IMPROVE OPTIONS FOR THE DYING

SB-839
Submitted on: 2/6/2021 10:11:11 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Judith A Mick	Individual	Support	No

Comments:

Please pass SB 839 so we can continue to ease the suffering of those who need and deserve out compassion and help. Thank you for your consideration. Judith Mick (kupuna), Kailua

SB-839
Submitted on: 2/6/2021 12:19:55 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Jane E Arnold	Individual	Support	No

Comments:

I am a resident of Hawaii, and I am requesting that your committee vote YES on SB839. This bill would improve access to medical aid in dying, especially for people on the outer islands.

SB-839
Submitted on: 2/6/2021 1:43:25 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Nora E. Wolf	Individual	Support	No

Comments:

Dear HTH Committee Members,

I am writing to you in support of bill SB 839. The State of Hawai'i has already agreed that terminally ill residents should have the choice to choose medical assistance to die with dignity, compassion, and autonomy. With the shortage of physicians offering this service to Hawai'i's terminally ill, advanced practice registered nurses (APRNs) offer a unique opportunity to remove barriers to access for qualified individuals. Hawaii gives APRNS full scope of practice licensure; therefore, allowing appropriately trained APRNs to provide this service will help ensure access to this very important option for Hawai'i's terminally ill. Another barrier than can easily be over come is to decrease Hawai'i's mandatory 20-day waiting period to the standard 15-day waiting period, and for those who have less than 15-days of life, a pathway to expedite the process. This will be most readily supported by allowing Psychiatric Nurse Practitioners, trained in this discipline, to participate in end-of life psyshological evaluations.

Thank you for your consideration

Nora E. Wolf

SB-839
Submitted on: 2/6/2021 2:09:51 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Francis Nakamoto	Individual	Support	No

Comments:

Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Vice Chair

Members of the Committee on Healh

I support SB839.

Hawai'I's Our Care Our Choice Law allows dying Citizens of Hawai'i the right to die with dignity, at a time and place of their choosing. Since its enactment, at least 135 Hawaii residents have sought to request prescriptions for medication to speed the inevitable end of their lives. With that power, they could choose to end unbearable pain, undignified loss of bodily functions and the time and place of their last breath with their loved ones.

Unfortunately, as Kaiser HI and Hawai'I Pacific Health data shows, 16% to 34% of terminally ill persons have been thwarted from receiving their medication, dying before the 20-day statutory wait period expired. Many are living in rural areas that lack medical providers able or willing to help. According to the State Department of Health, only one medical doctor on the Big Island and one on Maui are available for OCOC, only three consulting doctors on the Big Island, one each on Maui and Kauai. Other patients died before the medication could be obtained. The complications of Covid19 has exacerbated the difficulties of obtaining relief under OCOC.

For this reason, Advanced Practice Registered Nurses, who possess the qualifications and skill medical doctors have to assist these dying patients, should be authorized to

substitute for MDs where the latter is unavailable or unwilling to serve their patients' needs.

For this same reason also, the arbitrary 20-day wait period should be reduced to 15-days, or waived by the attending physician or APRN if the patient is not expected to survive the current wait period. SB839 has been introduce to correct the unintended deficiency in the current law.

It is time to amend the law to make it work as intended and make reasonable modifications to eliminate the arbitrary restrictions that have denied too many Hawaii residents their last and most important exercise of civil and personal rights. Please support SB839.

Francis M. Nakamoto

SB-839
Submitted on: 2/6/2021 2:29:02 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Carla Hess	Individual	Support	No

Comments:

I am an RN (38 years) who worked at Hospice Maui.

I am writing to ask that you:

Allow Advanced Practice Registered Nurses (APRNs) to support patients in the option of medical aid in dying by acting as the attending or consulting provider and mental health counselor;

Allow the attending provider the authority to waive the mandatory minimum 20-day waiting period if the eligible patient is unlikely to survive the waiting period (patient must still go through the rest of the qualifying process);

Reduce the mandatory minimum 20-day waiting period to 15 days like the other authorized states have.

It is only compassionate and humane to ensure that ALL eligible dying patients can access the compassionate option of medical aid in dying under the Our Care, Our Choice Act.

Thank you so much!

Carla Hess, RN

Wailuku, HI 96793

SB-839
Submitted on: 2/6/2021 2:21:06 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Brian Goodyear	Individual	Support	No

Comments:

Aloha Senators,

I am writing to express my strong support for SB839 and to ask you to support passage of this bill. I am a clinical psychologist who conducts mental health consultations for terminally ill patients who have requested medical aid in dying.

Since the Our Care, Our Choice Act went into effect I have had the privilege of doing over 50 of these consultations, mostly for Kaiser patients. Based on my experience thus far, I believe that the Act is working as intended for the most part. All of the patients that I have seen have been grateful and relieved to have this option available in case their suffering becomes unbearable at some point. I have also been impressed by how acceptant these patients have been of the fact that they have only a very limited amount of time remaining in their lives.

There are, however, some changes that should be made to the legislation to address certain problems that have arisen for some patients who have requested medical aid in dying and have not been able to take full advantage of the current law. SB839 directly addresses these problems.

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

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

Mahalo for your support of these proposed changes in last year's legislative session and for your continuing attention to these important issues.

Brian Goodyear, Ph.D.

2924 Alphonse Place, Honolulu, HI 96816

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bsgoodyear@aol.com

SB-839
Submitted on: 2/6/2021 4:31:03 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Vivien Wong	Individual	Oppose	No

Comments:

I am a practicing physician in this state. A few days ago, my mother died at the age of 94 from chronic illness. She was placed in hospice care 10 weeks ago. As a daughter and a physician, you have no idea how hard it has been for me to care for my mother and to watch her through this past 10 weeks. My mom was concerned that she is a burden to us and why she is still alive. Certainly, she would have qualified to end her life sooner with this bill. However, as a physician who has been trained to save life to our best ability, I don't think we should play the role of God and actively and purposely end life sooner than what God intends. To extend this "priviledge" to other advanced health professionals (PA and Nurse practitioners) are irresponsible. Please read the wording of this bill. "Reduces mantatory waiting period" and "Waives the mandatory waiting period for those terminally ill individuals not expected to survive the mantatory waiting period". How absurd does this sound! Let us allow active termination of life quickly because the person may die sooner naturally.

SB-839
Submitted on: 2/6/2021 6:06:02 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Jacob Bilmes	Individual	Support	No

Comments:

By the time a physician is able to say with certainty that a patient will die within the next 6 months, the patient may have only a few weeks (or days) left to live. It is therefore urgent that the patient be able to access medical aid in dying promptly. I respectfully urge you to pass this legislation.

Jacob Bilmes

1212 Punahou Street #1008, Honolulu 96826

SB-839
Submitted on: 2/6/2021 6:36:31 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

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

Comments:

It is critical that we remove unnecessary obstacles for those who wish to make their own end of life decisions. Several have suffered needlessly due to these obstacles. We have sufficient safeguards in place. Let's not prolong the suffering and pain.

SB-839
Submitted on: 2/6/2021 6:42:44 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Carol Iwamoto	Individual	Support	No

Comments:

I support SB839 because I believe in giving everyone the privilege of making end of life choices without burdensome restrictions. I also want to support AP registered nurses in their role in providing medical care.

SB-839
Submitted on: 2/6/2021 9:27:29 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Barbara J. Service	Individual	Support	No

Comments:

Please vote to remove the barriers to the Our Care, Our Choice Act so that ALL eligible dying patients can access the option of medical aid in dying.

Mahalo!

Barbara J. Service MSW (ret.)

SB-839
Submitted on: 2/7/2021 9:47:38 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Younghi Overly	Individual	Support	No

Comments:

I support SB839 for it would make "death with dignity" more accessible. Thank you for hearing this measure.

February 7, 2021

Committee on Health
Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Vice Chair

State Capitol
415 South Beretania St.
Conference Room 329
Honolulu, Hawaii 96813

I am a community member of Oahu and I am respectfully writing to express my support of SB 839. Passing this measure would remove barriers from the Our Care, Our Choice Act.

(1.) Authorizing advanced practice registered nurses, in addition to physicians, to practice medical aid in dying in accordance with their scope of practice and prescribing authority.
(2.) Authorizing psychiatric mental health nurse practitioners, in addition to psychiatrists, psychologists, and clinical social workers, to provide counseling to a qualified patient.

-Hawaii has a shortage of physicians which creates barriers to access for qualified terminally ill individuals. Finding a physician is burdensome, especially for individuals living in neighbor islands. Hawaii gives advanced practice registered nurses full scope of practice licensure and should also be given the authority to administer medical aid in dying thereby increasing access to care for individuals.

(3.) Reducing the mandatory waiting period between oral requests from twenty days to fifteen days.
(4.) Providing an expedited pathway for those terminally ill individuals not expected to survive the mandatory waiting period.

- There are terminally ill individuals who die while waiting to complete the regulatory requirements of twenty days. The state of Hawaii has the longest mandatory waiting period amongst all authorized states and the District of Columbia. Many patients in Hawaii are not surviving the mandatory twenty days.

Sincerely,

Lani Untalan

February 6, 2021

Honorable Chair Keohokalole, Vice Chair Baker, and Esteemed Senate Committee on Health Members,

I have practiced and taught full-time palliative medicine in Hawaii for over 16 years and I am writing, as an individual, in **opposition to SB839**

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

- **The law as written is factually incorrect. Certification of a terminal prognosis is not within the scope of practice for Advanced Practice Registered Nurses (APRN's).** APRN's are an essential component of any high-quality palliative care team. Personally, I am fortunate to work on a daily basis with the most skilled palliative care APRN's in the state. However, Medicare specifically prohibits APRN's from certifying 6-month prognosis for hospice (although they may serve as attending). This certification of six-month prognosis is an essential role of the attending and consulting physicians under the OCOCA. Why would Hawaii consider it scope of practice for APRNs to certify terminal prognosis when the federal government does not? On what evidence is this based as being safe or appropriate care?
- **APRN's do not meet the definition of the attending provider under the Our Care, Our Choice Act even as written in SB839.** The Our Care, Our Choice Act, like all other legally accelerated death laws in the US, defines the attending provider as having "responsibility for the care of the patient and treatment of the patient's terminal disease." APRN's do not meet this definition in that they do not have responsibility for the treatment of cancer or the neurodegenerative, pulmonary or cardiac diseases that are the most common terminal illnesses affecting people that pursue legally accelerated death.
- **Waiving the waiting period for those not expected to survive the waiting period is clinically illogical.** A physician can only reliably predict that a patient will only survive days and not weeks once the patient has entered the actively dying phase. Patients at this stage nearly always lack the ability to perform the cognitive and physical functions required to self-determine their care under the OCOCA. Passing this provision would open the door to abuse by authorizing patients that are unable to self-determine and self-administer the lethal drugs or abuse by physicians succumbing to pressure to expedite the process. While legally accelerated death is nearly always about controlling life's end, the idea of waiving waiting periods to hasten dying for people who are believed at high risk of dying too soon hardly seems worth any reduction in safety that may come from expediting the process.

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

Respectfully,

Daniel Fischberg, MD, PhD, FAAHPM
Kailua, HI

SB-839
Submitted on: 2/7/2021 9:17:33 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Caryn Ireland	Individual	Support	No

Comments:

It's very important to support these important improvements to the Our Care, Our Choice Act in order to meet the needs of our residents on all Islands. Advanced Practice Registered Nurses (APRNs) are educated, skilled and capable to be providers for this law. Please help to make these changes to help patients with their End of Life choices.

SB-839
Submitted on: 2/8/2021 7:38:30 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Holly Bent	Individual	Support	No

Comments:

I am an active Hawaii State **Advanced Practice Registered Nurse (APRN)** in support of **SB 839**.

I support the changes to the act as **my fully competent, dying mother *utilized the act in 2020*.**

No matter what your ethical or religious beliefs are; the following changes should be made:

1. Authorize advanced practice registered nurses, in addition to physicians, to practice medical aid in dying in accordance with their scope of practice and prescribing authority;

Why – APRN's make the same clinical decisions with their patients as medical doctors. Patients should not have to establish a new relationship with a medical doctor, when utilizing an APRN as their primary care provider.

1. Authorize psychiatric mental health nurse practitioners, in addition to psychiatrists, psychologists, and clinical social workers, to provide counseling to a qualified patient;

Why – Psychiatric APRN's function in the similar capacity of psychiatrists. It makes no sense that they are excluded from this ability.

(3) Reduce the mandatory waiting period between oral requests from twenty days to fifteen days; and

1. Provide an expedited pathway for those terminally ill individuals not expected to survive the mandatory waiting period.

Why – The waiting period was extremely difficult for my mother. Hopelessly sitting at her bedside, watching her suffer unnecessarily every day, was heart breaking and pointless.

SB-839
Submitted on: 2/8/2021 8:51:48 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Vickie Kibler	Individual	Support	No

Comments:

Aloha Hawaii State Legislature!

It is imperative that you pass SB839. There is too much need for those of us wanting to pursue this course of action and not enough physicians to support it. It is time to remove any barriers that make accessing this, our very right, more difficult. Compassion is what we need, not hurdles!

With warm aloha

Vickie Kibler

SB-839
Submitted on: 2/8/2021 8:59:36 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
kaira	Individual	Support	No

Comments:

I support APRNs to support dying patients under the OCOCA and allow the prescribing provider the ability to expedite the waiting period if an eligible patient is unlikely to survive it. My father did not make the waiting period, and I know it would bring such releife for terminally ill patients to not have to wait through the pain and suffering.

SB-839
Submitted on: 2/8/2021 9:15:06 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
James Long	Individual	Support	No

Comments:

Aloha,

I believe that SB839 will significantly improve the ‘Our Care, Our Choices Act‘.

Please pass this important and critical legislation for those who are suffering terminal illness.

Thank you,

James
Long
Na‘alehu, HI

SB-839
Submitted on: 2/8/2021 10:00:36 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Anita Trubitt	Individual	Support	No

Comments:

These changes to the existing bill will strengthen it considerably and eliminate the long wait in the existing bill

SB-839
Submitted on: 2/8/2021 11:14:15 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Allyn Bromley	Individual	Support	No

Comments:

I support passage of this bill.

Allyn Beromley, Manoa

SB-839
Submitted on: 2/8/2021 11:17:24 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Brian Baron	Individual	Support	No

Comments:

In Strong Support. Brian Baron

SB-839
Submitted on: 2/8/2021 11:20:31 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Brendon Friedman	Individual	Support	No

Comments:

I strongly support this measure -thank you!

Brendon Friedman, DNP, APRN-Rx, FNP-BC, PMHNP-BC, CME

Family & Psychiatric-Mental Health Nurse Practitioner, Assistant Professor, Private Practice Owner

2838 E. Manoa Rd

Honolulu, HI 96838-1964

SB-839
Submitted on: 2/8/2021 12:36:04 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Andrea Quinn	Individual	Support	No

Comments:

Dear Honorable Committee Members,

Please support SB839.

Thank you,

Andrea Quinn

SB-839
Submitted on: 2/8/2021 12:51:38 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Katharine Morgan	Individual	Support	No

Comments:

I am in support of SB 839 to make medical aid in dying more accessible to all who live in Hawaii.

February 8, 2021

Senator Jarret Keohokaole, Chair
Senator Roslyn H. Baker, Vice Chair
Senate Committee on Health
Hawaii State Capitol
415 South Beretania Street
Honolulu, HI 96813

RE: In strong support of SB 839 Relating to Health

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

Thank you for hearing SB 839. These important amendments to the Our Care Our Choice Act will improve access for all residents of the state.

The act, passed in 2018, helps to alleviate anxiety, pain and suffering of terminally ill individuals. We were aware, when the bill was enacted that it would require some "tweaks" which is why we are discussing it once again. Senate Bill 839 provides important options for sick people.

Medical care in Hawaii isn't as available as we need or would like, especially on the neighbor islands. Allowing qualified Advanced Practice Registered Nurses (APRN) to act as attending or consulting physicians will provide terminally ill people with more care options. Many of us have physicians who are uncomfortable writing prescriptions for medical aid in dying (MAID). This amendment would open the field to more attending and consulting providers who could help.

Too many terminally ill people are unable to access medical aid in dying while sticking to the times called for in the statute. For this reason, I also support an expedited process for terminally ill patients who are not expected to survive the regulatory waiting period.

I sincerely hope you will help more people and pass these important amendments to the Our Care Our Choice Act.

Mahalo nui loa,

Mary Steiner
808-225-4563

SB-839
Submitted on: 2/8/2021 2:42:01 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Christa Braun-Inglis	Individual	Support	No

Comments:

Please consider allow APRNs to support patients in the option of maedical aid in dying (MAID) by acting as an attending or consulting provider and mental health counselor. APRNs serve many different roles including primary care, specialty care and as mental health providers in Hawaii. By giving APRNs the opportunity to paticipate as a provider as lsited above in the OCOCA will increase access to MAID for our patients.

Sincerely,

Christa Braun-Inglis, MS, APRN, FNP-BC, AOCNP

SB-839
Submitted on: 2/8/2021 2:49:16 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Stacey Jimenez	Individual	Oppose	No

Comments:

I would like to thank you for this opportunity to offer comments regarding SB839. I am asking the Committee on Health to **OPPOSE** SB839. The people of Hawaii deserve only the best quality of healthcare. This bill would only decreases the quality of care provided in Hawaii by allowing advanced practice registered nurses to make medical decisions that should be left to doctors.

I have known people in my life that have received a grave diagnosis. They thought death was imminent but went on to live many happy years. Healthcare is the “practice” of medicine. The practice is not always exact in nature and errors happen. SB839 places this practice of making life and death medical decision into the hands of advanced practice registered nurses. Nurses do not have the same years of training and knowledge of accessing patients as physicians.

The risk of more errors, resulting in premature death of people, due to the inferior training and experience of advanced practice registered nurses far outweigh any *perceived* benefit to allowing the proposed changes made by SB839. Foreseeable mistakes made by less trained professionals could result in pre-mature death for some residents of Hawaii.

Please vote NO on SB839.

SB-839
Submitted on: 2/8/2021 4:29:06 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Carolann Biederman	Individual	Support	No

Comments:

Please support this bill to improve the existing law. The changes will make it easier for terminally ill adults with a prognosis of less than six months to live to access the medical aid in dying medication and be able to work through the often cumbersome process with an APRN or an MD, of which there are far too few in our state.

I've seen the statistics on the number of qualified patients who have not survived the waiting period to receive their medication, and this change to the law will help others to have a better end, if they indeed choose to exercise their right to use the law. Thank you for your consideration.

SB-839
Submitted on: 2/8/2021 4:46:26 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Alice Abellanida	Individual	Oppose	No

Comments:

Assisted suicide is assisted murder. Period.

There is nothing redeemable about this bill.

I strongly oppose.

Alice Abellanida

SB-839
Submitted on: 2/8/2021 5:41:56 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Roxanne	Individual	Support	No

Comments:

Support!

SB-839
Submitted on: 2/8/2021 6:39:24 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Darlene Pang	Individual	Support	No

Comments:

End of life decisions are some of the most agonizing plans a person will make. I supported the original bill and I have been supportive of all changes which make this decision faster and more accommodating to the person who is terminally ill. With the acute shortage of doctors in Hawaii and especially on neighbor islands, any measure which makes more health professionals able to assist a person in this difficult decision is a welcomed relief to those who choose to take their end of life process into their own hands. I totallly recommend that these amendments be accepted.

SB-839
Submitted on: 2/8/2021 8:32:03 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
marcy katz	Individual	Support	No

Comments:

I wholeheartedly support the beneficial changes and additions to the dying with dignity law that was enacted in 2018 and went into effect January 2019. The biggest challenge is to those deemed terminally ill are finding enough doctors in our state, to support their dying with dignity before the suffering gets any worse. Anyone diagnosed with six months or less to live by a physician or a nurse practitioner should have the right to decide and execute that right without having to wait An excruciating delay. Also nurse practitioners are usually the ones that attend to older and dying patients either in their homes or in group facilities and know the patient's needs best. It is my own experience with my own mother that the nurse practitioner should be the one to grant the prescription, and not the Doctor Who never sees her. To a lot of doctors their patients are just records on a computer screen. Again that was my own experience with my ailing mother. Hawaii has done a wonderful thing in passing the Compassion And Choices bill here. Please let's further their ability to aid people by giving them a choice of receiving the medicine without a long delaySo many of these people have been given peace of mind just having that medicine nearby. Again,We knew John Radcliffe as our friend and neighbor and it gave John the strength to get through many additional precious months of,living with his family knowing that he had the meds and that he could've taken it when things got painfully impossible for him. I commend you all for being this bill,to the table with everything else you are handling right now during COVID issues.

Blessings, Marcy and Bob Katz

SB-839
Submitted on: 2/8/2021 9:28:12 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Mike Golojuch, Sr.	Individual	Support	No

Comments:

Please pass SB839.

Mike Golojuch, Sr.

SB-839
Submitted on: 2/8/2021 9:30:45 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Wailua Brandman	Individual	Support	No

Comments:

My name is Wailua Brandman APRN FAANP. I have a private practice providing primary care to a psychiatric population. I am a Fellow of the American Association of Nurse Practitioners, Co-Founder of the Hawaii Association of Professional Nurses and current Treasurer and Legislative Committee member. Mahalo for the opportunity to submit testimony in STRONG SUPPORT as an individual stakeholder. I am in agreement with the testimony submitted by the HAPN President and Legislative Committee. Mahalo for your continuing support of the people of this great state.

Wailua Brandman APRN FAANP, Ke`ena Mauliola Nele Paia, LLC, 615 Piikoi Street, STE1406, Honolulu, HI 96814 (808)255-4442

MITCHELL | HAMLINE
School of Law

February 9, 2021

Hawaii Legislature
Senate Committee on Health

Re: February 10, 2021 Hearing on S.B. 839

Dear Committee Members:

I am a law professor who studies medical aid in dying and other laws governing end-of-life medical care. I write in support of S.B. 839 and its amendments to the *Our Care, Our Choice Act.*

1. Other jurisdictions permit MAID to be administered not only by physicians but also by APRNs. This materially improves the accessibility of MAID without compromising patient safety.

2. Other jurisdictions permit the waiting period to be waived if the patient cannot last that long. This materially improves the accessibility of MAID without compromising patient safety.

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

Sincerely,

Thaddeus Mason Pope

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

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JOURNAL OF HEALTH AND LIFE SCIENCES LAW

OFFICIAL JOURNAL OF AMERICAN HEALTH LAW ASSOCIATION

AMERICAN HEALTH LAW ASSOCIATION

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Featured Article

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

Thaddeus Mason Pope

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

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

MAID Variations Among U.S. State Laws

ARTICLE CONTENTS

INTRODUCTION

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

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

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

1 MAID is also known as "aid in dying," "physician assisted death" "death with dignity," and "voluntary assisted dying." Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.04 (3rd ed. 2020). MAID is sometimes referred to as "physician assisted suicide," but that term is generally disfavored because of the strong association of suicide with mental illness. In addition, suicide is typically compulsive, not planned, and suicidal individuals are typically not terminally ill. Press Release, Am. Ass'n of Suicidology, Statement of the American Association of Suicidology: "Suicide" Is Not the Same As "Physician Aid in Dying" (Oct. 30, 2017), https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf.

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

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

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

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

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

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

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

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

---

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

8 *Id.*

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

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

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

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

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

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

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

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

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

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

MEDICAL AID IN DYING

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

Why Hasten One's Death?

There are many circumstances under which a longer life is not a better life. When quality of life diminishes, some individuals would prefer to hasten death (or at least not prolong dying)

rather than endure the perils of what, at least to them, is an exceedingly poor quality of life.[15] What exactly comprises a "poor quality of life" covers a broad spectrum that varies significantly from person to person.

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

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

---

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

16 For years, the three most frequently reported end-of-life concerns of patients using MAID have been (1) decreasing ability to participate in activities that made life enjoyable, (2) loss of autonomy, and (3) loss of dignity. Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 6 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf.

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

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

19 Ladislav Volicer et al., *Assistance with Eating and Drinking Only When Requested Can Prevent Living with Advanced Dementia*, 20 J. Am. Med. Directors Ass'n 1353 (2019).

20 *See* Benzi M. Kluger, *Medical Aid in Living*, JAMA Neurology (Aug. 24, 2020); Stanley A. Terman, The Best Way to Say Goodbye: A Legal Peaceful Choice at the End of Life 326 (Ronald B. Miller & Michael S. Evans eds., 2007).

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

What Is MAID?

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

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

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

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

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

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

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

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

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

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

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

Who Uses MAID?

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

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

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

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

30 D-DMA entails Digitalis 30 minutes before Diazepam, Morphine, and Amitriptyline. DDMP2 uses Propranolol but results in a longer average time to death. *See, e.g.,* Anita Hannig, *The Complicated Science of a Medically Assisted Death*, Quillette (Mar. 18, 2020), https://quillette.com/2020/03/18/the-complicated-science-of-a-medically-assisted-death/; Christopher Harty et al., Canadian Ass'n of MAiD Assessors & Providers, The Oral MAiD Option in Canada: Part 1: Medication Protocols: Review and Recommendations (2018), https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Med.pdf.

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

32 *See infra* notes 97 to 101.

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

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

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

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

NON–STATUTORY APPROACHES

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

Montana

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

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

36 *Id.*

37 *Id.*

38 *Id.*

39 *Id.*

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

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

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

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

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

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

North Carolina

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

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

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45 *See infra* §§ III to V.

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

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

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

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

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

Other Non–Statutory Approaches

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

VARIATIONS IN ELIGIBILITY REQUIREMENTS

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

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

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

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

53 The Right to Die, § 12.02.

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

State Residency: How to Prove It?

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

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

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

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

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

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

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

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

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

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

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

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

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

Capacity Assessments: Two or Three?

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

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

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

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

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

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

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

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

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

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

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

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

69 D.C. Code § 7-661.03–.04.

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

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

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

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70 Colo. Rev. Stat. § 25-48-108.

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

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

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

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

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

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

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

VARIATIONS IN PROCEDURAL REQUIREMENTS

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

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

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

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

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

78 Haw. Rev. Stat. § 327L-1.

79 End of Life Option Act, Cal. Health & Safety Code § 443.3(a) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-104(1) (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.02(a)(1) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(11)–(13) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-10 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.840, .850 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(2) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.090, .110(1) (2020).

80 Cal. Health & Safety Code § 443.3(a). Some clinicians have taken the patient's request on the fifteenth day after the first request, but the plain language of every statute requires that the patient make the second request on the sixteenth day or later. Colo. Rev. Stat. § 25-48-104(1) ("separated by at least fifteen days"); D.C. Code § 7-661.02(a)(1) ("separated by at least 15 days"); N.J. Stat. Ann. §§ 26:16-10 ("at least 15 days shall elapse"); Or. Rev. Stat. §§ 127.840, .850 ("no less than 15 days after"); Vt. Stat. Ann. tit. 18, § 5283(a)(2) ("[n]o fewer than 15 days"); Wash. Rev. Code §§ 70.245.090, .110(1) ("at least fifteen days after").

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

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

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

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

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

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

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

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

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

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

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

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

Written Request Waiting Period: 0 or 48 Hours?

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

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

88 Buchbinder & Pope, *supra* note 83.

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

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

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

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

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

94 N.J. Stat. Ann. §§ 26:16-10(a)(6).

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

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

Route of Drug Administration: GI or IV?

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

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

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

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

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

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

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

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

100 Pope, *supra* note 2.

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

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

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

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

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

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102 End of Life Option Act, Cal. Health & Safety Code § 443.1(p); Death with Dignity Act of 2016, D.C. Code §§ 7-661.05(f) & (h)–(i), .09(b), .12, .13(b) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.875 (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(2)(L) (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.010(12) (2020).

103 Cal. Health & Safety Code § 443.1(p) (emphasis added).

104 *Id. passim.*

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

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

107 *Id.* ¶ 309.

108 Email from Kimberly Kirchmeyer, Executive Director of the Medical Board of California, to Gary Johanson, MD (Sept. 6, 2016); Thalia DeWolf, *Rectal Administration of Aid-in-Dying Medications*, Am. Clinicians Acad. on Med. Aid in Dying, https://www.acamaid.org/rectal-administration-of-aid-in-dying-medications/ (last visited Sept. 14, 2020).

109 Cal. Health & Safety Code § 443.14(a) (emphasis added).

110 *See* Cal. Penal Code § 401 (2020) ("Any person who deliberately aids . . . another to commit suicide is guilty of a felony.").

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

112 Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-3 (2020).

113 Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-102(7), (15) (2020); Vt. Stat. Ann. tit. 18, § 5284 (2020).

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

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

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

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114 *See, e.g.,* Texas Controlled Substances Act, Tex. Health & Safety Code § 481.002 (2020) (defining 'administer" to include "injection, inhalation, ingestion, or other means").

115 Bettie Lilley Nosek & Deborah Trendel-Leader, IV Therapy For Dummies (2012). Note that intravenously administered medication would not be the same medication as that which patients orally ingest. Indeed, U.S. clinicians have not yet worked out protocols and procedures for IV self-administration.

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

117 H.B. 2217, 80th Leg. Assemb., Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB2217/A-Engrossed (hearing on May 19, 2019). *See also* Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 43 (2020) (noting that 9 of 52 people to receive MAID in Victoria needed clinician administration because self-administration was not possible).

118 Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 11 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf; Washington State Department of Health, 2018 Death with Dignity Act Report 13 (July 2019), https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf. These problems were anticipated from the beginning. *See, e.g.,* Timothy Egan, *Suicide Law Placing Oregon on Several Uncharted Paths*, N.Y. Times (Nov. 25, 1994), at A1. They even threatened to cause the repeal of the Oregon Death with Dignity Act in 1997. *See, e.g.,* H.B. 2954 (Or. 1997); *Basics on Ballot Measure 51*, Or. Legis. Pol'y & Res. Off. (1997), https://digital.osl.state.or.us/islandora/object/osl%3A4732/datastream/OBJ/view.

119 Notably, in jurisdictions where both MAID and euthanasia are available, almost no patients use MAID. Health Can., Fourth Interim Report on Medical Assistance in Dying in Canada (2019), https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019/medical-assistance-dying-interim-report-april-2019-eng.pdf. In those rare cases when ingestion is used, Canadian clinicians are prepared to offer "IV rescue" as a backup in case oral self-administration is unsuccessful. Christopher Harty et al., Canadian Ass'n of MAiD Assessors & Providers, The Oral MAiD Option in Canada: Part 1: Medication Protocols: Review and Recommendations (2018).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OTHER VARIATIONS AMONG U.S. MAID STATUTES

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

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

Conscience–Based Objections by Clinicians

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

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

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

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

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

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

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

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

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

Conscience–Based Objections by Facilities

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

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

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

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

149 Vt. Stat. Ann. tit. 18, § 5282.

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

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

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

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

Telehealth Assessment and Counseling

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

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

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

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

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

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

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

157 Haw. Rev. Stat. § 327L-1.

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

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

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

Death Certificate Completion

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

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

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

160 *Id.*

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

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

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

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

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

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

Data Collection and Reporting

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

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

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

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

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

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

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

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

172 Abbott et al.

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

Sunset Clauses

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

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

FORTHCOMING VARIATIONS

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

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

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

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

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

177 Cal. Health & Safety Code § 443.215.

178 *Id.*

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

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

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

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

Scope of Practice: MD or APRN?

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

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

Terminal Illness: Six Months or Longer

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

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

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

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

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

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

186 42 C.F.R. §§ 418.3, .20 (2020).

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

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

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

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

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

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

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

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

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

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

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

Other Future Variations

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

CONCLUSION

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

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

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

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

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

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

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

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

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

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

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

Author Profile

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

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

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

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SB-839
Submitted on: 2/9/2021 11:31:07 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
stephanie marshall	Individual	Support	No

Comments:

Chair Jarrett Keohokalole, Vice Chair Rosalyn Baker, and members of the senate committee on health, thank you for the opportunity to provide testimony is support of SB839 which makes very necessary improvements to the Our Care, Our Choice Act.

I am a retired nurse practicing for over 40 years in both oncology and internal medicine. I have followed the law over the past 2 years closely and believe the recommendations made by the Stae of Hawaii Department of Health to the terms of this act address the very real difficulties Hawaii residents are experiencing in meeting the established criteria and safeguards to ensure a safe , compassionate, and patient centered end of life process.

As also retired nursing faculty from UH Manoa, I know first hand that Advanced Practice Registered Nurses are more than fully competent to act as attending and consulting providers in accordance with their scope of practice and prescribing authority

I respectfully request that SB 839 pass out of this committee. Thank you for your service to our great state and our residents

Respectfully,

Stephanie Marshall, RN, MS, FAAN

COMMITTEE ON HEALTH
Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Chair

Wednesday, February 10, 2021, 1:00PM, Via Videoconference

Aloha Respective Senators for the Committee on Health. My name is Kristin Kaniaupio and I am testifying in full support of Senate Bill 839, "Relating to Health."

Cancer never has a face until it is yours or someone you know. I knew cancer well and his name was Justin. On July 17, 2018, my brother-in-law received the devasting news that he was diagnosed with cancer. On this day he made a visit to a nearby Urgent Care Facility after experiencing back pain lasting over a period of three weeks. After an ultrasound, it was apparent that he had masses covering numerous organs in his body and was encouraged to immediately go to the nearest Emergency Room Department for further testing. It was there in the ER where he was given the news that he had stage IV cancer and the prognosis was not good. My brother-in-law never smoke, rarely touched alcohol, and maintained good physical health as he was employed as an officer with the Honolulu Police Department. His cancer was complicated as he was a rare case of someone who had two primary origins starting in his bile duct and ileocecal valve simultaneously. I was sitting in the room when the oncologist told him, "I'm sorry, but this cancer will take your life." I cannot even imagine the thoughts that must have run through his head in that moment. Despite this troubling news, he knew the best thing he could in that moment was to take ownership of his last days and live life on his own terms protecting his right to autonomy. From the time of his diagnosis, he ensured to be very involved in all medical decisions. He even flew out to Rochester, Minnesota to seek out a second opinion at the Mayo Clinic before agreeing to a suggested treatment plan by his medical team in Hawai‘i. It was important for him to not allow the disease the power to control his life at just 36 years young. Sadly, my brother Justin passed on February 3, 2019. I will not allow Justin's fight to be in vain. Terminal illness affects so many families here in our state. Whether it is cancer, congestive heart failure, end stage renal disease, or any other terminal diagnosis, patients deserve the right to decide how to live out their final days. For some, selecting the moment of when their last breath will be is how they can take back what the disease stole from them.

Under our current, "Our Care, Our Choice Act," terminally ill patients are required to request a consultation from three different providers with a waiting period of 20 days between each of these requests. This means that a patient must wait roughly two months for requests alone. The formalities of this policy make it extremely difficult for the patient especially when they only have six months or less to live. Attending physician, Dr. Chuck Miller (2019), reports that Hawai‘i is "the only state the requires a 20 day waiting period between the oral requests." This waiting period is unacceptable as some patients expire before completing the waiting period. Lowering the waiting time from 20 days to 15 days is a small step to help preserve the dignity of these patients. When time is of the essence, a person should not have to wait any second longer to have the chance to decide what path their life should take. I urge you to support Senate Bill

839, “Relating to Health.” Help me honor my brother’s legacy along with so many others that wish to take back control of their life crippled by a terminal diagnosis.

Thank you for your time and consideration,

Kristin Kaniaupio

SB-839
Submitted on: 2/9/2021 12:22:53 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Faylene Mahina Duarte	Individual	Support	No

Comments:

Aloha Legislators,

I am in full support of SB839 to amend the Our Care, Our Choice Act to:

(1) Authorize advanced practice registered nurses, in addition to physicians, to practice medical aid in dying in accordance with their scope of practice and prescribing authority;

(2) Authorize psychiatric mental health nurse practitioners, in addition to psychiatrists, psychologists, and clinical social workers, to provide counseling to a qualified patient;

(3) Reduce the mandatory waiting period between oral requests from twenty days to fifteen days; and

(4) Provide an expedited pathway for those terminally ill individuals not expected to survive the mandatory waiting period.

By passing this bill, we will enable all terminally ill individuals have the access to to the full-range of end-of-life care options.

Mahalo for your favor of SB839.

Faylene Duarte

SUPPORT TESTIMONY

February 9, 2021

SB839 RELATING TO HEALTH.
Senate Committee on Health
Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Vice Chair

Hearing: Wednesday, February 10, 2021 at 1:00 p.m.
Via Videoconference

Aloha a welina mai nei e nā kau kānāwai:

I strongly **SUPPORT SB839** which will authorize advanced practice registered nurses, in addition to physicians, to practice medical aid in dying in accordance with their scope of practice and prescribing authority. SB839 authorizes psychiatric mental health nurse practitioners, in addition to psychiatrists, psychologists, and clinical social workers, to provide counseling to a qualified patient. This bill also reduces the mandatory waiting period between oral requests from twenty days to fifteen days. Further, it waives the mandatory waiting period for those terminally ill individuals not expected to survive the mandatory waiting period.

Hawai'i is one of 22 states that give APRNs authority to independently carry out all medical acts consistent with their education and training, including prescribing all forms of medication and diagnosing terminal illness. Hawai'i is dealing with an ongoing shortage of physicians, making it very difficult to find the required two physicians to qualify for medical aid in dying, especially on neighbor islands. APRNs are already helping to fill the gaps across the board in medicine on Neighbor Islands and should be able to help patients at end of life as well. I believe that terminally ill individuals have a right to their improved care, expanded options and power to chart their end-of-life journey.

I urge the committee to **PASS SB839**.

Respectfully, me ka `oia`i`o.
Dr. Leanne K. Fox
2nd Congressional District ● Senate District 18 ● House District 39

SB839

HAWAII PROFESSIONALS
for APPROPRIATE and COMPASSIONATE CARE

Senate Committee On Health
Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Vice Chair

LATE

Testimony on **SB 839**
Position: **Strongly Opposed**
Recommendation: **Hold this bill until more data is provided or the issues and obstacles are studied more thoroughly**

The Hawaii Professionals for Appropriate and Compassionate Care (HPACC) has grave concerns about this bill which serves to amend a newly enacted law governing Medical Aid in Dying.

Much too early to make changes to the safeguards A number of bills have been introduced in the House and Senate this session to change the Our Care, Our Choice law that became effective just two years ago. As healthcare providers, we are concerned the safeguards that initially provided assurance that this new law would be the safest in the nation are already being dismantled. Proponents of medical aid in dying have already proposed to eliminate protections from abuse based on the first year of implementation — without any data to support the justification for these changes.

Waiting Periods are Important The waiting periods that the Hawaii Legislature set were designed to improve the safety and quality of the requests. Shortening or waiving requirements makes no sense. It only serves to lessen the safeguards that were agreed upon.
Waiving the waiting period for the actively dying is not needed. The dying are often not able to make such decisions during the last phase. You will be allowing caregivers to make this decision, opening up a possibility of abuse.

Reasons for provider scarcity Physicians don't want this. Physician providers that have actually agreed to perform aid in dying are few and far between. Adding APRNs as providers without understanding the reasons behind physician reluctance does not improve the quality of end-of-life care. We suggest that this committee do its due diligence by taking a step back to investigate both the need and the provider availability with a more comprehensive and neutral approach.

Actual Need The data from the Department of Health shows that less than 30 Hawaii residents participated in the OCOC option. This is not a tremendous community need or issue. Our understanding is that in the second year, the number of patients using this option has not significantly increased. The need for change is simply not there.

HAWAII PROFESSIONALS
for APPROPRIATE and COMPASSIONATE CARE

<u>This is not the year to debate these issues.</u> This is the year to focus on restoring economic stability and building our resilience as a state. Based on what we have gathered, we know those on both sides of the issue of medical aid in dying intend to draw attention to this bill, which will polarize our community at a critical time. We need to come together as a community and address issues of top concern to enhance the wellbeing of Hawai'i's people. We would like to humbly ask you to hold this bill instead of letting the accompanying theatrics become a distraction to the important tasks at hand for Hawai'i's legislators.

<u>Review the Data</u> Our providers recommend a review of the data gathered by DOH and an exploration of the reasons providers are reluctant or unavailable. Adding another class of providers and changing waiting periods is not the solution.

We would be glad to put you in touch with healthcare providers who will share their specific concerns with the bill, one-on-one in a respectful manner, in person or virtually. Please feel free to contact me at (808) 351-9240 or joy.yadao@gmail.com.

LATE

SB-839
Submitted on: 2/9/2021 9:23:57 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Martha Randolph	Testifying for Kupuna Caucus of the DPH	Support	No

Comments:

Dear Chair and members of the Committee

I must apologize for my late testimony on this bill but I honestly lost track of its progress.

The Kupuna caucus supports this bill unequivocally. The process of the Our Care Our Choice Act is long and complicated and the data supplied by Compassion and Choices clearly shows that at least one third of the patients requesting aid in dying decease between the 1st request and the second request. The reason is simple. There are not enough Medical doctors who are available to fulfill the requests.

A person dying of a terminal disease most often in agonizing pain has the right morally and legally to be assisted in choosing when and how they wish to end their life. Nurse practitioners are usually the most compassionate medical professionals and their qualifications are documented. Please allow them to assist the mature adults who feel they want some control over their end of life process.

Sincerely

Martha E Randolph

Treasurer of the Kupuna Caucus of the DPH

SCC representative for the Environmental Caucus od the DPH

President of DPH Precinct 4

LATE

SB-839
Submitted on: 2/9/2021 1:22:32 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Robert Fontana	Individual	Support	No

Comments:

I am writing to express my support for this bill. The last thing that a terminally ill person needs to contend with is governmental red tape, expecially when preparing to die. And dying is the only RIGHT left to such a person. Personally, should I ever find myself in such a position, I DO NOT want a government to impede what right I have left to determine how I wish to depart. This bill simply cleans up some loose ends that the original law intended, and it is imparative that the legislature do what it can to allow those who suffer so to be able to leave as peacefully as possible.

LATE

SB-839
Submitted on: 2/9/2021 2:49:41 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Erin Chinen	Individual	Oppose	No

Comments:

Please vote NO on this bill as it conflicts with my religious beliefs that death should take its natural course. Thank you!

To: Senator Bennette E. Misalucha, Chair
Senator Brian T. Taniguchi , Chair
Committee on Health

LATE

Subject: SB839 Relating to Health

Position: Support

My name is Kiana Madeira and I am testifying in favor of bill SB839. I am a resident of Oahu, I have grown up here and have lived here my entire life. From my experience I have seen many of my family members struggle with illnesses that eventually took over and ended their lives, my grandfather being one of them. Thinking ahead for my parents' generation and when it's their time, I would like to see a more comfortable experience for them. I believe with more advanced registered nurses, and a shorter waiting period, or a waived mandatory waiting period for terminally ill individuals, this will provide the right assistance that is needed for our elderly and individuals who become sick.

I strongly support this bill and thank you for this opportunity to testify.

Sincerely,

Kiana Madeira

LATE

SB-839
Submitted on: 2/9/2021 10:53:33 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Rick Tabor	Individual	Support	No

Comments:

To Whom It Concerns,

I'm writing testimony tonight, as a concerned individual with five decades of mental health professional experience. Three of the six states I lived in passed a medical aid in dying law, while I was a counselor and clinical casemanager in thier state; Oregon, Washington and after retiring from mental health, we, Hawai'i passed Our Care, Our Choice. Sadly, too late for some of our family KÅ«puna who talked about a desire to exercise the option in lieu of the end of life experience they feared. Granted, this death with dignity decision is one of the most sensitive, soul searching, thought provoking decisions anyone can ever make. It's a decision most will never know how they'll feel, until, sadly, a time comes, where they may face the option with an awareness never before experienced, and find themselves/ourself, in deep thought, as we make our end of life decision, hoping for the peace of mind, Our Care and Our Choice dignifies us. The choice is an individual one, once made, becoming a goal the terminally ill individual will focus on until all the required steps are accomplished and, if still alive, and capable, they actually recieve thier medical aid medication, freeing them of the burden, anxiouness and concerns of an unbearable death. The peace of mind, knowing there's a peaceful option is often times what's needed to be able to breathe free of worry in the company of loved ones. Sadly, Our Care, Our Choice, in it's current framework, lacks the equity needed for much of Hawai'i. Too few Primary Care Physicians and the twenty day wait period on top of all the necessary steps, creates too long a process for those fortunate enough to accomplish all the requirements. This is why I support APRNs as assessors & prescribers and no waiting period as recommended by other states, the CDC and SB389.

Thank you for your time & consideration.

LATE

50 States Say NO

Nurses **cannot legally** diagnose terminal illness

Nurses **should not legally** write prescriptions to kill people

…even if asked

No to SB839

Jackie Mishler RN BSN PCCN PO Box 892 Kula, Hawaii 96790 jackiem@instantexpress.net
Opposition to SB839 Hearing on 2/1/021 at 1:00 PM Senate Health Committee

Honorable Senators:

1. Expanding the availability of and ease of access to lethal drugs puts more than just the suicidal patient at risk.
    a. Handling of these so-called suicide drugs is loose, ill-regulated, and adds a societal risk which is ignored by all these bills.
    b. Traditionally lethal drugs are tightly controlled and carefully tracked. The opposite is the situation with these PAS bills. There is little or no tracking as to what becomes of unused doses. PAS drugs prescribed for a single patient could present potential harm to others.

2. Counseling training in this area is at cross purposes with these bills.
    a. Mental health professionals, to the extent they are trained to counsel about suicidal ideation are trained to help patients recover from it. These bills essentially promote suicide. What training is provided doctors, let alone nurses, to deal with this direct conflict with traditional training?
    b. Shortening waiting periods, expanding participants, loosening standards all undermine concerns about dealing with suicidal wishes in a careful professional context. There is no data to suggest these changes are needed, let alone beneficial.
    c. Is there any professional training under respected academic auspices that equips doctors, let alone nurses, with the professional competence to deal with this situation?

3. These bills are examples of advocacy without concern for effects.
    a. One would search in vain for data that supports the social need for easier assisted suicide. Better arguments and data is available to the contrary.
    b. If expertise and accuracy in assessment and treatment is desired, what one would expect to see is the development of careful, clear standards for what is supposed to be accomplished and how. These standards would be established and enacted. Then professional programs are developed to teach these standards to those interested in working in this area. Finally, this treatment or therapy is made available to the public. What these bills propose is completely backwards, establishing the ends desired by activists without any work to develop the means..

Sincerely, Jackie Mishler Please feel free to contact me with questions or concerns.

NASW HAWAI'I CHAPTER
National Association of Social Workers

LATE

SENATE COMMITTEE ON HEALTH
Senator Jarrett Keohokalole, Chair,
Senator Rosalyn H. Baker, Vice Chair

DATE: February 10, 2021 1:00 P.M. - VIA VIDEO CONFERENCE

Testimony in Support and Comments on SB839 HEALTH

The National Association of Social Workers – Hawai'i (NASW- HI) supports SB839, giving advanced practice registered nurses (APRNs) and psychiatric mental health nurse practitioners the authority to engage in certain medical aid in dying services, as well as reduce the waiting time for patients to be eligible for the program.

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

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

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

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

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

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

Sincerely,

Sonja Bigalke-Bannan, MSW, LCSW

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

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