2018 Hawaii "Our Care, Our Choice Act" (H.B. 2739) Analysis

Patterned on Oregon's doctor-prescribed suicide law, this bill would transform Hawaii's crime of assisted suicide[1] into a medical treatment. The bill, if passed would permit a health care provider to prescribe "medication" to end a qualified patient's life.[2] Many people assume that the "medication" would be "a pill" the patient could take and then "slip peacefully away." This is false.

In states where doctor-prescribed suicide is legal, the vast majority of prescriptions are for 100 times the normal dose of drugs used for medicinal purposes. When the prescription is taken, the individual dies of a massive drug overdose.

If the bill becomes law:

Non-physicians could diagnose a patient and prescribe drugs to cause that patient's death.

The bill permits an "attending provider,"[3] which includes not only a physician but also an advanced practice registered nurse, to diagnose a patient's terminal disease. It also authorizes an attending provider to prescribe the lethal drugs for assisted suicide.

"Attending providers" could prescribe a lethal overdose of drugs to patients who could live for many years.

Proponents of doctor-prescribed suicide invariably point to the requirement that a person must be terminally ill to obtain the prescription. They point out that the person must have been diagnosed with a six-month or less life expectancy. They call this a safeguard.

But they leave out the fact that, in the proposed Hawaii law – as well as in all the assisted-suicide laws that have passed in the various states – the definition of "terminal" allows doctors to prescribe lethal drugs to individuals who could live for many years.[4]

This is because the Hawaii measure defines a "terminal disease" as an incurable or irreversible disease that will "produce death within 6 months."[5] But it does not specify that death will occur *with or without appropriate treatment.*

There is documentation that, under Oregon's assisted-suicide law, patients who could have lived for years, even decades, have died using legally prescribed lethal drugs. In official Oregon reports, diabetes is noted as the underlying terminal condition that made the patient eligible for a lethal prescription.[6] If insulin-dependent diabetics do not take insulin, they will die within six months. So, they meet the requirements for the definition of "terminal." If they do take insulin, they can live for many years.

Another such case was described by Dr. Charles Blanke, an oncologist and professor of medicine at Oregon Health and Science University who acknowledges that he has written dozens of prescriptions for assisted suicide.[7] He explained that a young woman with a serious illness had a 90 percent chance of living for decades with recommended treatment. The woman, however, refused the treatment. "That was a very challenging situation," he said. "You have to ask yourself, 'Why doesn't that patient want to take a relatively non-toxic treatment and live for another seven decades?'" Blanke ended up prescribing the deadly overdose for the woman anyway.[8]

Should doctors be able to prescribe assisted suicide for patients who could live for many years?

Government bureaucrats and profit-driven health insurance programs could cut costs by denying payment for treatment that patients need and want, while approving payment for less costly assisted suicide deaths.

There is documented information about terminally ill patients in Oregon and California who were denied coverage for treatment by insurance providers and, instead, were told that assisted suicide would be covered.[9]

Referring to payment for assisted suicide, the Oregon Department of Human Services explains, "Individual insurers determine whether the procedure is covered under their policies, just as they do any other medical procedure."[10]

If the Hawaii bill is approved, will insurance programs do the right thing – or the cheap thing?

The written request for prescribed suicide could be witnessed by someone who would gain financially from the patient's death.

The written request must be witnessed by two individuals, only one of whom may not be someone who would be entitled to any portion of the patient's estate.[11] Thus, one witness may be a potential heir who is pressuring the patient to sign the request. The second witness could be the "best friend" of the potential heir.

This places victims of elder abuse and domestic abuse in great danger since they are unlikely to share their fears with outsiders or to reveal that they are being pressured by family members to "choose" assisted suicide.

The bill permits a person who would benefit financially from the person's death to pick up and deliver the lethal prescription.

The drugs can be dispensed to "an expressly identified agent of the qualified patient."[12] A potential heir could encourage the patient to authorize him or her to pick up the drugs for delivery to the patient's residence.

Severely depressed or mentally ill patients could receive a prescription for suicide, without having any form of counseling.

Counseling is only required "as necessary."[13]

Even if the patient is severely depressed or has a mental illness, an attending provider does not need to refer the patient for counseling unless the attending provider believes the patient has "impaired judgment," that prevents the patient from making an informed decision.[14] If the depressed or mentally ill patient understands and acknowledges the relevant facts related to the request for prescribed suicide, he or she is considered able to make an informed decision and would not be referred for counseling.

A patient could be led to request assisted suicide based on fear of being a burden to others.

Many families are under tremendous strain. It would be foolhardy to ignore the role that finances could play when making life and death decisions.

Would some patients feel that they should request prescribed suicide so that they wouldn't be a financial or emotional burden on their family?

Even in families where there would be emotional and practical support for a patient diagnosed with a terminal illness, patients could feel that they are being selfish for not sparing others from caring for them. This has been documented in Oregon as a reason for requesting the prescription for death.

According to Oregon's latest official report, 48.9 percent of patients who died using that state's assisted suicide law did so to avoid being a burden on their family, friends or caregivers. (That number far exceeded those who cited pain or concern about pain as their reason.)[15]

While we would all like to believe that family means warmth, love and protection, we need to face the reality that dysfunctional families are not rare and elder abuse – much of it at the hands of a family member – is a fact of life.

Patients would have no protection once the prescription is filled.

The patient's attending provider is not required to be present when the patient takes the lethal drugs. Providers, however, are urged to tell patients that it is important to have another person present when the deadly overdose is taken.[16] But there is no way to know who, if anyone is present or what actually takes place leading up to the patient's death. The patient could be tricked or forced into taking the overdose. And no one would ever know.

Why aren't there any protections at the most important part of the process?

A health care facility could not prevent deaths from prescribed suicide on its premises. Furthermore, a facility willing to permit assisted-suicide deaths could require some nurses, pharmacists and certain other individuals to facilitate such deaths.

The bill states that "a health care provider may prohibit another health care provider from *participating* in actions covered by this chapter on the premises" if certain notification is provided.[17]

It also states that "no health care provider may be under any duty, whether by contract, by statute or by any other legal requirement, to *participate* in the provision to a qualified patient of a prescription or of medication to end the qualified patient's life."[18]

However, the phrase *"participate in actions covered by this chapter"* is very narrowly defined in the bill.[19] It refers only to performing the duties of the attending provider, the consulting provider or one who carries out the counseling, if performed. It does not include certain nurses, pharmacists and other individuals.

Therefore, facilities permitting prescribed suicide could require pharmacists to dispense the lethal drugs and non-attending providers to bring the drugs to a patient since such activities would not constitute "participation" as defined in the proposal.

Likewise, facilities would not be able to ban others from bringing a lethal drug prescription to a patient or resident to self-administer on the premises. Facilities would not be able to prevent the witnessing of the written requests for prescribed suicide; would not be able to prohibit a pharmacy on the premises from dispensing the drugs; and would not be able to prevent nurses or others from bringing them to a patient or resident.

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[1] Haw. Rev. Stat., § 707-702 (1) (b).
[2] HB 2739, § - 1, definition of "prescription."
[3] HB 2739, § - 1, definition of "attending provider."
[4] See "Comparison of State Laws Permitting Doctor-Prescribed Suicide: Laws as of September 2017," Available at: http://www.patientsrightscouncil.org/site/comparison-of-state-laws-permitting-doctor-prescribed-suicide. (Last accessed 12/14/17.)
[5] HB 2739, § - 1, definition of "terminal disease."
[6] Official report for 2016 deaths under Oregon's Death with Dignity Act, Oregon Public Health Division, "Oregon's Death with Dignity Act – 2016, " pg. 11, fn. 2. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf (Last accessed 12/12/17.)
[7] Lynne Terry, "Oregon's Death with Dignity: Barriers remain 20 years later," *Oregon Live: The Oregonian*, October 27, 2017.

[8] Tara Bannow, "Rural Oregonians Still Face Death with Dignity Barriers," *Bend* Bulletin, August 14, 2017.
[9] See, for example: Bradford Richardson, "Assisted-suicide law prompts insurance company to deny coverage to terminally ill California woman," *Washington Times*, October 20, 2016. Available at: http://www.washingtontimes.com/news/2016/oct/20/assisted-suicide-law-prompts-insurance-company-den. (Last accessed 2/1/18.)
Also see: Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," *ABC News,* August 6, 2008. Available at: http://abcnews.go.com/Health/story?id=5517492&page=1. (Last accessed 2/1/18.)
[10] Oregon Dept. of Human Services, "FAQs about the Death with Dignity Act." Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/faqs.pdf. (Last accessed 2/1/18.)
[11] HB 2739, § - 3 (b) (2).
[12] HB 2739, § - 4 (a) (12) (B) (ii).
[13] HB 2739, § - 1. (Definition of "counseling.")
[14] HB 2739, § - 4 (a) (5); HB 2739 § - 6; and HB 2739, § - 12 (5).
[15] Official report for 2016 deaths under Oregon's Death with Dignity Act, p. 10. Released in February 2017. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf. (Last accessed 1/14/18.)
[16] HB 2739, § -4 (a) (7).
[17] HB 2739, § - 19 (b). (Emphasis added.)
[18] HB 2739, § - 19 (a) (4).
[19] HB 2739, § - 18 (e), definition of " participate in actions covered by this chapter."

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