Hawaii's Assisted-Suicide Proposal Analysis

Currently, assisted suicide is a crime in Hawaii. Any person who intentionally assists another to commit suicide commits the offense of manslaughter, a class A felony. [Haw. Rev. Stat. § 707-702 (1)(b)]

H.B. 806, called the "Death with Dignity" Act, is modeled on Oregon's assisted-suicide law. It would transform the crime of assisted suicide into a medical treatment.

HAWAII'S ASSISTED-SUICIDE BILL:

- **Does not require that the lethal drugs be self-administered.**

  Unlike Oregon's assisted-suicide law, the Hawaii bill requires a "monitor." The monitor "shall be present at the time of the actual administration of the medication *to the patient*." [§ 41 (a)] [Emphasis added] According to the proposal, the monitor will have the power to "stop the administration" if it hasn't been carried out and if it seems that the patient has had a change of mind. [§ 41 (a)] This provision implies that someone other than the patient may administer the lethal drugs.

- **Allows someone who will benefit from the patient's death to play a key role in signing the patient up for an assisted-suicide prescription.**

  A patient's written request for assisted suicide must be witnessed by two people. [§ 22 (a)] *One* of those witnesses may not be a relative or a person who would inherit the patient's property or an owner, operator or employee of the health care facility where the patient is being treated. [§ 22 (b)] But this means that one of the witnesses *may* fall into those categories. Then, that person could select a personal friend or acquaintance to be the second witness.

  It allows those who will benefit from the patient's death to play a key role in facilitating an assisted-suicide prescription, setting the stage for elder abuse and premature transfer of assets. According to the National Center on Elder Abuse, between 1 and 2 million Americans, 65 and older, are abused each year by someone they depend on for care and protection.[1]

- **Lets doctors help depressed or mentally ill patients commit suicide without providing any type of counseling or psychological evaluation.**

  A referral for counseling is only necessary "if, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder *causing impaired judgment."* [§ 33] [Emphasis added] So, while a person may be depressed or mentally ill, a referral for counseling is necessary only if the physician believes the patient's judgment is impaired (i.e., the patient is unable to make decisions regarding personal, interpersonal, financial and/or medical affairs). Many people who are depressed or mentally ill are capable of making such decisions.

According to Oregon's tenth annual assisted-suicide report, not one patient was referred for a psychological or psychiatric evaluation before receiving an assisted-suicide prescription.[2] Yet a recent Oregon Health & Science University study found that one in four Oregonians who request assisted suicide are likely to be clinically depressed, and the assisted-suicide law may fail to protect these patients.[3]

- **Lets a doctor help a patient commit suicide even after the patient is found to have impaired judgment.**

If a patient is found to have impaired judgment, the assisted-suicide bill does not prohibit a health care provider, family member or other person from arranging for the patient to be evaluated by other counselors until one is found who will declare the patient qualified for assisted suicide.

In Oregon, it has been noted that "a psychological disorder – senility, for example – does not necessarily disqualify a person" from receiving assisted suicide. An Oregon woman who was suffering from early dementia died of assisted suicide even though her own physician declined to provide the lethal prescription. When counseling to determine her capacity was sought, a psychiatrist determined that she was not eligible for assisted suicide since she was not explicitly seeking it, and because her daughter seemed to be coaching her to do so. She was then taken to a psychologist who determined that she was competent but possibly under the influence of her daughter who was "somewhat coercive." Finally, a managed care ethicist, who was overseeing her case, determined that she was qualified for assisted suicide, and the drugs were prescribed.[4]

- **Gives government health programs, managed care programs and others the opportunity to cut health care costs by encouraging vulnerable patients to request assisted suicide.**

Tragically, elder abuse is a common occurrence in today's society. Elderly patients could easily be pressured by family members or unscrupulous health care providers into requesting assisted suicide. Although the bill specifically states that it prohibits coercing or using undue influence on a patient to request the deadly drugs [§ 52 (b)], nothing in the bill prohibits managed care providers, insurance companies or others from suggesting assisted suicide to a patient or from encouraging a patient to request a lethal prescription.

During debate on a similar proposal in California, Sen. Joe Dunn (D-Santa Ana) cast the deciding "No" vote to defeat the bill because the "power of money" would influence HMO's, health insurers and the state to save money while cutting back on patient care.[5]

In Oregon, some patients have been told by their health insurance provider that a costly drug prescribed by a doctor to treat the patient's illness would not be covered but inexpensive lethal drugs for assisted suicide would be.[6]

- **Lets a doctor write an assisted-suicide prescription for a patient without seeing the patient in person after diagnosis of a terminal condition is made.**

The bill requires patients to make three requests for assisted suicide – two oral requests which do not need to be witnessed and one written witnessed request. [§ 36] However, none of those requests must be made in person. The two oral requests could be made by telephone and the written request could be sent by mail or fax.

➲ **Allows prescriptions to be mailed to pharmacies which can then dispense the lethal drugs to a family member, friend or designated agent.**

The bill does not require that the drugs be provided directly to the patient. [§ 31 (12) (B) (ii)] In one known Oregon assisted-suicide death, the patient received his lethal overdose by Federal Express.[7] Under Hawaii's proposal, Federal Express could be the "expressly identified agent" to bring the drugs to the patient.

➲ **Forces hospitals, nursing homes and other care facilities to allow assisted-suicide referrals on the premises.**

The bill states that providers shall not be under any duty to participate in assisted suicide. [§ 51(a) and (b) (1) (2)] However, the bill specifically states that referral does not constitute participation. [§ 51 (b) (3) (2)(C)]

➲ **Does not contain any provisions to investigate inaccurate, incomplete and misleading reports or to investigate abuse surrounding assisted-suicide deaths.**

Although assisted-suicide advocates claim that Oregon's official reports about the practice of assisted suicide prove that there have been no problems or abuses, those claims are, at best, misleading.

According to data provided by Compassion & Choices – the assisted-suicide advocacy group that is the chief promoter of "Death with Dignity" bills – the organization has participated in three quarters of Oregon's assisted-suicide deaths.[8] Oregon's largest newspaper characterized this as a situation in which "essentially, a coterie of insiders run the program, with a handful of doctors and others deciding what the public may know."[9]

As with Oregon's assisted-suicide law, the Hawaii bill requires doctors who write prescriptions for assisted-suicide drugs to report those cases to the state [§ 42] but, as in Oregon's law, there are no penalties for non-reporting or for inaccurate or incomplete reporting.

From the time that Oregon's law went into effect, state officials have acknowledged that "it is difficult, if not impossible to detect accurately" whether reports are complete.[10] State officials have acknowledged that they "assume, however, that physicians were their usual careful and accurate selves" when filing reports about their involvement in assisted suicide.[11]

One Oregon official explained that investigation into potential assisted-suicide irregularities cannot take place since "not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves." [12]

[1] Nation Center on Elder Abuse, "Fact Sheet: Elder Abuse Prevalence and Incidence" (2005), page 1.
[2] DHS, "Tenth Annual Report on Oregon's Death with Dignity Act," March 18, 2008, Table I.

[3] Linda Ganzini, Elizabeth Goy, Steven Dobscha, "Prevalence of depression and anxiety in patients requesting physician' aid in dying: cross sectional survey," *British Medical Journal*, Oct. 8, 2007, pp. 973-975.
[4] Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.
[5] Greg Lucas, "Committee votes down assisted-suicide bill," *San Francisco Chronicle,* June 27, 2006.
[6] *KATU TV;* Portland, OR; July 31, 2008.
[7] Erin Hoover, "Dilemma of assisted suicide: When?" *Oregonian*, Jan. 17,1999.
[8] "Compassion & Choices of Oregon Summary of Deceased Patients, 1/1/98 through 9/25/08" distributed by George Eighmey, Executive Director of C & C of Oregon, Vancouver, WA Public Library Forum on I-1000, Sept. 25, 2008.
[9] Editorial Board, "Washington state's assisted-suicide measure: Don't go there," *Oregonian,* Sept. 20, 2008.
[10] *New Eng. J. Med,* Feb. 18, 1999, p. 583.
[11] OHD, CD Summary, vol. 48, no. 6, March 16, 1999.
[12] Testimony of Dr. Katrina Hedberg before the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence*. Apr. 4, 2005, p. 266, question 615.

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