Hawaii (2019-)

Assisted suicide became legal in Hawaii from 1 January 2019. The Our Care, Our Choice Act is modelled on the Oregon and Washington laws but has some differences.[1]

Competency to suicide assessed by telehealth

The Act requires the "attending provider" to refer every person who requests assisted suicide for "counselling" which is defined as "one or more consultations, **which may be provided through telehealth**, as necessary between a psychiatrist, psychologist or clinical social worker 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.

The use of telehealth for this purpose has been criticised by Katherine Drabiak, an assistant professor in the College of Public Health at the University of Southern Florida. She writes:

"Understanding the patient's psychological condition is important because research in Oregon has found that patients considering PAS [physician assisted suicide] have concerns relating to loss of autonomy, ability to engage in activities that make life enjoyable, and loss of dignity. (Contrary to popular belief, excruciating pain is not a substantial factor in patient decisions to seek PAS.) Under Hawaii's law, however, a patient may obtain a consultation via telehealth. While telehealth promises to reduce cost and increase efficiency to address other health care issues, ***we should pause to consider the sufficiency and ethics of a remote consultation with patients to discuss their motivations and screen for potential problems****.*

I take issue with what I see as a pro forma requirement. It looks like a protection, but it's not designed to address underlying issues such as a patient's depression and whether it could be relieved. Patients facing psychological, social, or existential concerns deserve compassion in the form of reassurance, social support, and practical solutions to address feeling like a burden on others. Needing connection and validation throughout our life–and especially at our most vulnerable when we require assistance from others–translates to knowing that we are meaningful and loved."[2]

Minimal reporting

The Act requires an annual report to be issued, however, there is no requirement under the Act for any information to be reported to the Department of Health on the reasons for requesting assisted suicide (apart from the underlying condition), on the length of the patient-doctor relationship, on the length of time from first request to death or from ingestion to either unconsciousness or death.

Complications

The form to be completed by the prescribing physician 30 days after the death – whether by ingestion of the lethal substance or otherwise – does ask: *Were there any complications or barriers?*[3]

However, there is no requirement for the physician – or indeed any witness – to be present at the ingestion of the lethal substance, even though the Act refers to the physician who writes the lethal

[1] https://health.hawaii.gov/opppd/files/2018/11/OCOC-Act2.pdf

[2] https://www.thehastingscenter.org/hawaiis-new-end-life-law-additional-safeguards-withstand-scrutiny/

[3] https://health.hawaii.gov/opppd/files/2018/12/Attending-Physician-Follow-up-Form-eff.-1_1_19.pdf

prescription as the "*attending provider*". Nor does the form ask whether or not the physician was present.

The claim in the July 2020 Legislative Report that in 2019 "There were no reported complications due to ingesting the medications" is therefore of little value.[4]

Nonetheless it is reported that in the first half of 2020 one person took **more than six hours to die** after ingesting a prescribed lethal dose of DDMP2 and that in the second half of 2020 "*there was one complication with ingesting DDMP2*".

There was one complication reported for 2021 where the prolonged **time to death was** approximately **12 hours**.

Numbers

According to the July 2020 Legislative Report, of the 30 people for whom a prescription for a lethal substance was written in 2019, 23 were reported dead, with 15 reported as having ingested the lethal substance and 8 having died without ingesting it.

According to the July 2021 Legislative Report in 2020, 37 people were prescribed a lethal dose, mostly of DDMP2, and of these 25 had already ingested it and died; 7 died without ingesting it and the status of the remaining 4 is unknown.

According to the July 2022 Legislative Report in 2021, 70 people were prescribed a lethal dose, mostly of DDMP2, and of these 29 had already ingested it and died; 20 died without ingesting it and the status of the remaining 21 is unknown.

Deaths by ingestion of lethal poison prescribed under the Act nearly doubled (93% increase) from 2019 to 2021.

This represents 0.22% of all deaths in 2021. It took 14 years for assisted suicide deaths in Oregon to reach this rate

No safe place?

Although the Act contains explicit provisions protecting the right of a health care facility to prevent health care providers in its employ or on its premises from "participating" in the provision of assisted suicide there may be gaps in these provisions.

The American Civil Liberties Union threatened a law suit against Kahala Nui,[5] a continuing care retirement community, which is run by a non-profit organisation and is situated on land owned by the Catholic Church, to force it to repeal a provision in its residents agreement which makes it clear that acts of assisted suicide under Hawaii's new law are not permitted in the community.[6]

Kahala Nui subsequently announced that while no assisted suicide could take place in its assisted living and nursing center, it would not prevent residents in its independent living wing from accessing assisted suicide.[7]

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[4] https://health.hawaii.gov/opppd/files/2020/06/2020-Annual-OCCOA-Report-1.pdf p.2

[5] https://www.aclu.org/news/aclu-hawaii-calls-kahala-nui-retirement-community-stop-religious-discrimination ; https://acluhawaii.files.wordpress.com/2018/11/2018-11-1-letter-to-kahala-nui.pdf

[6] http://www.tribtown.com/2018/11/01/us-retirement-home-medically-assisted-suicide-the-latest/

[7] https://apnews.com/f981b6d1dfe64ed4aaef0ac56c9f502f

The proponents of assisted suicide bitterly and aggressively object to any organisation seeking to preserve a life-affirming ethos.

Call to waive waiting periods and let nurses write lethal prescriptions

The Department of Health drafted a bill to amend the law[8] – after just one year – by allowing advance practice registered nurses to serve as attending providers for patients seeking assisted suicide, giving them the power to assess people as eligible and to write lethal prescriptions.

The draft bill would also allow the 20 day waiting period between the first request and writing a lethal prescription, and the 48 hour waiting period between the final written request and writing lethal prescription to be waived if the attending provider and the consultant provider agree that the person is "*likely to die prior to the end of the waiting periods*".

Based on this draft bill, SB2582, passed the Senate 19 votes to 4 on 28 February 2020. This Bill also reduced the mandatory waiting period between the first request and writing a lethal prescription from 20 days to 15 days.

These measures would increase the risk of wrongful deaths.

The companion House Bill HB 2451 was amended in the House Commerce and Consumer Protection Committee so it would not come into effect until 1 July 2050 "*to encourage further discussion*".

Nonetheless the Department of Health still included in its report on 2020 the following recommendations for changes to the Act:

1. Waiver of any waiting periods if the attending provider and consulting provider agree that patient death is likely prior to the end of the waiting periods.

2. Given access to health care providers is limited, the DOH recommends authorizing advance practice registered nurses to serve as attending providers for patients seeking medical aid in dying.

Conclusion

The lack of data from Hawaii's experiment with assisted suicide prevents any proper scrutiny. The novel use of telehealth in assessing competence to request assisted suicide is disturbing.

[8] https://health.hawaii.gov/opppd/files/2020/01/OPPPD-Our-Care-Our-Choice-Act-Annual-Report-2019-3.pdf