

*End-of-life Law and Policy in Hawaii Aid in Dying*

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**I. INTRODUCTION**

Modern medicine can extend the dying process so long that a patient dying of a terminal illness, even with excellent pain and symptom management, may feel trapped a torturous inexorable lingering decline with suffering the patient finds intolerable. Some patients, hoping for a swifter, more peaceful end, will ask their physician to prescribe medication the patient may ingest to bring about a peaceful death. This practice, known as aid in dying, is increasingly widely accepted, including by the American Medical Women's Association, the American Medical Student Association, the American Public Health Association, and the American College of Legal Medicine among others. In the past, some referred to this intervention as 'physician-assisted suicide,' see e.g., Lindsay N. McAneeley, *Physician Assisted Suicide: Expanding the Laboratory to the State of Hawaii*, 29 U. Haw. L. Rev. 269, 284-285 (2006), but that term has been rejected as inaccurate, with growing recognition that the choice of a dying patient for a peaceful death is not suicide.<sup>[1]</sup>

In 2002, Hawaii nearly became the second state to enact a specific statutory permission for aid in dying, which Oregon did in 1994. However, the bill was voted down by a narrow margin on the final day of the session.<sup>[2]</sup> Since then, proposals to establish a specific statutory permission for this intervention have not received a full vote in the Hawaii State Legislature.<sup>[3]</sup>

Even though opponents defeated enactment of a permissive statute, they have not defeated Hawaii's broad public support for aid in dying.<sup>[4]</sup> An overwhelming majority of Hawaiians supports the availability of this option.

A careful review of Hawaii's existing statutory landscape indicates that physicians can provide this intervention without fear of criminal sanction, as there is no basis for such in the law. In the absence of a prohibition, it is not necessary to enact a statutory permission, as medical care is typically governed by standard of care, not statute or court decision that either prohibits or authorizes specific types of care.<sup>[5]</sup> Hawaii's existing statutory landscape, discussed below, already empowers patients to make autonomous decisions regarding their end-of-life care and treatment for pain. The local standard of care already incorporates other life-ending practices such as withdrawal of life-sustaining treatment, cessation of nutrition and hydration, and palliative sedation. Hawaii is a jurisdiction in which physicians

who so choose can provide aid in dying subject to professional standards of care.

## II. HAWAII LAW GOVERNING END-OF-LIFE CARE

### A. Hawaii Law Empowers Patients to Make Autonomous End-of-Life Treatment Decisions

Hawaii's statutory framework recognizes and respects the autonomy of patients in their decisions regarding end-of-life care. Existing laws empower patients to be able to effectively treat their pain and to refuse or withdraw life-sustaining treatment.<sup>[6]</sup> Hawaii, like many states, has passed a version of the Uniform Health-Care Decisions Act, which allows patients to specify if and when they wish to refuse or withdraw life-sustaining medical care.<sup>[7]</sup> Additionally, in 2004 Hawaii enacted the Pain Patient's Bill of Rights, and in doing so recognized that inadequate treatment of pain is a significant health problem.<sup>[8]</sup>

Hawaii law also contains a unique provision that gives physicians broad discretion when treating terminally ill patients:

“[W]hen a duly licensed physician or osteopathic physician pronounces a person affected with any disease hopeless and beyond recovery and gives a written certificate to that effect to the person affected or the person's attendant nothing herein shall forbid any person from giving or furnishing any remedial agent or measure when so requested by or on behalf of the affected person.”<sup>[9]</sup>

Added in 1909, the purpose of this provision was to give terminally ill patients the option to obtain treatment that had not yet been approved by the government.<sup>[10]</sup> This provision, like the Pain Patient's Bill of Rights and the Uniform Health-Care Decision Act, gives terminally ill patients significant freedom of choice to determine their course of medical care at the end of life and protection to physicians who provide care.

### B. Criminal Prohibitions Governing End-of-life Care

The only existing criminal provision that could possibly have bearing on a physician's conduct in providing aid in dying is Hawaii's manslaughter statute, which provides that an individual commits manslaughter if, “[t]he person intentionally causes another person to commit suicide.”<sup>[11]</sup> A physician's role in aid in dying could hardly be classified as “causing” a “suicide,” because the physician, at the request of a competent terminally ill patient, merely provides a prescription for medication that a patient can choose, or not choose, to ingest to bring about a peaceful death.

The manslaughter statute also requires that an individual act with the intent to cause another to commit suicide.<sup>[12]</sup> Many patients who obtain a prescription for aid in dying choose not to ingest the medication, deriving comfort from knowing they have the ability to exercise control over their time and manner of death if suffering becomes unbearable: In Oregon, approximately one-third of patients who obtain a prescription under that State's Death with Dignity Act choose not to ingest the medication, and instead die of their underlying disease.<sup>[13]</sup> The experience in

Oregon illustrates that with aid in dying physicians intend to comfort and empower their patients, not to “cause another to commit suicide.”

Moreover, a death that is precipitated by aid in dying is no form of “suicide.” It is critical to note that it is widely recognized by mental health professionals that there is a stark and fundamental difference between the act of “suicide” and the choice of a mentally competent, terminally ill patient to bring about a peaceful death.<sup>[14]</sup>

Finding that a physician who provides aid in dying acts with the intent to cause another to “commit suicide” would also potentially criminalize other forms of end-of-life care. Practices such as palliative sedation, discontinuing life-sustaining medical care, and providing palliative support to a patient who chooses to stop eating and drinking could all be characterized as intended to end life. Yet these practices are widely accepted as intending to comfort and empower patients who wish to have a peaceful death. None has been found to be illegal or unprofessional under Hawaii law.

Other than the manslaughter statute, there are no laws that could possibly apply to prohibit aid in dying. Given Hawaii’s laws that seek to empower patients to make autonomous decisions about end-of-life care and pain management, and the absence of a criminal prohibition that could reach aid in dying, it is reasonable to conclude that Hawaii physicians who so choose can provide this intervention to their mentally competent terminally ill patients without fear of prosecution, subject to professional standards of care.

#### **AID IN DYING SHOULD BE GOVERNED BY STANDARD OF CARE.**

Most medical care is not governed by statute or court decision, but by conformance to professional standards of care.<sup>[15]</sup> Hawaii physicians have a duty to possess and utilize the knowledge and skill ordinarily possessed by a physician practicing in the same field under similar circumstances, as established by expert testimony.<sup>[16]</sup> As discussed *supra*, Hawaii’s statutory framework empowers patients to make autonomous decisions regarding their end-of-life care. Under this framework a standard of care has already begun to emerge in which physicians engage in other potentially life-ending practices for terminally ill patients.

For example, physicians can, and should, provide palliative support to patients who choose to stop eating and drinking. Physicians can also discontinue life-sustaining treatment such as respiratory support, pacemakers, dialysis and medication for patients who wish to end life-prolonging interventions. Physicians in Hawaii have already witnessed the emergence of a standard of care that respects a patient’s autonomy and accepts life-ending practices. For

physicians who believe that their competent terminally ill patients should be able to choose aid in dying and are willing to provide it, a professional standard for this intervention will also emerge, likely influenced by the practice in other states and guidance in the professional literature.

## **AID IN DYING IN OTHER STATES**

### **A. Aid in Dying in Oregon**

Oregonians enacted the Death with Dignity Act in 1994.<sup>[17]</sup> After a court challenge to the Act was resolved, patients began to access this intervention in 1998.<sup>[18]</sup> The Act allows a mentally competent, terminally ill adult to request a prescription for medication that may be ingested to bring about a peaceful death.<sup>[19]</sup> Despite the fears of those opposed to aid in dying, its availability has been demonstrated to improve end-of-life care while posing no risks to patients or physicians. Relatively few dying patients choose aid in dying. In 13 years of Oregon experience only 525 patients have chosen to utilize aid in dying to bring about a peaceful death.<sup>[20]</sup> Patients opting for this intervention were predominantly well-educated, insured Caucasians dying of cancer<sup>[21]</sup>—disproving speculation the option would be forced upon the poor, undereducated and disadvantaged. Availability of this end-of-life intervention has yielded important benefits: Physicians were motivated to increase their knowledge of how to treat pain and other distressing symptoms, to prescribe more pain medications, to improve their ability to diagnose depression, and to make referrals to hospice earlier and more frequently.<sup>[22]</sup>

### **B. Aid in Dying in Washington**

In 2008, Washington voters approved a law nearly identical to Oregon's, through the initiative process.<sup>[23]</sup> As in Oregon, most who choose aid in dying under Washington's law are well educated Caucasians suffering from cancer.<sup>[24]</sup> Since the law went into effect a total of 152 patients have received prescriptions, and of those 87 chose to ingest the medication.<sup>[25]</sup>

### **C. Aid in Dying in Montana**

In Montana a decision by the Montana Supreme Court recognized the right of its citizens to choose aid in dying. Robert Baxter, a terminally ill patient, sued the State of Montana to establish his right to choose aid in dying.<sup>[26]</sup> The court held that aid in dying is not against the state's public policy, and thus the state's consent defense statute

shields physicians from homicide liability.<sup>[27]</sup> Willing physicians may provide aid in dying without fear of prosecution. Montana physicians are not subject to the statutory frameworks that govern the practice in Oregon and Washington. Although the limitations provided by the Acts in Oregon and Washington do not apply to Montana physicians, the Montana Supreme Court recognized certain boundaries which are similar to the Oregon and Washington Acts: A patient must be terminally ill, mentally competent, and the physician is limited to providing a prescription for medication which a patient may or may not choose to ingest.

## **CONCLUSION: AID IN DYING CAN AND SHOULD EMERGE AS AN END-OF-LIFE OPTION IN HAWAII AS A PRACTICE GOVERNED BY STANDARD OF CARE**

End-of-life medical practice in Oregon, Washington and Montana, and the clear trend among medical and health-policy organizations to adopt policy supportive of aid in dying,<sup>[28]</sup> demonstrate growing acceptance of this intervention.<sup>[29]</sup> These polices and the practice in Oregon, Washington and Montana will certainly influence a developing standard of care elsewhere.

It is timely for the practice of aid in dying to emerge in Hawaii as an end-of-life option governed by standard of care. The thirteen years of positive outcomes in Oregon, the recent adoption of aid in dying in both Washington and Montana, strong public support for the intervention, and the trend of many major national medical and health-policy groups to adopt supportive policy combined with the existing statutory landscape in Hawaii, which vests patients with great autonomy in end-of-life decisions and has no prohibitory measure that could reach the practice, all suggest that aid in dying can emerge within end-of-life medical practice governed by standard of care. This would extend an important additional choice to mentally competent, terminally ill Hawaiians who confront a dying process that they find unbearable.

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[1] See Reah K. Faberman, *Terminal Illness and Hastened Death Requests: The Important Role of the Mental Health Professional*, 28 *Professional Psychology: Research and Practice* 544 (1997). See also, John Michael Bostwick & Lewis M. Cohen, *Differentiating Suicide from Life-Ending Acts and End-of-Life Decisions: A Model Based on Chronic Kidney Disease and Dialysis*, 50 *Psychosomatics* 1 (2009).

[2] B.J. Reyes, *Assisted Suicide Bill Stalls*, Honolulu Star-Advertiser, February 8, 2011.

[3] *Id.*

- [4] News Release, QMark Research and Polling, Press Release, [http://hawaiiidwdsociety.org/polls/2003\\_QMark\\_Poll\\_FINAL.pdf](http://hawaiiidwdsociety.org/polls/2003_QMark_Poll_FINAL.pdf) 1 (2003) (“[V]oters in Hawaii support proposed Death with Dignity legislation by an overwhelming 71%.”).
- [5] 61 Am. Jur. 2d Physicians, Surgeons, Etc. § 189.
- [6] See Haw. Rev. Stat. Ann. § 327H-1 (2011); Haw. Rev. Stat. Ann. § 327E-2 (2011).
- [7] Haw. Rev. Stat. Ann. § 327E-2 (2011).
- [8] Haw. Rev. Stat. Ann. § 327H-1 (2011).
- [9] Haw. Rev. Stat. Ann. § 453-1 (2011).
- [10] Paul S. Kawai, *Should the Right to Die Be Protected? Physician Assisted Suicide and Its Potential Effect on Hawai'i*, 19 U. Haw. L. Rev. 783, 806 (1997).
- [11] Haw. Rev. Stat. Ann. § 707-702(1)(b) (2011).
- [12] See Haw. Rev. Stat. Ann. § 707-702(1)(b) (2011).
- [13] Or. Health Authority, Oregon’s Death with Dignity Act-2010 (2011), available at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx> [hereinafter *Oregon’s Death with Dignity Act-2010*].
- [14] See Reah K. Faberman, *Terminal Illness and Hastened Death Requests: The Important Role of the Mental Health Professional*, 28 Professional Psychology: Research and Practice 544 (1997). See also, John Michael Bostwick & Lewis M. Cohen, *Differentiating Suicide from Life-Ending Acts and End-of-Life Decisions: A Model Based on Chronic Kidney Disease and Dialysis*, 50 Psychosomatics 1 (2009).
- [15] 61 Am. Jur. 2d Physicians, Surgeons, Etc. § 189.
- [16] See HI R CIV JURY Instr. 14.2; HI R CIV JURY Instr. 14.3.
- [17] Or. Rev. Stat. Ann. § 127.800 (2011).
- [18] Or. Health Authority, Death with Dignity Act, <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx> (last visited June 28, 2011).
- [19] Or. Rev. Stat. Ann. § 127.805 (2011).
- [20] *Id.*
- [21] *Id.*
- [22] Courtney S. Campbell, Ten Years of “Death with Dignity,” 22 New Atlantis 33, 40-41 (2008) available at <http://www.thenewatlantis.com/publications/ten-years-of-death-with-dignity>.
- [23] Wash. Rev. Code Ann. § 70.245.010 (2011).
- [24] Wa. State Dept. of Health, 2010 Death with Dignity Act Report (2010), available at <http://www.doh.wa.gov/dwda/>.
- [25] *Id.*
- [26] *Baxter v. State of Montana*, 224 P.3d 1211, 1214, reh'g denied (Mar. 3, 2010).
- [27] *Id.* at 1215.
- [28] See Kathryn Tucker, *At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy Associations*, 10 Harv. Health Pol’y Rev. 45 (2009)(discussing organizations adopting policy in support of aid in dying including the American Medical Women’s Association (AMWA), available at <http://amwa-doc.org> (follow Advocacy link; then follow Position Statements link; found under Ethical Issues) (last visited July 8, 2011); the American Medical Students’ Association (AMSA), available at [http://www.amsa.org/AMSA/Libraries/Exec\\_Docs/2011PPP.sflb.ashx](http://www.amsa.org/AMSA/Libraries/Exec_Docs/2011PPP.sflb.ashx) (see p. 74) (last visited July 8, 2011), the American College of Legal Medicine (ACLM), available at [http://www.aclm.org/resources/amicus\\_briefs/ACLM%20Aid%20in%20Dying%20Policy.pdf](http://www.aclm.org/resources/amicus_briefs/ACLM%20Aid%20in%20Dying%20Policy.pdf) (last visited July 8, 2011); and the American Public Health Association (APHA), available at <http://www.apha.org/advocacy/policy/policysearch/> (search for Policy Number 20086) (last visited July 8, 2011).
- [29] *Id.*