An Introduction to Medical Aid in Dying

HAWAIʻI

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Our Care, Our Choice Act

Medical aid in dying is the practice in which a terminally ill, mentally competent adult patient voluntarily requests and receives a prescription medication from a physician that they can self-administer to die peacefully. This allows patients to end their lives on their own terms. Medical aid in dying is authorized in 11 jurisdictions with regulations varying by jurisdiction to ensure that the process is carried out ethically and safely.

The Our Care, Our Choice Act authorizes the practice of medical aid in dying, allowing a terminally ill, mentally capable adult with six months or less to live to request from their healthcare provider a prescription for medication that the patient can decide to self-ingest to die peacefully if their suffering becomes unbearable.

It was put into effect on January 1st, 2019 and amended in June, 2023 to increase access to the Our Care, Our Choice Act.

Eligibility

To be eligible to use the law, the individual must:

- Be 18 years or older
- Have been diagnosed with a terminal illness
- Have a prognosis of six months or less to live
- Be mentally capable of making their own healthcare decisions

The patient must also be:

- A resident of Hawai‘i
- Capable of self-ingesting the aid-in-dying medication
- Making an informed decision and voluntary request

A person is not eligible for medical aid in dying solely because of age or disability.

Summary of Process to Obtain Medical Aid in Dying

Two Hawai‘i healthcare providers (either physician or advanced practice registered nurse) must confirm the patient’s eligibility to use the Our Care, Our Choice Act, as well as confirm that the patient is making an informed decision and voluntarily requesting the aid-in-dying

medication. The attending healthcare provider prescribes the medication, and the consulting healthcare provider confirms eligibility, capacity, and voluntariness. (An attending healthcare provider is described as a healthcare provider who has primary responsibility for care of the individual and their disease.) A patient's mental capacity must also be confirmed by a psychiatrist, psychologist, or licensed clinical social worker, advanced practice registered nurse or marriage and family therapist. This evaluation may be provided through telehealth (by phone or video).

The patient may change their mind at any time and withdraw their request, or choose not to take the medication.

Making A Request

The patient must make three requests to their attending healthcare provider to use the Our Care, Our Choice Act: two verbal requests and one written one. The written request is the Request for Medication to End My Life form provided by the state, which is included in this packet. Only the patient can make these requests; they cannot be made through an advance directive or by a family member or friend. The requests must be made to a healthcare provider, not office staff. Please see the "Steps" section of this document for details.

Medication

The type and dosage of aid-in-dying medication healthcare providers prescribe, including medications to prevent nausea and vomiting, varies with each individual. The medication cannot be injected. The patient must be able to ingest the medication, usually by swallowing or by using a feeding tube. **The prescribing healthcare provider must send the prescription directly to the pharmacy. The pharmacy will NOT accept a prescription directly from a patient.** A designated family member, friend or healthcare provider may pick up the medications.

If the prescribing healthcare provider has any questions about medications or participating pharmacies, the healthcare provider can call Compassion & Choices' free and confidential Doc2Doc consultation line at 800.247.7421.

Once the prescription is written, the patient may choose to keep it on file at the pharmacy if and until they decide to use the medication. The patient does not need to pay for the medication until the prescription is filled. The prescription can be mailed to the patient's residence to be signed for and kept in a safe location.

The patient may ask their provider or pharmacy about the cost of these medications. Some insurance policies, including Hawai'i Medicaid, cover the cost of the medication and/or the healthcare provider visits. Please contact the insurance provider to find out what the policy covers. It should also be noted that many compounding pharmacies do not work with insurance and instead offer medications at a cash-only rate.

Unused Medication

There is no obligation to take the medication, even after the prescription has been filled. If the person who was prescribed the medication does not use it,it should be disposed of in accordance with state and federal law. **Please note it is illegal to use another person's medication.**

To safely discard unused medication:

- Do NOT flush down the toilet, sink or other drain
- Remove all personal information on bottle labels and medicine packaging
- Use the following website to search for a controlled substance public disposal location nearby: https://www.hawaiiopioid.org/drug-take-back
- Use the following website to search for other authorized drug collection/disposal locations near you: https://www.fda.gov/drugs/disposal-unused-medicines-what-you-should-know/drug-disposal-drug-take-back-locations
- Contact the pharmacist who filled the prescription for more assistance.

Death Certificates

Life insurance benefits are not affected by using the Our Care, Our Choice Act. The underlying illness will be listed as the cause of death. The law specifies that a death resulting from self-administering aid-in-dying medication is not suicide.

Steps for Accessing Medical Aid in Dying in Hawai‘i

The first step is to speak with your physician or advanced practice registered nurse* to discuss your interest in medical aid in dying. Be sure to be explicit in your discussion, and ask if they will support this option by writing a prescription. Review the "Talking With Your Provider" section of this packet for prompts you can use to begin your discussion.

If you are considering medical aid in dying, it is also a good time to think about any additional planning that you may need to begin, including consideration of hospice enrollment.

Note: Hospice is a specialized service (covered by insurance and Medicare), providing wonderful individualized support to people at the end of their lives. Those eligible for medical aid in dying are also eligible to receive hospice services. **Many hospice organizations have a policy regarding medical aid in dying, so it is important to review and discuss that policy if enrolled in hospice and pursuing this option.**

*You may ask any healthcare provider who is treating you.

If your Healthcare Provider says no:

If your provider decides not to participate, or is unable to, you should ask for a referral to another clinician who has chosen to participate. If additional assistance is needed, some health systems offer the support of a care navigator or social worker to assist with resources and referrals. If your provider does not provide a referral, or your health system does not allow medical aid in dying, you may consider establishing care with a system or facility that will support you in medical aid in dying.

Don't be afraid to advocate for the end-of-life experience you want. For more information and resources, visit candc.link/personal-advocacy

Compassion & Choices' End-of-Life Consultants are available to offer personalized support, resources and information at no cost. You can reach out to them via email at eolc@CompassionAndChoices.org or leave a voicemail at 800.247.7421; in both instances, consultants will respond to you in 1-2 business days. Language interpreter services are available.

If your Healthcare Provider says yes:

1. Ask your healthcare provider to write down your first verbal request in your medical record. Your first verbal request is when you state that you would like to pursue medical aid in dying, asking your doctor to write a prescription, or stating that you would like to begin the process of requesting medical aid in dying.

2. **You are required by law to ask your attending healthcare provider at least two times for medical aid in dying**. The second time you ask has to be a minimum of five days after the first time you ask.

3. In addition to an attending healthcare provider, **a consulting healthcare provider must certify that the patient is eligible to use the law and that they are making both an informed decision and voluntary request.**

4. **A patient's mental capacity must also be confirmed** by a psychiatrist, psychologist, licensed clinical social worker, advanced practice registered nurse or marriage and family therapist. This evaluation may be provided through telehealth (by phone or video).

5. **The patient must fill out the Request for Medication to End My Life form** and give the completed form directly to the attending healthcare provider. **This form must be witnessed by two people.** Please read the form carefully to determine who may or may not be a witness.

6. **At least 48 hours after the Request for Medication to End My Life form is signed and dated, the attending healthcare provider may write the prescription.** The prescription must be sent directly to the pharmacy by the prescribing healthcare provider , not by the patient, a family member or friend. The pharmacy may need time to order the medication.

7. The attending healthcare provider will also provide the patient with a **Final Attestation form. The patient must fill out and sign this form within 48 hours before they plan to take the aid-in-dying medication.** The form should be sent or turned in to the attending healthcare provider after the patient's death to ensure it is added to the medical record.

8. Pick up your prescription OR have a designated person or healthcare provider pick it up for you. The pharmacist will go over the medication details with you and let you know what to do with it if you do not end up taking it.

9. **Planning for the day of ingestion is also important to do during this time, and allows your healthcare team and loved ones to support you as you wish**. This could include discussing who you want to present, what kind of sounds or smells you would like to experience, managing symptoms prior to ingestion, and what you would like the day to feel like. This is also a good time to review or discuss final arrangements.

10. When the time has come, you can take the medication if you still feel it is necessary*.

    *You can always decide not to take the medication. Individuals can enroll in hospice and may choose to have at least one person with them when they take their medication. Hospice is a service (covered by insurance and Medicare), providing incredible support for people at the end of their lives.

Talking With Your Healthcare Provider

The process to access medical aid in dying can take weeks and sometimes months. We encourage people to start the process early. You don't have to wait until you're sick to ask your healthcare provider if they would support you in accessing medical aid in dying if you should become eligible for it. Your provider may not be familiar with the Our Care, Our Choice Act itself, and may have some questions; see information about our Doc2Doc line at the end of this section for a resource you can share.

Some people feel anxious about discussing end-of-life issues with their healthcare provider, but doing so will enable you to have an end-of-life care experience consistent with your values. If you are uncomfortable with talking to your healthcare provider about this, you can bring a friend to help you or start the conversation in writing. It is important to make sure you are able to access the end of life option you want.

Both healthcare providers and health systems are allowed to opt out of providing medical aid in dying, so it's important to make sure that you are able to access it.

No one but you can make this request. It is important to speak directly with the clinician, either your physician or advanced practice registered nurse; do not ask the office staff,, or leave a request on voicemail. Below are some examples of ways to ask your clinician about their ability to support you in a way that aligns with your values.

Language for someone who DOES have a terminal illness:

- *Though I am not currently facing a terminal illness, access to the option of medical aid in dying, if I were to qualify, is important to me. I would like to know if you/this hospital system would support that decision to access the Our Care, Our Choice Act.*
- *I want to live with as much quality as possible for as long as I can, and I've thought long and hard about what I want my end-of-life experience to look like. If I ever meet the legal requirements, I would like to have the option of using the Our Care, Our Choice Act. Is that something you would be able to support me in seeking?*
- *I hope you will honor my decisions and respect my values, as I respect yours. Will you write a prescription for aid-in-dying medication in accordance with the Our Care, Our Choice Act when I am eligible? If you are not able to honor that request, I would like to find out now.*

Language for someone who DOES have a terminal illness:

- *I have thought about this for quite some time, and am interested in accessing the Our Care, Our Choice Act. Is this a decision that you would support me in?*
- *I want to die the way I've lived: on my own terms. That's why I'm interested in the Our Care, Our Choice Act. It's my understanding that in order to initiate the process, I need to first make a verbal request. I also understand that anyone facing a terminal*

illness would benefit from hospice support. Could you please document my verbal request today and place a referral to hospice?

Whether your provider elects to participate in your medical aid in dying process or not, it is important to ask that your request be recorded in your medical record.

If your healthcare provider says no, you can ask for a referral to another healthcare provider who has chosen to participate. In some health systems supportive of medical aid in dying, there are established internal referral systems within the network. That means that if your healthcare provider won't do it, they should be able to refer you to another healthcare provider in your health system who will support you. If your healthcare provider won't refer you, or your health system does not allow medical aid in dying, then you can try to re-establish care with a system or facility that will support you in medical aid in dying.

Compassion & Choices Doc2Doc Consultation Program provides free and confidential consultation to providers who have questions about end-of-life care options, including medical aid in dying. If your clinician is willing to participate but needs support please refer them to the Doc2Doc phone line at 800.247.7421. Tell them that a physician who has prescribed medical aid in dying will respond to their call.

End-of-Life Care Planning Checklist

Please visit the Compassion & Choices website for more resources at CompassionAndChoices.org/plan.

Many people postpone making arrangements for healthcare at the end of life. Planning ahead allows individuals to spend their final days with friends and family while focusing on the present. Informing loved ones of wishes ahead of time relieves them of the possible burden of making decisions about your final arrangements.

Please consider whether any of the following are appropriate for your situation:

- ☐ Discuss your wishes with family and loved ones
- ☐ Discuss your wishes with your provider(s) and healthcare team
- ☐ Provide a copy of your current Advance Directive to
  - ☐ Healthcare Provider(s)
  - ☐ Healthcare entity
  - ☐ Agent named as surrogate decision maker
  - ☐ Hospice team (if applicable)
- ☐ Create and/or locate important documents
  - ☐ Advance Directive or Living Will
  - ☐ Durable Power of Attorney for Healthcare
  - ☐ Durable Power of Attorney for Finances
  - ☐ Last Will and Testament
    - > Compassion & Choices has partnered with Free Will to offer this documentation at no cost, available at: CompassionAndChoices.org/ways-to-give/free-will
  - ☐ Living Trust
  - ☐ Life Insurance policies (with beneficiary information)
  - ☐ Information for financial accounts, assets property
  - ☐ Information for final arrangements, funeral plans, prepaid services
- ☐ Ensure important documents are up to date and reflect your current wishes
- ☐ Name a guardian for children, pets

Glossary

advance care planning

Includes a person's living will, medical durable power of attorney (or health care proxy – see below), do not resuscitate, and portable medical orders. Called "advance" because it is ideally prepared prior to a health crisis in which it would guide medical care. Advance care planning documents vary by state and can include other documents, such as a dementia provision. See also "living will" below. Find state specific advance directives on Compassion & Choices' website at: CompassionAndChoices.org/our-issues/advance-care-planning

advance directive

a general term for any document that contains instructions pertaining to a person's wishes related to medical treatment if they can not make care decisions on their own. More information can be found here:
CompassionAndChoices.org/resource/putting-priorities-paper-advance-directive

attending healthcare provider

An attending healthcare provider is defined as a healthcare provider who has primary responsibility for care of the individual and the treatment of their disease. In the medical aid in dying process, the attending healthcare provider is the healthcare provider who writes the prescription for aid-in-dying medication.

medical aid in dying

A safe, time tested, and trusted medical practice in which a terminally ill, mentally capable adult with a prognosis of six months or less to live may request from their healthcare provider a prescription for medication that they can choose to self-ingest to bring about a peaceful death. Where medical aid in dying is currently authorized, providers are required to confirm that a patient is fully informed and provide the patient with information about additional end-of-life options, including comfort care, hospice and pain control, before providing a prescription.

Medical aid in dying is the preferred terminology of several healthcare organizations. (see below for more explanation).

DNR

Stands for "do not resuscitate," a medical order making clear an individual's request that no measures be taken to resuscitate them if their heart or breathing stops. The order is made while the individual is mentally capable and conscious, or by that individual's health care proxy (see below) if they are not.

health care proxy

A health care proxy — also known as a representative, surrogate, agent or durable power of attorney for health care — is a person authorized to make health care decisions if someone is unable to make their own. They work closely with your health care team to ensure your care and treatment preferences are followed. Selecting a health care proxy is an important part of advance care planning (see "advance care planning " above).

hospice

A program in which an interdisciplinary team of caregivers provides comfort and support to terminally ill people when medical treatment is no longer desired, expected to cure or prolong life. Hospice is provided wherever the person resides, most often at home. It is voluntary and also involves and supports the individual's family and/or loved ones. According to state reports, the majority of people who access medical aid in dying are also enrolled in hospice.

living will

A document that expresses a person's end-of-life preferences if they become unable to speak for themselves. A living will is just one component of advance care planning (see "advance care planning " above).

MOLST/POLST

Stands for Medical (or Physician) Orders for Life Sustaining Treatment. An important form to provide detailed guidance about an individual's wishes for end-of-life medical care. The order

is part of advance care planning and is prepared by a medical professional. It is often printed on brightly colored pink paper and placed on a refrigerator so it can easily be found during an emergency.

palliative sedation

Palliative sedation — also referred to as terminal sedation — is the continuous administration of medication to relieve severe, intractable symptoms that cannot be controlled while keeping the person conscious. Must be managed carefully by a medical team.

refusing medical treatment

The legal right to decline medical treatment even if that treatment is necessary to sustain life. These interventions can include dialysis, medications, ventilators, feeding tubes, and pacemakers.

terminally ill

When a disease or illness cannot be cured and is likely to lead to death, it is considered a terminal illness.

terminal prognosis

Terminal prognosis refers to the estimated time an individual has left to live. Medical aid-in-dying laws and hospice eligibility require a terminal prognosis of six months or less.

VSED

Stands for "voluntarily stopping eating and drinking," a legal option for any seriously ill individual with decision-making capacity, who wishes to shorten their dying process, refusing foods and fluids of any kind, including artificial nutrition and/or hydration.

Tracking of End-of-Life Plans & Documents

Individual Name:_____ Individual Birthdate: _____

Choosing medical aid in dying is a process that requires conversation, planning and coordination. This document is designed to help organize essential information related to the process and share with others if you choose to do so.

Advance Directive:

- Location of advance directive documents _____
- Durable power of attorney for health care (name/relationship/phone):

  _____

Hospice (if enrolled):

- Name of organization: _____
- Contact Person: _____
- Contact Email or Phone: _____
- Is Hospice aware of and able to support end of life plans? Yes _____ No _____
- If no, what is the plan for making sure end of life plans are honored?

  _____

  _____
- Any special arrangements need to be made with Hospice to make sure end of life plans are supported? Yes _____ No _____

- If so, what are they and who is in charge of getting those in place?

  _____

> Will you be requesting someone from the Hospice present? Yes _____ No _____

- If so, who?: _____

Final Arrangements:

> Have these arrangements been made? Yes _____ No _____

- If yes, name of Mortuary/Funeral Home: _____
- If yes, what information/details should be shared: _____

  _____

  _____

  _____

  _____

  _____

Medical Aid in Dying:

> Attending provider:_____ Phone: _____

> Consulting provider:_____ Phone: _____

> Mental capacity evaluation *(only if requested by healthcare provider)*:

  Yes _____ No _____

> Date of 1st verbal request: _____

  Healthcare Provider Name: _____

- Date of 2nd verbal request: _____

  Healthcare Provider Name: _____

- Date of mental capacity evaluation: _____

  Evaluator's Name: _____

- Date written request submitted: _____
- Date aid-in-dying medications prescribed: _____
- Date aid-in-dying medications picked up/received: _____
  - Medications: _____
- Name of pharmacy: _____
- Location or contact person for instructions on disposing of unused medication:

  _____

Plans for Ingestion:

- Date of planned ingestion: _____
- Who knows about your plan: _____
- Who will be present during ingestion: _____
- Describe how you you want the day to go (environment, smells, sounds, activities):

  _____

  _____

  _____

  _____

  _____

- Plan for unexpected event (such as prolonged dying process, vomiting, waking up, etc)
    - Date(s) discussed: _____
    - Plan details: _____

      _____

      _____

      _____

      _____

For California Only:

Date Final Attestation form completed: _____

Person delivering form to prescribing physician: _____

Additional Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Request for Medication Form

For Provider/Health Care Organization Use:
Medical Record #: _____
Or Patient Name: _____

Patient's Written Request for Medication, Declaration of Two Witnesses, and Written Consent for the Attending Physician to Contact the Patient's Choice of Pharmacy Form

Instructions: This form is to be completed by the **qualified patient** and his or her two witnesses. A qualified patient is a capable adult who is a resident of the state of Hawai`i and has satisfied the requirements of the Our Care Our Choice Act. Please complete and provide this form to the attending physician after completion of the counseling provider's evaluation (e.g. mental capacity evaluation or assessment) and consulting physician examination.

Waiting Period: Not less than 48 hours shall elapse between the date of the attending physician's receipt of this completed written request and taking of steps to make available a prescription. Additionally, not less than 20 days shall elapse between the date of the initial oral request with the Attending Physician and date of the prescription.

I, _____ (print full name), am an adult of sound mind. I am suffering from _____, which my attending physician has determined is a terminal disease and that has been medically confirmed by a consulting physician.

I have received counseling to determine that I am capable and not suffering from undertreatment or nontreatment of depression or other conditions which may interfere with my ability to make an informed decision.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, the possibility that I may choose not to obtain or not to use the medication, and the feasible alternatives or additional treatment options, including comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that I may self-administer to end my life.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.
_____ I have decided not to inform my family of my decision.
_____ I have no family to inform of my decision.

For Provider/Health Care Organization Use:
Medical Record #: _____
Or Patient Name: _____

Patient's Written Request for Medication, Declaration of Two Witnesses, and Written Consent for the Attending Physician to Contact the Patient's Choice of Pharmacy Form

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer, and my attending physician has counseled me about this possibility.

I am fully aware that the prescribed medication will end my life and while I expect to die when I take the medication prescribed. I also understand that my death may not be immediate, and my attending physician has counseled me about this possibility.

I make this request voluntarily and without reservation and I accept full moral responsibility for my actions.

Patient's Full Name: (Print): _____

Patient's Signature: _____ Date: _____

For Provider/Health Care Organization Use:
Medical Record #: _____
Or Patient Name: _____

Patient's Written Request for Medication, Declaration of Two Witnesses, and Written Consent for the Attending Physician to Contact the Patient's Choice of Pharmacy Form

Declaration of Witnesses

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress or to have been induced by fraud, or subjected to undue influence when signing the request; **and**

(d) Is not a patient for whom either of us is the attending physician.

Witness #1: _____
(print full name)
Witness #1: _____ Date: _____
(signature)
Witness #2: _____
(print full name)
Witness #2: _____ Date: _____
(signature)

NOTE: One witness shall not be a relative (by blood, marriage, or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate, or be employed at a health care facility where the person is a patient or resident.

Written Consent:

I consent for the attending physician to contact the pharmacist of my choice, to inform the pharmacist of the prescription, and to allow the attending physician to transmit the written prescription personally, by mail, or electronically to the pharmacist.

Patient's Full Name (Print): _____

Patient's Signature: _____ Date: _____