Special Issue on Death and Dying
Hawaii Emergency Physicians Associated, Inc.
HEPA

Serving:

Castle Medical Center
Wahiawa General Hospital
Hilo Medical Center
North Hawaii Community Hospital

Established: 1971

Congratulations!
Frederick C. Holschuh, M.D.

This HMA Journal Special Issue is Dedicated to You!

Doctor Holschuh is Past President,
Hawaii Medical Association, a Director,
Hawaii Emergency Physicians Associated, Inc. and
an Emergency Physician at Hilo Medical Center

HEPA is a participating provider with:

HMSA—continuous since 1971
Kaiser—continuous since 1971
PGMA
CHAMPUS
MEDICARE
HDS
HMMA

Aloha Care
HMSA
Kaiser
Queen's
Straub

Hawaii Emergency Physicians Associated
P.O. Box 1266 • Kailua, HI 96734 • (808) 261-3326 • Fax: (808) 262-0514
Contents

Editorial
Norman Goldstein MD .......................................................... 249
HMA President's Message
John S. Spangler MD ........................................................... 249
Military Medicine
Ben Berg MD ................................................................. 250
An Emergency Physician's Perspective on Death with Dignity
Frederick C. Holschuh MD ................................................ 252
Death with Dignity: A Case of Physician-Assisted Suicide
Norman Goldstein MD, FA.C.P ...................................... 255
Choosing to Die
Max G. Botticelli MD ......................................................... 257
The Elderly and Disabled in Hawaii
Ah Quon McElrath ............................................................ 258
Cultural Issues in Death and Dying
Kathryn L. Braon DrPH, Rhea Nichols MSW ..................... 260
An Attitudinal Survey of Euthanasia in Windward Oahu
Timothy Littlejohn and Jeanne Barrows-Johnson .......... 265
Euthanasia: Murder or Mercy?
Kenneth W. Phifer .......................................................... 270
Why I Do Not Believe in Mercy Killing
S.Y. Tan MD, JD ............................................................ 273
Lethal Aid—Physician or Lawyer-Assisted Suicide?
James H. Pietsch JD .......................................................... 274
St. Francis Hospice: Medicare and Health Care Reform
Michael A. Warren RN, BSN, MA ................................ 276
Life and Death in Hawaii: Ethnic Variations in
Life Expectancy and Mortality, 1980-1990
Kathryn L. Braon DrPH, Haiou Yang PhD, 
Alvin T. Onaka PhD, Brian Y. Horiuchi MPH .......... 278
Models of Physician-Assisted Dying
Faye Girsh EdD ............................................................. 284
A View of Death and Dying Among the Chinese and Japanese
Donald F.B. Char MD, K.S. Tom MD, George C.K. Young, 
Rev. Toshio Murakami, Roger Ames PhD ................... 286
Death with Dignity: There's Plenty More that We Can Do
Gary Johnson MD .......................................................... 291
Care of the Dying at the John A. Burns School of Medicine
University of Hawaii
Leslie Q. Tam PhD .......................................................... 293
To Die or Not to Die – Is that the Question?
Educating Physicians about End-of-Life Care
Richard MacDonald MD .................................................. 294
How Hawaii Doctors Feel about Physician-Assisted Suicide
and Euthanasia: An Overview
Lorene K. Siaw MD and S.Y. Tan MD, JD ......................... 296
Lives in the Balance '96—A Letter to Members of Hemlock Hawaii
Mikki Lawson ................................................................. 299
Primary Care Update—Highlights of the HMA Scientific Section
Elizabeth Adams MD ........................................................ 301
Classified Ads ............................................................... 302
Index to the Hawaii Medical Journal, Volume 55, 1996 ........ 304
Weathervane
Russell T. Stodd MD ......................................................... 310
We have over 200 specialists who can immediately turn to one another for assistance. But we’re not here just for each other. Straub would like to be a valuable resource to other physicians in Hawaii as well. Many of our specialists regularly visit the neighbor islands and are available for consultations.

We respect the relationship you have with your patient, which means we work closely with you to meet your needs and then return your patient to your care as soon as possible.

If you’d like consultation on a case, just call us at one of the numbers listed on the left. Or, if you’d like to talk to us about providing your services at our hospital or at one of our 11 clinics, please call Dr. John Berthiaume, Vice President, Professional Affairs, at 522-3973.

Give us a call today. After all, we’re here to help you help your patients.
Editorial

Norman Goldstein MD

Dedication to Fred C. Holschuh, MD

This issue of the Journal is dedicated to a very special colleague, Hawaii Medical Association’s past President and Big Island Emergency Room physician, Dr Fred Holschuh.

Fred has had a varied professional career. After obtaining a medical degree at Columbia, he served his internship at Queen’s Medical Center and then a pediatric residency at Children’s Hospital. So far, not so unusual. But then Fred went with Dr Michael DeBakey’s team to the People’s Republic of China in 1973 and served as a medical missionary in Guatemala. In 1986, he participated in the first Sino-American Emergency Medical and Critical Care Conference in China. In 1971, he co-founded the Hawaii Emergency Physicians Association, and has been in Emergency Medical practice for a quarter of a century!

Fred and his wife live in Honokaa, where he has been very active in organized medicine. Through his various positions with the Hawaii Medical Association, Fred has served the entire State and continues to do so. When asked to contribute a manuscript for this Special Issue, Fred said, “Sure, but what I really want to do is share some of my many ER experiences relating to Death with Dignity.” And he does it so well in our lead article.

Mahalo nui loa, Fred.

Good Life—Good Death

In most cultures, there exists a ceremonial raising of the cup to celebrate life. The Hebrew toast is “La Chaim,” but a better one might be “La Chaim Tov”—To the Good Life. Perhaps the best salute would include the sentiment found on the logo of the Hemlock Society, “Good Life—Good Death.” This special issue is devoted to that end; a good death for our patients. There are several excellent books to round out your reading on this subject, including: Final Exit; the Right to Die; Let me Die Before I Wake; Final Choices: When It’s Right to Die; and Death with Dignity. These and other related volumes are now available at the Hawaii Medical Library’s section on Death with Dignity, and from Hemlock Society USA (see the ad and membership information in this issue).

My personal interest in death with dignity began two and a half years ago, and I am frequently asked why a dermatologist is concerned with this subject, since “skin patients never die!” Well, we all die eventually, though usually not of skin related illness, so it is sensible to consider how we would want our final days to elapse if given the choice. While still an intern in New York City, I started carrying a copy of my “Last Wishes” in my wallet. At that time, I wanted to be kept alive—no matter what! I did not want anyone to “pull the plug” under any circumstance. I wanted to stay around as long as possible, regardless of my state of awareness and despite any medical maladies. This outlook has changed with the wisdom of age and the passing of my parents.

Today we are blessed as a society with the ability to prolong healthy, productive lives and provide compassionate pain-free care to those with terminal illnesses. During this season of reflection, you might raise your glass in a tribute to a time of enlightened medical care.

Here’s to “Good Life, Good Death.”

HMA President’s Message

John S. Spangler MD

This great issue of death with dignity involves all of us as we all will need rational help at the time of our death. Physicians need to contemplate and analyze their own feelings about this topic.

We all need family support at the time of death with dying being a normal function of a living animal. Our pets receive comprehensive care in this manner. Someday we’ll hope that we will have a death with dignity for all.

I congratulate the editor for dedicated work on this issue. Please read and discuss these articles with your family and loved ones.

Cover art and descriptive text by Dietrich Varez, Volcano, Hawaii. All rights reserved by the artist.

“Damien”

Father Damien, a Belgian priest, lived with the Leprosy patients at their isolated colony at Kalaupapa on the island of Molokai. His mission was to mend their sores as well as their souls. Inevitably he died of Leprosy and has since been beatified. He is now a candidate for canonization.
Dateline: Boualapha, Laos

Ben Berg MD

Dr Edward Chu, staff cardiologist at Tripler Regional Medical Center was deployed to provide medical care for a team of U.S. personnel during a 26 day mission to Laos in October, 1996. The team was on a regularly scheduled mission to search for and recover the remains of servicemen who remain missing, or were killed in action, during the Vietnam Conflict. This team is part of a standing Hawaii based joint task force which has conducted the ongoing recovery mission for the past 18 years. Dr Chu was accompanied by 4 trained medics, from the Army, Navy, and Air Force. His report of this experience follows.

During the month of October, at the end of the rainy season, the weather was very hot but dry, with a few days of high humidity and heavy rain. Mosquitos, large centipedes and snakes were regular visitors to the Boualapha base camp site, as this is normally a prairie for the town water buffaloes, pigs and chickens.

Medical care was provided in the Khammouan and Savannakhet provinces, Laos Peoples' Democratic Republic from 2-28 October 1996. This included thirteen Medical Assistance Programs for the local civilian population. Workers and/or villagers at field sites, and at Boualapha District Hospital of the Khammouan province were evaluated and treated. Villagers in the towns surrounding Ban Passang of the Savannakhet province and in the town of Ban Nantanchai of the Khammouan province were also evaluated and treated. A total of 465 patients were seen.

Most villages have a “village healer.” Larger villages or towns may have a nurse who is trained at Vientiane. District hospitals have physicians and nurses. Boualapha District Hospital has 4 physicians who are from the district and are trained at a four year medical “school,” and 29 other personnel. Muang Xepon District Hospital has 2 physicians and 20 nurses.

The physicians are trained at the “medical school” at Vientiane, a four year program following high school. They then are sent to district level hospitals for “on-the-job-training” but rarely have a very senior physician. The physician with whom I primarily worked, Dr Sisombat, seemed concerned, interested in learning, and knowledgeable about the local diseases. He had little understanding of pathophysiology or pharmacology. I would estimate that the local Lao physician has an equivalent level of training to US physician assistants.

The Lao patients were generally healthy, with the majority performing manual labor as farmers. Most complaints were associated with work related injuries/exposures or communicable tropical diseases. Commonly encountered conditions included: Ectoparasites: lice or mites; “worms”/intestinal parasites: likely to be either Ascaris Lumbricoides, Tricuris trichiura, Enterobius vermicularis, Strongyloides stercoralis, Taenia solium, or a combination, and malaria or Dengue fever. Medications for these diagnoses were limited and depleted early in the course of the mission. Malaria was frequently seen as a chronic illness with massive hepatosplenomegaly and had a significant impact on pediatric growth retardation.

Villagers were open to western medicine, however had faith in the local traditional healer. The women tended to be shy and refused gynecologic exams when complaining of pelvic pain. Although having an exam by a male “foreigner” is likely to be a significant factor, I suspect that this a medicine taboo. The overwhelming majority of people smoked, from as early as age 3. Many women chewed betel nut. Most men drank the local rice whisky, lao lao.

Preventive dental kits were distributed at all sites to 144 children and adults with significant gingivitis. All women of child bearing age, pregnant or after recent delivery received prenatal vitamins. Preventive health measures are generally absent in the villages.

Water was generally untreated from the local river or stream. Food consisted of rice, water buffalo and chicken meat and local greens. Sanitation in the smaller villages appeared quite good but the larger towns or cities were very dirty. This is probably due to the common belief, in the tropics, that the jungle or the ocean will consume the wastes. This is very true without western products (plastics, heavy paper goods and metal cans), but with increasing population density and western products, sanitation is poor.

Boualapha district hospital

The hospital is open 24 hours a day and always has a physician on duty. The maximum capacity of the hospital is 12 patients, with the monthly census of about 30 patients. The hospital was clean but with limited facilities to include an open air room for minor surgical procedures, a delivery room, a “laboratory” consisting of an ambient light microscope for malaria smears and a pharmacy, primarily stocked by previous U.S. team missions and locally acquired herbal “therapies.” Herbal medications included products from roots and small trees in the local hills. These preparations were used to treat maladies ranging from rheumatism to headache, to “women’s” problems. The instruments for surgery appeared old, rusted and non-sterile but clean.

The hospital receives funding and supplies from the provincial capitol but frequently operate without medications or sterile supplies. Needles, IV tubing and bottles, “disposable” surgical equipment and catheters are reused after “cleaning.”

The top three diagnoses noted by Laotian physicians were malaria, bronchitis, and diarrhea. Trauma was generally minor except after harvest season when a “slash and burn” technique for farming reap a 10-15 cluster bomb explosions, with the majority resulting in death. There is a team from the district hospital that travels to the villages once a year to vaccinate for the following: measles, diphtheria, polio, pertussis, small pox, and for tuberculosis protection. There have been attempts to eradicate worms and provide iodized salt supplements to prevent thyroid goiters.

Clinical Cases

An elderly villager fell from her elevated house and suffered an apparent open mid shaft femur fracture. A U.S. team was sent from their worksite to the village and care was provided by the team medic. Although she was transferred to the site for medical evaluation, she and her family declined further care and she was then transported to the care of the “village healer” and died three days later.

Two burn patients in the village of Ban Napang were treated. The burns were incurred from mosquito netting fire and burned a woman in her 30's, a 6-year-old child and an infant who expired shortly after the injury. Initial evaluation and treatment was denied by the Lao officials, but allowed after a visit to the village by the U.S. team. Escharotomies were performed to 4 to 6% second and third degree burns. The child survived after debridement of the wounds.
**Do you agree**

- With the 75% of Americans who, in a 1996 Gallup poll, said Yes to the question: "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life if the patient and his or her family request it?"

- With the majority of physicians in Washington, Oregon, Michigan and Colorado who endorse the idea that doctors should be able to offer patients help in dying as part of the continuum of terminal care?

**Make your voice heard. Join**

The Hemlock Society USA

- Hemlock is the oldest and largest right to die organization in the US.
- Founded in 1980 there are 90 Hemlock chapters and in 40 states.
- Hemlock provides information, education to physicians, and legislative assistance.
- Hemlock supports laws which will safeguard physicians and patients.

Dues are only $35 a year or $15 for full-time students. You will receive quarterly copies of Time Lines and a free copy of Final Exit.

Call **800-247-7421** to charge membership to your credit card or to receive an information packet.

Members can order books from Hemlock's extensive collection at a discount.

Fax: 303-639-1224  
Web site: http://www.hemlock.org/hemlock  
E-mail: hemlock@privatei.com  
Address: PO Box 101810 Denver CO 80250-1810
An Emergency Physician’s Perspective on Death with Dignity

Frederick C. Holschuh MD

Paramedics respond to the cardiac arrest of an elderly man in his home. As they start CPR, the son produces a valid living will with “no resuscitation” instructions. While they are discussing this with me at the Medicom base station, another son runs in, tears up the living will, punches his brother and demands CPR, which was then restarted.

A young hanging victim with a hopeless brain injury has a cardiac arrest. I spend more time after responding to the ICU, helping the mother come to grips with stopping futile CPR than actually doing “medical care.”

A comatose man with a horrendous brain injury from a gunshot wound goes to ICU on a ventilator after I had a long discussion with the mother about organ donation. He ultimately leaves rehab walking and talking.

A 95-year-old man with terminal metastatic cancer comes to the ER in cardiac arrest. The family demands that “everything be done.” He spends his final days in ICU comatose with multiple tubes, machines, etc.

A chronically ill woman with a valid living will has a respiratory and cardiac arrest at home when her guardian is out shopping. After CPR, she is on the ventilator in the ER when the family arrives with all the documents and begs me to stop treatment and let her die at home. We discontinue everything, they take her home and after dying at home, the body is returned three hours later for pronouncement. Incidentally, I had to ask the police officer to reword his report that said “patient came to ER with trouble breathing and Dr Holschuh sent her home to die.”

An elderly woman with smoking-related terminal chronic obstructive pulmonary disease (COPD) with a valid living will stating “No ventilator care or intubation,” comes by ambulance in pulmonary failure. As she is slipping into unconsciousness, in spite of initial treatment, from CO2 retention, her eyes open and she gasps “Please save me.” Since she verbally countered her advanced directive she was immediately intubated and survived that episode.

A 50-year-old man walked alone into the emergency department up to the nursing desk. He reached out to get attention and collapsed in cardiac arrest. The crash cart was brought to the spot, he was defibrillated immediately and about one week later came by the emergency department to thank the staff for “his life.” We had no idea who he was or whether he had an advance directive that first day.

All of these are real cases that happened to me within the last few years in Hilo. All of them demonstrate how complex end-of-life decision making can become and the importance of good communication in the process. Whatever one believes about God or a Creator, man may have been given wisdom and skill by the Creator, but the Creator didn’t produce the machines or technology. Our scientific advances have far outstripped our ethical understanding, good intentions, and common sense. We have a legal system that at times paralyzes caregivers who attempt to make sound decisions. And, we are now faced with emerging health delivery models that some patients fear may someday stop lifesaving treatments for chronically ill people to save money.

At the June 1996 Annual AMA House of Delegates meeting in Chicago, a nationally publicized debate took place regarding resolutions that asked the AMA to alter its position against physician-assisted suicide to at least a neutral position. Recent U.S. Circuit Court of Appeals decisions on the east coast and the 9th Circuit Court (which includes Hawaii) have essentially removed prohibitions on physician-assisted suicide. I got the feeling that many of the physicians who spoke at the reference committee and on the floor of the AMA House of Delegates against physician-assisted suicide might in private discussion feel differently if they felt they had no voice in terminating their own end of life care.

The U.S. Supreme Court is taking up the circuit court decisions, and the AMA held to its position against physician-assisted suicide but some very interesting discussions occurred at the AMA which lead me to think we must continue to participate in all these discussions and debates, keeping the patent’s best interests as our focus.

The activist group “Not Dead Yet” which represents many disabled individuals, lobbied against physician-assisted suicide at the AMA meeting. They have been very outspoken nationally and have called Dr Jack Kevorkian a “serial killer.” I spoke with some of the protest group members including a very articulate attorney who is afflicted with some neuromuscular disorder and is wheelchair bound. She emphasized the very real concern that many of them have, that a vote to change the AMA position might eventually lead to overzealous attempts by managed care organizations to end the lives of severely challenged people. Many of their members are on home ventilators and fear attempts to discontinue their use. Some points of debate and discussion which I feel need to be continued:

1. Physicians must be sure the discussion on dying is brought up early on with patients and families. Families and patients must be counseled that withholding resuscitative efforts and extreme technological support is not equivalent to lack of caring. Quite the opposite; often not treating a specific terminal condition and addressing the dying process may be the ultimate act of caring.

2. Physicians must be able to relieve pain and suffering, even if it hastens death; without fear of legal challenges.

3. As Dr. Stephen Wallach, Honolulu cardiologist, has often said, we don’t want to damage the existing living will laws, but we can make it work better without legislation by good communication with patients and families. When my parents did their first living wills, my mom wouldn’t have allowed the Heimlich maneuver until I explained specific details of resuscitation. For instance, if a patient has a living will addressing a terminal condition and has an electric shock or near drowning, do you not treat these reversible conditions? It gets back to common sense and good communication.

4. Physicians must be more proactive with advanced directives. I see many chronically ill patients in the emergency department who
Dynamic Duo

Benzamycin® prescribed with
tretinoin¹ for rational acne therapy²,³

* Efficiency of 3 modes of action using only 2 products
* Prescribing Benzamycin® in addition to tretinoin provides:
  - reduced erythema¹
  - faster lesion clearing¹

BENZAMYCIN® Topical Gel
(3% erythromycin, 5% benzoyl peroxide)

Adverse conditions infrequently reported include dryness, erythema and pruritus.

Please see references and prescribing information on adjacent page.
Benzamycin® Topical Gel
(3% erythromycin, 5% benzoyl peroxide)

Reconstitute Before Dispensing

Description: Each gram of Benzamycin (erythromycin—benzoyl peroxide) topical gel contains, as dispensed, 30 mg (3%) active erythromycin and 50 mg (5%) benzoyl peroxide in a gel vehicle of purified water, cornstarch (90%), alcohol (9%), and propylene glycol (0.1%). Erythromycin (C_{22}H_{40}O_{6}) is produced by a strain of Streptomyces erythraea and belongs to the macrolide group of antibiotics. Erythromycin has a molecular weight of 373.34 and is represented by the following structural formula:

\[
\text{C}_{22}\text{H}_{40}\text{O}_{6}
\]

Benzoyl peroxide (C_{13}H_{2}O_{5}) is an antibacterial and keratolytic agent. The structural formula is:

\[
\text{C}_{13}\text{H}_{2}\text{O}_{5}
\]

Clinical Pharmacology: Erythromycin is a bacteriostatic macrolide antibiotic, but may be bacteriocidal in high concentrations. Although the mechanism by which erythromycin acts in reducing inflammatory lesions of acne vulgaris is unknown, it is presumed to be due to its antibiotic action. Antagonism has been demonstrated between cinoxacin, clindamycin, and erythromycin.

Benzoyl peroxide is an antibacterial agent which has been shown to be effective against P. acnes, but is probably more useful as an additive to other acne therapies. The antibacterial action of benzoyl peroxide is believed to be due to the release of active oxygen. Benzoyl peroxide has a keratolytic and desquamic effect which may also contribute to its efficacy.

Benzamycin® Topical Gel has been shown to be absorbed by the skin where it is converted to benzoyl alcohol.

Indications and Usage: Benzamycin® Topical Gel is indicated for the topical control of acne vulgaris.

Contraindications: Benzamycin® Topical Gel is contraindicated in those patients with a history of hypersensitivity to erythromycin, benzoyl peroxide, or any of the other listed ingredients.

Precautions: General: For external use only. Not for ophthalmic use. Avoid contact with eyes and mucous membranes. Concomitant topical and systemic antibiotic therapy should be used with caution because a possible cumulative skin reaction may occur, especially with desquamating or abrasive agents. If severe irritation develops, discontinue use and institute appropriate therapy.

The use of antibiotic agents may be associated with the overgrowth of antibiotic-resistant organisms. If this occurs, administration of this drug should be discontinued and appropriate measures taken.

Information for Patients: Patients—Patients using Benzamycin® Topical Gel should receive the following information and instructions:

1. Benzamycin® Topical Gel is for external use only. Avoid contact with the eyes and mucous membranes.
2. Patient should not use any other topical acne preparation unless otherwise directed by physician.
3. Benzamycin® Topical Gel may bleach hair or colored fabric.
4. If excessive irritation or dryness occurs, patient should discontinue medication and consult physician.
5. Discard product after 3 months and obtain fresh material.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term studies in animals have not been performed to evaluate carcinogenic potential or the effect on fertility.

Pregnancy Category C: Animal reproduction studies have not been conducted with Benzamycin® Topical Gel. It is also not known whether Benzamycin® Topical Gel can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Benzamycin® Topical Gel should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Benzamycin® Topical Gel is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 have not been established.

Adverse Reactions: Adverse reactions which may occur include dryness, erythema, and pruritus. Of a total of 195 patients treated with Benzamycin® Topical Gel during clinical trials, 4 patients, or 2%, experienced adverse reactions, of whom 3 experienced erythema and one an urticarial reaction which resolved within 24 hours after discontinuation of treatment.

Dosage and Administration: Benzamycin® Topical Gel should be applied twice daily, morning and evening, or as directed by physician, to affected areas after the skin is thoroughly washed, massed with warm water and gently patted dry.

Below are the steps for applying the gel:

1. Wash affected area with warm water and mild soap.
2. Dry gently.
3. Apply a thin film of Benzamycin® Topical Gel to the affected area.
4. Do not cover with gauze or other dressing.
5. Do not wash affected areas for 4 hours after application.

Effective: Benzamycin® Topical Gel is effective in controlling acne vulgaris. It is believed to be most effective when used in combination with other acne therapies. Use Benzamycin® Topical Gel as directed and do not discontinue use until a significant improvement in acne has been achieved or for 8 to 12 weeks after improvement has been achieved.

References:

have never had living will discussions brought up by their doctors. I recently had a discussion about advanced directives with the children of a patient with end stage heart disease, who thought the discussion of a living will was the equivalent of contemplating euthanasia. We as a medical association must help with far reaching public education.

We must be able to discuss the benefits of doing so. A recent New England Journal of Medicine article on the results of resuscitation on "ER," "Cancer Hope" and "Rescue 911" showed that the public is given an "unrealistic impression of CPR and its chances for success."

I've actually had people in the Hilo ER assume that arrival by ambulance at the hospital after a cardiac arrest equals survival.

Physicians must support the patient's valid advanced directives. I'm very distressed at seeing family members sometimes successfully coerce a treating physician into not following mom or dad's advanced directive. In my opinion, this should include decisions on organ donation. There must be sanctity in these decisions. We would want nothing less for ourselves.

(7) Because so many people are addressing physician-assisted suicide and voluntary euthanasia, I think organized medicine and health care policy organizations should at least be involved in these discussions.

Finally, a George Washington University gerontologist says she can get intensive care for her patients easier than she can get them eyeglasses.

The late Dr David Eckstein, former chair of the medical society of New Jersey Committee on Biomedical Ethics stated "Do the best for the patient—not necessarily the most."

Dr William Knaus quoted in a People Magazine article "Last Passage" said: "Death is universal; its never too early to start talking about it. We need to recognize that dying is one of the more important things we will do in life. It will be the last memory we leave to those who love us. If we want to do it better, than we're going to have to talk about it."
Death with Dignity: The Case of Physician-Assisted Suicide

Norman Goldstein MD, FACP*

As a higher percentage of our population turns gray, we are forced to think about the final days of our loved ones. With increasing morbidity from AIDS and HIV among other serious terminal illnesses, we can no longer depend on the miracles of medicine to keep us alive. There are those who die peacefully, but more who suffer pathetically — needlessly — and we all know of those who have been kept alive with pipes and pumps.

You might ask “why is a dermatologist concerned with physician-assisted suicide?” My patients, just like our State’s population, are living longer — and they die of cancer, of HIV infection, and of the many other infections that can be fatal. Every week I see patients asking for information about death with dignity. I have to tell them that in Hawaii and all other states, it is illegal to render aid, and a physician can lose his or her medical license or go to prison for doing so.” Refer these patients to the Hemlock Society of Hawaii. My wife and I are Life Members in Hemlock Society. Hemlock has many excellent publications and resource materials on passive and active Death with Dignity. Many of these books are now available at the Hawaii Medical Library.

At a recent meeting of The Hemlock and Mortuary Societies of Hawaii, A.A. “Bud” Smyser, contributing editor of the Honolulu Star-Bulletin and Hawaii’s leading advocate for physician-assisted suicide, spoke to a full house on “Dying is Looking Better.” Bud’s very popular “Hawaii’s World” column dealing with death with dignity appearing in the Honolulu Star-Bulletin and has been reprinted in our Journal over the past six months.

All dying can be assisted by pain control, which is readily available today. Why then do some physicians withhold strong pain medication for fear of getting their patients addicted? When death is near and suffering persists, it is the doctor’s role to alleviate that suffering. Our State House of Representatives may be seeking legislation to encourage physicians to administer higher doses of pain medications when needed.

When my 88-year-old father came to live with us in Hawaii, he had both prostate and lung cancer, which had spread to his bones. His mind was astute, but his body was failing. He wanted “neither pipes nor pumps, heroics nor hospital.” He lived in our home for the last year and a half of his life. Thanks to his geriatrician, Gary Johnson, MD, weekly visits by compassionate nurses, and a long-lasting pain pill, he was alert, without any pain, even on his dying day.

As a California hospice director told Bud Smyser, a good death should also focus on the survivors, because “the memories are with us for a long time.” We want them to be happy ones.

The Hospice Movement

The first modern hospice was opened in London in 1967. The hospice concept started on the mainland in New Haven, Connecticut and Marin County, California in 1977. The next year, the late Sister Maureen Keleher established Hawaii’s first hospice. We now have eight. The Hospice Program focuses on providing positive deaths and family support instead of using life-extending measures.

While hospices serve a portion of Hawaii’s dying population, there are not enough programs. Many patients need more active assistance. In the 1950’s, a majority of Americans died at home. In 1983, 80% of America’s two million deaths occurred in institutions, which are extremely expensive. (Editor’s Note: see the manuscript by Warren, “St. Francis Hospice: Medicare and Health Care Reform” on page 276)

Max Botticelli, MD, emeritus Professor and former Chief of Medicine at the UH medical school, wrote in “The High Cost of Dying” (Honolulu Advertiser - June 11, 1995) “Since the 1960’s, about 30% of annual Medicare expenditures have been for care provided to patients who die in the same year; 12% for care given in the last month of life!” Dr Botticelli suggests some steps to a “Happy Death.”

- Stop striving to attain immortality on earth. Eventual death of our bodies makes good religious and biologic sense.
- Make physicians more aware of their responsibilities to dying patients. The prescription of futile care is unethical and unprofessional.
- Establish a commission to set priorities for health care services.

Botticelli feels the soaring costs of health care cannot be solely at the feet of physicians who exercise poor judgment. The community at large is also at fault. This includes some in the legal profession, some religious leaders, the general public and the family and friends of the terminally ill patient. His manuscript on “Choosing to Die” which appears on page 257 is a poignant piece of prose — and reality.

We are making progress in relieving suffering for the terminally ill here in Hawaii. When Dr Reginald Ho was president of the
American Cancer Society, they adopted a national policy recommending no limitation on pain medicine administration. Drs. Botticelli and Ho are part of an ad hoc committee, chaired by the ever-energetic Ah Quon McElrath, dealing with Death with Dignity. McElrath contributed a manuscript on "The Elderly and Disabled in Hawaii." (see page 258)

**Hippocrates Didn’t Know Everything!**

Hippocrates lived in Greece from 460 to 370 BC. One of the world’s most famous physician-teachers, he had phenomenal influence on medicine more than two thousand years ago, and still does, but much of what he taught has now been proven wrong. Over the centuries, many legends were attributed to him; for example, honey from a bee hive on top of his tomb was supposed to have had “exceptional curative powers.”

He thought that nerves were hollow and confused them with ligaments. He did not understand the difference between arteries and veins, or that the retina was the organ of sight. He thought “semen” from the left ovary produced girls.

Despite these and other medical errors, the Hippocratic Oath continues to be administered to medical school graduates at most schools in the country, including our own. Many have modified the oath so that Hippocrates probably would still recognize it, but might disagree with it.

The original oath says, in part:

“I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly, I will not give to a woman an abortive remedy. I will not use the knife, even on suffering from (kidney) stone.”

The modified version, administered for many years by the late Charles Judd, MD, to Hawaii’s medical school graduates, includes:

“I will not endanger a patient’s life by prescribing unnecessary dangerous drugs, nor will I give advice which will cause harm. I will endeavor to be my patient’s advocate before society, and to aid my patients and their family in weighing and making the serious decisions that surround illness and death. Although life is sacred, death is inevitable, I recognize that it is the duty to treat the whole patient. The continued life of the patient’s body is one consideration, but I will also consider the impact of treatment on quality of life and psychological well-being in making therapeutic decisions.”

Choice in Dying, Inc., a national not-for-profit organization dedicated to fostering communication about complex end-of-life decisions among individuals, their loved ones and health care professionals, is now working with ten medical schools across the country to improve medical education in the care of dying, beginning this semester. At the end of this five-year project, the results will be compiled into a technical manual that will help other medical schools integrate similar death and dying teaching into their programs.

Our medical school is not part of this study but, according to Leslie Q. Tam, PhD, Director of Medical Education, we do have an active program at the John A. Burns School of Medicine.

In the first year, students spend one half-day a week in a community medicine hospice experience. They go through a 20-hour orientation program at St. Francis or Queens hospital and are then assigned their own patient whom they visit once a week for the 15 weeks. Often, students develop strong relationships with terminally-ill patients and continue the hospice experience until the patient dies. It is a rich and touching role for some students, coming early in their education.

Over the first two years, students meet in tutorials and study a total of seventy health care problems. Among these problems are patients and families who must deal with death and dying. Examples are a 50-year-old nurse with breast cancer, an adult male with transitional cell carcinoma, and a lone-immigrant to Hawaii with colon cancer. In tutorials, students are encouraged to discuss not only the biological and clinical aspects of the problem, but also the populational and behavioral aspects of the case, including death and dying. Many of these discussions are profound. Some are superficial, depending on the make-up of the tutorial, the maturity and readiness of the student to discuss such issues and the ability of the tutor to facilitate discussion.

Finally, the school has offered colloquia by Max Botticelli, S.Y. Tan, Mits Aoki and Ken Kipnis on subjects such as “Death and Dying,” palliative care and ethical issues.

While there are no formal courses on “Care of the Dying” or “Choice in Dying,” students are exposed to these problems by the methods described above. Whether or not these experiences are effective is as yet unknown.

Richard MacDonald, MD, Medical Director of the Hemlock Society U.S.A., noted the conclusions drawn by Dr. S.Y. Tan in the April 1995 special issue of the Hawaii Medical Journal on Medicine, Law and Bioethics, saying “Lawyers and the courts are overly intrusive in patient-care matters. Like Damocles’ sword, the law hangs over the heads of health care providers, frequently impeding rather than fostering their efforts to look after the best interest of their patients.” Dr. MacDonald has also submitted a manuscript for this issue on the training of medical students on page 294.

The manuscripts in this Special Issue were submitted by—people concerned with the lives and deaths of their patients, their family members, their friends and themselves.

As Bud Smyser said in his August 13, 1996 “Hawaii’s World” column—“Hawaii needs a policy on assisted suicide.” (November 1996 Hawaii Medical Journal, page 230). It is hoped that this Special Issue of the Journal will help to stimulate our medical community as well as the lawyers and legislators in Hawaii, to decide on a sensible policy dealing with Death with Dignity.

**Editor’s Note:**

This manuscript is based on a major story in the Honolulu Advertiser December 17, 1995: "Should Doctors Help End Lives?" I took the "yes" position—allow patients to Die with Dignity. S.Y. Tan, MD took the opposing view, "No; would hurt infirm; open to abuse." Dr. Tan was Guest Editor for our Special Issue on Medicine, Law and Bioethics in April 1995, and has another provocative manuscript, "Why I Do Not Believe in Euthanasia" in this issue (page 275).

**References**

1. Tam, Leslie Q. "How Students are Trained in the Care of the Dying at the John A. Burns School of Medicine (Letter to the Editor, September 18, 1996)
2. *Choice in Dying, 200 Varick Street, New York, NY 10014*
Choosing to Die

Max G. Botticelli MD

Margaret was 90 years old when she suddenly became irretrievably demented and bedridden. A devout Episcopalian and accomplished poet, she had valued her active and enjoyable life but was unafraid of death. She once wrote:

"It may be spring when death comes by,
Or summer’s heat or autumn’s flare
Or winter’s frost, I do not care.
I’ve breathed too long this earthly air
I’ve lived with faith; with faith I’ll die."

Hoping to avoid a prolonged death, she had completed a living will with instructions that she not be kept alive with feeding tubes or other extraordinary means. But despite strict compliance with her instructions, she continued to languish another eighteen months. She was fortunate, this lifeless existence could have lasted much longer.

Her friend Greta chose differently. As a sprightly and active 89 year old despite persistent painful symptoms, she came to the realization that her exemplary life was at its spiritual end and committed suicide. This decision was discussed thoroughly with her family who asked that they be allowed to take part in her death. They dined together the night before, sharing lighthearted and loving reminiscences. The following day she took a lethal dose of barbiturates prescribed by a compassionate and caring physician and died in her own home in the company of her family.

Suicide was not an option for Margaret partly because her life was physically enjoyable and spiritually fulfilling. She had no desire to end it before her illness and once she became incapacitated she was unable to do so. Supposing, however, she had included advanced directives in her living will instructing her family and physician to help her die in the event of her incapacity. Could they have legally provided such help?

There was a short period of time when helping someone commit suicide was legal in Hawaii. The legislature of the State of Washington had enacted a law making physician assisted suicide a crime. It was challenged in the United States Ninth Circuit Court of Appeals which declared any such statute unconstitutional. This had the effect of making such acts legal in the states of the ninth district. Subsequently, Supreme Court Justice O’Connor issued a stay of that decision making it illegal again.

Even during that window of opportunity, however, the help that Margaret would have needed to die could not have been provided legally. In its decision the court made a distinction between degrees of assistance. Providing a lethal agent to a patient who uses it to commit suicide, as did Greta, was called “physician assisted suicide”. Administering the lethal agent to a patient who has left instructions to do so, as would have been necessary in Margaret’s instance, was defined as “physician aided dying”. Euthanasia was distinguished from both as being “an involuntary act” occurring without instructions from a terminally ill competent adult. The court excluded both physician aided dying and euthanasia from its decision.

It was a moot point anyway because Margaret considered suicide a violation of the deeply held religious faith by which she lived and died. She was free to make this choice which was consistent with the teachings of most religions which accept the inevitability of death while characterizing suicide as immoral and physician assisted suicide as murder.

But, life expectancy has been extended far beyond what jurists, philosophers and church fathers could have imagined. The laws and religious taboos created by them for more natural times are considered by some as unreasonably limiting for the elderly in this technological age.

Because most Americans are religious and because the fear of death is so ingrained in our culture, suicide will never become a popular way to die. Yet polls suggest that a large segment of our population supports giving competent adults assistance when they are ready to end their lives. They are apparently unconvinced that there is a compelling interest on the part of the government to thwart the desired deaths of those of us who are in the twilight of our lives. Nor are they concerned that this represents a slippery slope leading towards involuntary euthanasia.

Unfortunately, it requires more than a poll to give us this freedom. We need a change in public policy so that the elderly are assumed:

• Protection against overly aggressive medical care.
• Assisted suicide for the terminally ill.
• Assisted dying for those who leave advanced directives defining when they would prefer to die.
• Protection against involuntary euthanasia.

Margaret and Greta had significantly different religious views which made suicide an option for one and not for the other. However, neither of these gentle and understanding humans, would have presumed to judge the other’s actions. That degree of tolerance is what is needed now. Those who value life more than dignity and are free to choose how they might die should help their fellow humans who value dignity more than life gain the same freedom.

Editor’s Note:
Max Botticelli has been a professional colleague and personal friend for almost three decades. Now that he is retired, he devotes a great deal of his time speaking and writing on Death with Dignity related subjects, and is a very active member of AhQuon McElrath’s ad hoc committee. His feature in the Focus section of the Honolulu Advertiser on the “High Cost of Dying: Too Much is Spent Delaying the Inevitable” in Section B, Sunday, June 4, 1995 is in today’s jargon “Right On.” Many thanks, my friend.
The Elderly and Disabled in Hawaii

Ah Quon McElrath

Any discussion on death and dying must take place within the context of Hawaii’s multi-ethnic and multi-cultural environment as well as other factors such as pertinent laws, the nature of the population, economic well-being and its effects on housing, health care, leisure activities, availability of services, and the cost of taking care of the aged and disabled.

The following information provides the background against which articles in this very special issue on Death with Dignity can be given added meaning and urgency.

Population

Approximately 1.2 million of which 56% are born in Hawaii, 26% on the mainland, and 18% are foreign born.

Ethnicity

24.1% Caucasian; 20.4% Japanese; 18.8% Hawaiian and part Hawaiian; 11.4% Filipino; 11.1% Korean, 1.5% Black; 0.6% Puerto Rican/Samoan; 17.5% mixed non-Hawaiian.

Age

12% 65 years and older, of which 52.5% are female; projected to increase to 17% by year 2020, when baby boomers begin reaching 65 by year 2011 and when the elderly will be fasted growing segment of population.

Immigration to Hawaii accentuates the Asian-Pacific influence that pervades the state’s culture. Since the Immigration & Nationality Act of 1965 with its amendments is based primarily on the philosophy of family reunification, it is likely that Hawaii will continue to be the destination of future immigrants. Annually 6,500 to 8,500 new immigrants come to Hawaii.

• 7,746 immigrants in 1994 (latest available figure) from 11 countries, of which 3,258 were from the Philippines and 714 from the Peoples Republic of China.

Life Expectancy

• 75 years for males; 81 years for females; second only to Japan.

Income

Hawaii’s aged and disabled individuals have income derived from government or private pensions; personal assets; Old Age; Survivors, & Disability Insurance (“OASDI,” but more popularly known as Social Security); Supplemental Security Income (SSI—the need based money payment program for the aged, blind, and disabled); family contributions; and employment.

• 23% have no income or income under $5,000
• 58% have income between $5,000 and $29,999
• 19% have income between $30,000 and over $50,000
• $19,534 median income of older men not living alone
• $16,228 median income for men living alone
• $8,040 median income for older women not living alone

• 11,804 median income for women living alone
• 14% of older persons live below, at or 125% of the federal poverty level, which in 1996 was $8,910 for a single person and $11,920 for a couple.

At the end of December, 1994, over 10% of Hawaii’s population received OASDI, or social security. Average monthly benefit was $627.20 and covered retired and disabled workers with widowed spouses, parents, and children.

• 161,840 total number of beneficiaries
• 113,240 retired workers, with monthly benefits from less $300 to $1,100 or more
• 9,380 disabled workers, with monthly benefit from less than $300 to $1100 or more
• 14,300 non-disabled widowed spouses with monthly benefit from less than $300 to $1,100 or more
• 12,250 children, with 9,870 under age 18 and 160 students between 18-19

At the end of December, 1995, there were 18,731 individuals receiving supplemental security income. Eligibility is based on need and as of 1996, an individual could receive a maximum monthly payment of $470, while a couple could receive $705, with a small state supplementation.

• 7,552 aged with average monthly amount of $318.58
• 159 blind with average monthly amount of $430.31
• 11,020 disabled with average monthly amount of $419.44

Food Stamps

A need-based program with less stringent eligibility requirements than those for Aid to Families with Dependent Children. The number of recipients is affected by economic conditions. In Hawaii the rolls have increased because of Hurricane Iniki, closure of sugar and pineapple plantations, and downsizing of other industries. Value of stamps range from $197 for an individual to $1,193 for a family of eight.

• 131,049 beneficiaries in 58,886 households as of June, 1996.

Employment

Labor force of 592,700 as of June, 1996, of which 556,000 were employed. Unemployment rate of 6.2%. Twenty percent of employed in county, state, and federal governments.

The projection is that by 2020, there will be only two to three people of working age for every one person 65 years and over; in 1950 there were 13-1/2 persons of working age for that age group.

• 78.4% of Hawaii’s elderly do not work
• 21.6% work less than half time to more than full time.
Housing
Although home ownership in Hawaii is not as high as that on the mainland, the percentage of renters among the elderly indicates they either own their own homes or live with relatives. Of the 20.6% of the elderly who rent, a large number have accommodations in government sponsored elderly housing.

Adult Residential Care Homes (ARCHs) provide accommodations for the elderly and disabled who are ambulatory. Payment is through private sources or through allocation of social security/SSI benefits with state subsidy according to level of care needed by individuals.

- 525 state-wide ARCHs - up to five placements
- 12 state-wide ARCHs - up to eight placements

Long Term Care
Community based services include home delivered meals, personal and chore services, home health care, day centers, hospice care-funded privately or by government.

Institutional care includes skilled nursing (where there is no requirement for 24-hour nursing services), intermediate care (where there is no requirement for 24-hour nursing services) and hospice (for the terminally ill).

Medicare Part A (hospital insurance/HI) pays for hospice care and skilled nursing (usually on a post-operative and post-hospitalization basis) for specified number of days.

Medicaid pays for these same services on a need basis. In addition, Medicaid pays for intermediate care which does not require the same services as those in a skilled nursing facility.

Hawaii has one of the lowest ratios of skilled nursing beds to the general population.

- 41 facilities providing long term care beds are as follows: skilled nursing; intermediate care; skilled nursing/intermediate care; acute/skilled nursing ("swing beds")
- 3,533 total number of beds
- 1,151 total number of bed being developed
- 35% of beds proprietary
- 39% of beds non-proprietary
- 26% of beds government operated
- 45% of beds are hospital based
- 98% overall occupancy rate

In addition to these long term care beds for the elderly and disabled, there are 254 specialty care beds (psychiatric, tuberculosis, mentally retarded, and others).

Health Care Costs
Health care costs are born privately (business, unions, individuals) and publicly (federal, state, county governments). Private payments come in the form of individually purchased plans; individual responsibility for co-payments and deductibles, premium payments, or non-coverage; taxes on government programs, such as Medicare Part A.

Public payments come from federal government general funds as in the case of Medicare Part B (Medical Insurance/MI); veterans and armed forces health care; public health programs; Native Americans/Hawaiians; etc.

Medicaid is a state/federal government matching entitlement program for the poor. Federal reimbursement is determined by a formula that compares a state’s per capita income level with the national average—the Federal Medical Assistance Percentage (FMAP). The FMAP cannot be lower than 50% nor greater than 83%. Under this formula, states with high per capita income receive lower reimbursement than states which have low per capita income.

Hawaii, with high per capita income, received only 50% reimbursement for fiscal years '94, '95, '96, while Mississippi, with low per capita income, received for the same years reimbursements of 78.85%, 78.58%, and 78.07%, respectively.

- Medicare Part A: 37 million beneficiaries nationwide (4 million disabled)
- Medicare Part B: several thousand fewer than Part A since this is a voluntary program.
- Medicare Parts A & B: 133,000 beneficiaries in Hawaii
- Medicaid: 33 million recipients nationwide
- Medicaid: 156,000 recipients in Hawaii

The Board of Trustees of the Medicare Trust Funds report that in 1995, taxes for Part A were insufficient to cover costs and that if nothing is done, the trust fund balance of $130 billion will be depleted by 2001. It calculates that the present payroll tax of 2.9% would have to be increased to 7.42% immediately to avoid a large deficit anticipated in 2070.

- About half of Medicare costs are incurred during the last 60 days of life and about 40% in the last 30 days, with hospital costs accounting for more than 70% of the expenditures for descendants.
- $271,777,919 spent by Hawaii in FY 95 for nursing home and medical services for the aged, blind and disabled.
- $123,663,876 or 46%, were for nursing home care for 6,821 individuals

General References
5. Andrew Mason, Director, Program on Population, East-West Center, The Demographic Revolution and Hawaii, undated

Editor's Note:
Ah Quon McElrath, a retired social worker with ILWU Local 142 which has pioneered in health care for Hawaii’s workers and families through collective bargaining and political action, is a member of the Board of Regents of the University of Hawaii. She has also been one of the founders of the Committee on Welfare Concerns, a 10-year old coalition of individuals and representatives of non-profit organization which works with and on behalf of individuals and families who receive public assistance.

Her energy is boundless! She organized an Ad Hoc committee on dealing with Death with Dignity a year ago and is the driving force of this very important group of people. Mahalo Ah Quon.
Cultural Issues in Death and Dying
Kathryn L. Braun DrPH*, Rhea Nichols MSW

Although all of us experience death, not all of us think about death or respond to death the same way. This study begins to explore how cultural traditions, education, and tenure in Hawaii impact views of advanced directives, organ donation, suicide, and euthanasia. This information is useful to physicians who need to engage patients and families in discussions about death and end-of-life decision making.

Introduction
All people have, and will, experience death. But not all people view death or respond to death in the same way. As we increase our life expectancy and our ability to prolong life artificially, issues surrounding death and dying become more controversial. How do different cultures look at death? What factors, besides culture, impact one’s perceptions of issues like advanced directives, organ donation, suicide, euthanasia? These questions were asked in a qualitative study of death and dying in Honolulu among five Asian and Pacific Islander (API) groups—Chinese, Filipinos, Japanese, Native Hawaiians, and Vietnamese.

Expanding knowledge of cultural issues in death and dying is important for two major reasons. First, as health care professionals, we need to understand and respect cultural differences if we hope to provide care that is relevant and acceptable to our clients. Second, as educators, we need to encourage individuals to share their differences with each other as our society develops policies and social structures related to end-of-life decision making. This is especially crucial given the recent decisions by the 2nd and 9th Circuit Courts supporting the right to physician-assisted suicide. Although the Supreme Court has issued a stay on these decisions, many feel it is only a matter of time before assisted dying is legalized in the United States.

Literature Review
Literature and educational materials on cultural-specific responses to death and dying among API Americans are scarce. Even where literature exists, it most often focuses on Japanese Americans and show generational differences in response to death, with issei (first generation) respondents more likely to practice customs and traditions of Japan compared to sansei (third generation) and yonsei (fourth generation). Students of traditional Chinese culture have reported that Chinese are often hesitant to talk about death, as this is considered bad luck. Other reports describe the importance of funeral rituals in Chinese culture, from determining the right day of burial, to burning paper money to send with the deceased on his/her journey. If a person is buried without strict adherence to proper funeral rites, a hungry ghost may return to plague the living. The carrying-out of traditional death rituals is considered the most important act of filial piety among Vietnamese, from the rite of feeding the deceased to the rite of reburial, where bones of the deceased are collected, washed and preserved in a sacred jar for reburial. Ancestor worship is also important, and many Vietnamese Americans tend ancestral altars at home. Very little literature appears about Filipino Americans. Several cross-cultural studies of suicide, however, suggest that suicide rates among Chinese, Japanese, Filipino, and Vietnamese Americans are lower than suicide rates of Caucasian Americans and lower than those of their compatriots at home.

In summary, while some information is available about traditional death rituals, literature on how these traditions are practiced in the U.S. and on views of suicide, euthanasia, advanced directives, and organ donation is limited. This study begins to fill the gap by presenting information from interviews on death and dying practices with five Asian American and Pacific Islander groups in Hawaii—Chinese, Filipinos, Japanese, Native Hawaiians, and Vietnamese.

Method
Data were gathered from July 1995 to February 1996 through in-depth interviews with individuals of Chinese, Filipino, Japanese, Native Hawaiian, and Vietnamese descent. From each of the ethnic groups studied, two key informants (a religious leader and a bilingual health/social service professional) and five to eight focus group participants were interviewed. Key informants were selected because of their level of knowledge about their community’s practices in this area; they were generally older adults who were well educated, bilingual, and respected by their communities as experts. Focus group members were identified by key informants and were affiliated with the religious and/or social service groups represented by the key informants. Because focus group members in the Chinese, Filipino, and Vietnamese groups were first-generation immigrants to the U.S., many were interviewed with the assistance of bilingual students.

The study’s interview questions explored six broad areas including: 1) the underlying philosophy/religion influencing death and dying in the culture; 2) burial, memorial services, and bereavement; 3) suicide and euthanasia; 4) advanced directives and organ donation; 5) how beliefs/practices have changed over time; and 6) advice for health care professionals working with dying patients from the culture. Transcripts of the interviews were analyzed for common
and differentiating themes. An initial draft of the summary of findings for each group was sent to one or more of the key informants, who were asked to provide corrections and/or to validate that the information contained therein was accurate to the best of their knowledge.

The study identified a number of differences among and within the ethnic groups, a full description of which is provided elsewhere. The current paper presents information from the study that is relevant to the more controversial aspects of death and dying—advanced directives (e.g., will, living wills, and documents giving power of attorney for health care decisions), organ donation, suicide, and euthanasia (e.g., withholding treatment, withdrawing treatment, and aiding death).

Findings
Historical Background of the Five Ethnic Groups

The Native Hawaiian people (or kanaka maoli) are indigenous to the islands of Hawaii, establishing their arrival as early as 100 A.D. They are of Polynesian extraction, sharing a common ancestry with the indigenous people across the South Pacific. Following contact with the West, the native population was reduced drastically as Native Hawaiians contracted and died from newly imported infectious diseases. This loss of cheap labor led to the “importation” of labor from Asia and this, in turn, helped contribute to the erosion of Native Hawaiian traditions and customs. Since the 1960s, the state has seen an increased appreciation of Hawaiian heritage and a resurgence of the traditional language and cultural traditions. In 1990, Native Hawaiians comprised about 19 percent of the state’s population.

The Chinese were the first of the Asian groups to immigrate to Hawaii in significant numbers, arriving in the mid-to-late-1800s to work on sugar plantations. Fears about the loss of jobs for Caucasians stimulated a series of laws that substantially reduced Chinese immigration, including the Chinese Exclusion Act of 1882 and the Oriental Exclusion Act of 1924. Immigration restrictions began to relax in the 1940s, in part to recognize China’s position as a U.S. ally in World War II. Since the Immigration Act of 1965, which allowed 20,000 immigrants per year per country, Chinese immigration from Taiwan, mainland China, and Hong Kong has greatly increased. In 1990, about 6 percent of Hawaii’s population was Chinese.

The first major wave of Japanese immigration started after the Chinese Exclusion Act of 1882 when Hawaii sugar plantations looked to Japan for a new source of cheap labor. Almost 150,000 Japanese came to Hawaii between 1882 and 1908, when the Gentlemen’s Agreement restricted immigration from Japan to wives of Japanese men already in the U.S. All Japanese immigration was effectively halted in 1924 with the Oriental Exclusion Act. It restarted in the 1950s with the immigration of Japanese wives of U.S. servicemen. Although the Immigration Act of 1965 allowed 20,000 per country to immigrate to the U.S., fewer than 5,000 Japanese nationals have chosen to immigrate each year. Today, two-thirds of all Japanese Americans are U.S. born, compared to about 37% of all API Americans, and about half marry non-Japanese. In 1990, about 23 percent of the state’s population was Japanese.

Filipino immigration began following U.S. victory over Spain in 1892, at which time the Philippines was ceded to the U.S. As a U.S. territory, Filipinos were considered U.S. nationals and, therefore, immigration was unrestricted. Almost 120,000 Filipinos came to work on Hawaii sugar plantations between 1906 and 1934. Immigration was severely curtailed in 1935, when the Philippines was granted commonwealth status. But with the Immigration Act of 1965, Filipino immigration accelerated and, in 1990, Filipinos comprised about 15% of the state’s population.

The Vietnamese are among our most recent immigrant groups, first arriving in the U.S. after the fall of Saigon to the Vietnamese Communists in 1975. A second group, called “boat people,” are those who fled Communist rule on foot or boat, often spending time in refugee camps before relocation. Established in the early 1980s, Vietnam’s Orderly Departure Program allowed controlled immigration directly from Vietnam for political prisoners, Amer-Asians, and those whose family members were already U.S. citizens. The 1990 Census estimated the Vietnamese population in the U.S. at 614,547, a 134% increase over 1980. Vietnamese comprise less than 1% of the Hawaii’s population.

Traditional Beliefs about Death

Native Hawaiian beliefs about death and dying are influenced by both Native Hawaiian traditions and Christianity. A focus group member explained that death is accepted as a part of life by most Native Hawaiians, who see an “openingness” between this life and the next. For example, a participant explained that when we complete our tasks on earth, it is time to die and “move on to the next realm.” Others believed that, upon death, people are reunited with loved ones who have died before. We heard several stories about communication between realms, e.g., either dreaming about or seeing signs about the deceased. We also heard that touching a dead body may make you sick, as the dead body is “empty and can take the living person’s mana.”

Chinese participants reported that their traditions are influenced by three religions—Confucianism, Taoism, and Buddhism. In Confucianism, it is believed that the body should be preserved in order to respect one’s parents, and that ancestor worship is very important. In Taoism, longevity is emphasized and stimulates discussions about the right foods to eat in order to maintain health and obtain long life. The Buddhist religion teaches that one must be good in the present life in order to be reincarnated on a higher level in the next life. A premature death is considered bad luck, as this is thought to mean that someone has done something bad and is being punished. To prevent this, one should avoid offending anyone, treat parents with respect (filial piety), and take care of the older generation in this life.

Vietnamese Buddhist beliefs are similar to traditional Chinese beliefs, as China dominated Vietnam for many centuries. The concept of karma is important. While death is the final destruction of the body, the soul remains and is reborn; but how a person is reborn depends on his/her actions. If a person dies a terrible death (through accident or illness), it is because he/she is being punished for bad behavior in this life or a past life. A child may die because he/she is paying for a misdeed in a past life or for a misdeed of someone else in the family. If a child commits a crime, a parent may have to pay for it in his next life. Many children are very good so that their parents will have a good next life. The goal is to be reborn as a person without karmic debts and then to continue achieving a higher level of rebirth. You can tell when someone has been reborn at a higher level because they are “good-looking and live a comfortable life.” While Buddhism is the dominant religion, a number of Vietnamese in the U.S. are Catholic, a remnant of an 80-year occupation by the French.

Japanese Buddhist participants said that death is a part of the natural process of life and is not a finality. In fact, the present world is painful and unsatisfactory because of the worldly attachments people have to it. The next world is a better place because people are relieved of those attachments and there is peace. It is felt that when
a person who has faithfully listened to the teachings of the Buddha dies, his/her soul can be reborn into this better place, sometimes called the Pure Land. There is a belief in Buddhism that the last thoughts of a person before his or her death determines the rebirth. If one is confused or angry at the time of death, one’s soul would likely be reborn in a different (worse) state than if this person had died peacefully. Despite the belief that karma affects life events, study participants said that personal karma is not openly discussed and that it is not appropriate to say, “you must accept it because it is your karma.” Along with personal karma, there is also a collective karma over which there is no control (hurricanes, typhoons, war, etc.). We also heard that many Japanese in Hawaii left Buddhism following Japan’s bombing of Pearl Harbor in World War II, as Japanese Buddhist ministers (and others in leadership positions) were sent to internment camps. Some Japanese Americans became Christians at this time and others stopped participating in organized religion altogether.

Our Filipino informants said that the Catholic religion had an important influence on death and dying in Filipino culture. This is not surprising given that the vast majority of Filipinos are Catholic as a result of 330 years of Spanish rule. In Catholicism, there is no need to fear death “because the Lord has created us and will be the one to take our lives back. If a person is worthy, and has followed the doctrines of the Lord, he/she will go to heaven after death. Sinners will go to hell or purgatory.”

**Advance Directives**

**Native Hawaiian participants** agreed that few Native Hawaiians talk about wills or living wills. A reason was that the property automatically goes to the spouse and then to the children, so there was not need for a will. We heard that some members of the older generation may believe that talking about death will bring on death. Participants in research, however, said that they knew many Native Hawaiians who do make their wishes concerning death known to their loved ones. For example, a participant had already told her family about the kind of funeral she wants when she dies, including the foods to be served.

Chinese participants noted that Chinese people have traditionally thought it was bad luck to talk about death. Recent immigrants noted that living wills are not promoted in Hong Kong or in mainland China. The younger generation of Chinese in Asia and the U.S., along with the long-time U.S. residents, are more Westernized and more open to advanced planning. In addition, we heard that Chinese become very interested in living wills once they have witnessed our ability to prolong life. For example, a participant stated that, as a result of her grandfather lingering in a coma for 4 years, both of her parents decided to get living wills. Although participants were generally in favor of living wills, and believed that the best time to complete them was when a person was young and healthy, few had them.

Among Japanese Buddhist participants, there was a general consensus that planning for death was a good idea. For Buddhists, we heard, “if you don’t think about death, you cannot live.” On the practice side, participants thought that most Japanese Americans saw the usefulness of advanced directives and many had already executed such documents, although the Buddhist temple does not yet have a specific stand on advanced directives.

Among the Filipino participants, the most educated (including a Catholic nun) had thought about and/or executed living wills and funeral plans. Others, who were linked with social service agencies, remembered a lecture by an attorney who helped many of them complete living wills. However, the newer immigrants and those with the least education were quiet on the subject, finally saying that “Filipinos don’t like to talk about death or funerals; at the most, they may have picked a cemetery plot.” The youngest focus group member said that she had discussed life support with her father, who told her he would not want to be sustained by machines. However, she has been unable to get him to put these wishes in the form of a living will.

Very few of the Vietnamese participants were familiar with living wills or with giving power of attorney. In response to this question, we heard that “in planning for death, people pray a lot” and that people should put aside money to cover funeral expenses. Another participant thought it was a good idea to prepare a will dispensing property.

**Organ Donation**

Native Hawaiian participants had varying feelings about organ donation. One was in favor of it and had designated so on her driver’s license. Another said she would not donate her organs, nor would any of her family, because she believed that God made her body and she should leave this world with her body as it is. The others said they were unsure about donating organs, although they recognized the merit in it.

Chinese participants said that resistance to organ donation stems from the desire to die intact and from the Confucian belief that one’s organs are gifts from one’s parents and that it would be disrespectful to destroy them or give them away. There was also some concern that people who receive donated organs may be reborn with the donor’s face. Of the participants, one reported carrying a donor card and two others were supportive of organ donation but had not taken any action to indicate so. Another said that it “gives me a creepy feeling to think that someone would cut me up” so he was against it. One doubted whether doctors who needed kidneys for another patient would treat the donor’s disease or injury aggressively. The remaining Chinese participants were unsure.

Few Vietnamese informants were in favor of organ donation as they did not want to be born into the next life missing an organ. One said it was unsanitary and another thought that it was scary. According to the Buddhist reverend we interviewed, Buddhism makes no direct reference to organ donation so it is not known if organ donation is an acceptable practice. Theoretically, it would be a good idea since in death, the body means nothing (only the soul is reborn) and organ donation may help another. Although the reverend thought that donating organs to help others was a “wonderful idea,” he thought that few in his congregation would consider it.

Among the Japanese Buddhists, resistance to organ donation stems from the resistance to deface one’s body, which is a sacred gift from the ancestors. It was also believed that you “have to go whole.” Again it was noted that Buddhist thinking would support organ donation, as only the soul is reborn and it would be good to help others by donating organs. Participants, however, said that the topic was not openly discussed. They were willing to discuss it with us and one participant changed her mind in favor of organ donation when she learned that no one would be able to see any difference in her body at the mortuary after the organ was removed (i.e., the body would look intact).

The Filipino participants also gave a variety of responses. Theoretically, helping others by donating an organ would be good and, if only the soul goes to heaven, why not give body parts to the living who are in need. In reality, few of the first generation Filipino Americans had considered the idea or were open it. The more educated participants and the second generation participants had thought about organ donation and were willing to consider the idea, although none were official organ donors.
Suicide

Among the Filipino participants, there was consensus among participants that suicide is not acceptable as it goes against the Fifth Commandment: Thou shalt not kill. If a person commits suicide, the priest may refuse to perform a funeral service and may not allow the body to be buried in the Catholic cemetery. Focus group participants made these comments: “You don’t go to heaven if you commit suicide,” “you are not forgiven,” and “you are a sinner.” The single Protestant Filipino participant reported that her church would allow a service to be performed for someone who committed suicide, as they believe that Jesus forgives this person.

The Native Hawaiian participants said that if someone commits suicide, it’s often the fault of someone else who has rejected them or hurt them in some way. Most felt that those who commit suicide should be given a church burial and felt it was harsh of the Catholic Church to not allow those who commit suicide a Catholic funeral or interment.

Chinese participants reported that suicide is considered wrong among Chinese. In traditional Chinese culture, however, suicide may have been acceptable for females who were raped or wanted to avoid being raped and people captured by enemies during war. In fact, a woman who commits suicide because of being raped may return as a hungry ghost to haunt the person who raped her. While the burial service would be the same, the family of a person who has committed suicide would attempt to cover up the suicide because of shame, and they would likely mourn privately.

Vietnamese participants told us that Buddhist teaching equates suicide with killing. Most Vietnamese think that suicide is wrong and teach this to their children at a very young age. The only exception is in war; a military man who commits suicide instead of surrendering to the enemy will go to “a higher place in the after life.” However, most go to Suicide Land and are very unhappy since they have not paid back their karma and it will follow them. For example, the soul of a person who commits suicide at age 30, but was supposed to live until age 80, will live in Suicide Land for the next 50 years to make up the difference. The unhappy ghost of the person who commits suicide may also return to bother the living. The funeral is the same for a person who commits suicide, but mourners feel more sorrow for the surviving family members.

Japanese informants concluded that there are two ways to look at suicide. One is that a person was bestowed life by parents and ancestors, and should take care of it so as not to hurt the ancestors. In addition, the taking of any life is wrong, even one’s own. But, although suicide “is not good,” sometimes it is the only way out of a bad situation. In the Buddhist belief, it doesn’t matter how a person dies because the Buddha is compassionate and embraces all beings without discrimination and the funeral service is the same, regardless. Thus, participants felt it was best to take a compassionate and non-judgmental view of suicide.

Euthanasia

Few of the recent Filipino immigrants had any experience with passive or active euthanasia and were not even that familiar with the terms. When terms were defined, participants felt that hastening death would be wrong because it resulted in killing, which is against the Fifth Commandment. Again, those who were more educated and those who had worked with aged and terminally ill patients, agreed that “allowing death to come” by withholding life support or increasing pain medication was acceptable. They were not in favor of more active measures or assisted suicide, however.

The Vietnamese participants told us that euthanasia is not acceptable because killing is immoral and because people have their own karma to fulfill. Therefore, families would probably not allow the life of a family member to be shortened, even if the suffering was great. The exception seemed to be if the dying person was in an institution that the family couldn’t afford. In this case, the hastening of death may be allowed, but this was not something the family could openly discuss. A participant explained that, in this case, if life support was removed and the person died, then it would signify that it was time for that person to go. Several stated that they themselves would not want to be kept alive on life support.

Among the Chinese participants, there was a general consensus that disconnecting tubes or providing an overdose of pain medicine to end suffering of a loved one was acceptable to most Chinese Americans. Participants would expect careful control and extensive discussion before supporting any activity that may cause death. They would also want some assurance that this was within the person’s wishes and would hope to see such a wish in writing. A focus group member noted that, given the importance of filial piety, it would be difficult for children to remove life support from the parents as relatives may say, “oh, how come you can do this to your parents?”

From Japanese participants, we heard that there was no Buddhist stand on euthanasia but that the Buddhist temple would support the family’s decision in relation to the withholding or withdrawal of life support. We heard the Japanese word *akirameru* which means “to leave things as they are.” That is, instead of using technological means to sustain life, people could allow loved ones to die naturally.

All of the Native Hawaiian participants were in favor of passive euthanasia. One stated that, “for me personally, I tell my family to make sure they do all they can to save me, but then let me go and I won’t come back and bother you guys.” Another said that, in her family, they have all decided they will allow the person to “leave” and not keep them on artificial support. They felt that machines just extend death and, as a result, the spirit is stuck half-way in between this realm and the next. At this point, it was “better to allow them to go.”

Discussion

Findings from this cross-cultural study of responses to death and dying revealed similarities and differences among the five ethnic groups. An important similarity was the participants’ willingness to discuss their experiences with death, despite our expectations of reluctance. Given this, physicians and other health care professionals should be less hesitant to broach the subject with their patients.

The differences among groups, however, were also apparent. Although the Japanese, Chinese, and Vietnamese groups share a Buddhist history, they varied in their views of karma and suicide. For example, in Japanese Buddhist culture, personal karma is not openly discussed, nor are misfortunes attributed to a person’s past karma. In Vietnamese and Chinese cultures, accidents, illnesses, and premature death are often considered a result of a person’s misdeeds in a past life. Suicide was considered unacceptable by Vietnamese and Chinese groups and a mortal sin by Catholics, whereas the Japanese Buddhist group thought suicide should be viewed in a compassionate, non-judgmental manner.

Within-group differences were also observed, based on length of time in the U.S. and level of education. For example, beliefs among our Chinese American informants differed depending on if they were third and fourth generation Chinese Americans who grew up Christian, new immigrants who were young and Christian, and new immigrants who were older and Buddhist/Confucian. Among the Vietnamese and Filipinos, differences were seen between the more educated key informants and the less educated focus group members. In general, although the traditions of the native culture are known and respected, those who were more educated and accultur-
ated were more likely to have thought about living wills, organ donation, and euthanasia.

Of interest as well is the concept of using the values inherent in the different cultures as a base for education about death-related issues. For example, Buddhism and Catholicism both emphasize the importance of "giving" and "helping others." They also believe that it is the soul, not the body, that "is reborn" or "goes to heaven." Can these concepts be incorporated into educational strategies that will increase their willingness to become organ donors? Similarly, the Buddhist concept of akirameru could be incorporated into discussions about euthanasia. On the other hand, proponents of physician-assisted suicide may want to change their terminology (perhaps to "assisted dying") as suicide had such negative connotations for our Chinese, Filipino, and Vietnamese respondents. Findings along this line point out the sensitivity of centering discussions about such controversial issues as physician-assisted suicide within churches, as they play an important role in explaining and celebrating life (and death) events.

Financial concerns also emerged as a trigger for changing attitudes toward euthanasia. Several informants in the Vietnamese and Chinese groups mentioned that "pulling the plug on a family member who had no hope of recovery" may be justified if the family could not afford to pay for prolonged life support. The economic argument is powerful and will become more impressive as federal insurance benefits are reduced and individual out-of-pocket expenses increase.

Methodologically, the study was constrained by a small sample, limited to a few key informants and a handful of focus group participants for each ethnic group. Thus, findings from this work cannot be generalized to the larger population. Future studies are indicated and interviews should include larger and more representative samples from each group. It would also be important to ask more detailed questions about physician-assisted suicide.

Given the shortage of existing literature on cultural differences in death and dying practices, this study provides a modest amount of information on the thoughts of five different ethnic groups on the more controversial aspects of death and dying—advanced directives, organ donation, suicide, and euthanasia. The findings also suggest that customs are affected by a number of factors—years in the U.S., educational attainment, economics, religion—and are changing rapidly. Thus, the importance of the study lies less in the cultural details provided by the participants and more in the fact that differences exist and need to be assessed and respected. The study also provides insight into cultural traditions that could be incorporated into educational efforts about end-of-life decision making and the anticipated legalization of physician-assisted suicide.

Acknowledgments

Acknowledgments are tendered to the University of Hawaii Office of Research Administration for their financial support of this research. Thanks also to the key informants and focus group participants for sharing their experiences and insights with us. We also thank Carol Matsumiya and Kim Sugawa-Fujinaga for their editorial assistance and Virginia Tanji for her assistance with the literature review. An earlier version of this paper was presented as part of a panel discussion sponsored by the Hawaii Pacific Gerontological Society in June 1996.

References

An Attitudinal Survey of Euthanasia in Windward Oahu
A Cross-Sectional Pilot Study of Four Age Groups

Timothy Littlejohn* and Jeanne Burrows-Johnson**

Exploring the attitudes of 185 respondents toward euthanasia, this 1990 cross-sectional pilot study utilized 12 survey questions addressing participants’ demographic profiles and 18 focusing on: abortion; capital punishment; euthanasia; sterilization; and suicide. Cross-tabulation of structural, behavioral and attitudinal variables revealed age and education were the key factors in this study’s finding that the greater a person’s life experience, the more favorable one’s attitude toward euthanasia.

To the ancient Greeks, “euthanasia,” meant to die easily or happily, with dignity. Today it is generally defined as the voluntary termination of one’s life, or more particularly, putting to death painlessly or allowing to die those who suffer from an incurable disease or condition. Benign as these descriptions may seem to some, the issue of euthanasia, like abortion and capital punishment is controversial and poses an ongoing struggle legally, morally, and spiritually. Even complex categorization through qualifying terms like “active,” “passive,” “voluntary” and “involuntary,” do little to unite views on this explosive subject.

The significance of this social concern is evidenced in the attention the subject draws in broadcast and print media. In addition to highly visible cases such as Dr Jack Kevorkian, periodicals throughout the U.S. are exploring myriad aspects of this controversial issue. The range of emotional responses expressed by proponents and opponents, indicates that euthanasia can be a key element in studying societal attitudes toward aging, death and dying.

Given current levels of life expectancy, people of all demographic characteristics are facing choices in life-sustaining medical treatment for themselves and their loved ones. The search for individual and collective answers has led to in-depth examination of examples of past social acceptance of both active and passive euthanasia.

Historical Context
In ancient Greek society, euthanasia was a standard practice, particularly among the elderly. Aged individuals, feeling they were no longer beneficial to society, might gather for one last celebration and then drink hemlock. At the other end of life’s spectrum, newborn babies were routinely examined to determine their physical worthiness. If a flaw was found, or the parents were judged to be inferior themselves, the child was killed in order to keep society free from potentially weak and non-contributing individuals.

Euthanasia was also practiced within some Native American cultures, such as the Inuit, Plains Indians and the Apache. Within these groups, the infirm and aged were sometimes left to die when they were too weak to care for themselves, or could no longer tangibly contribute to their society. In modern American society, however, high value is placed on extending one’s life as long as possible. The reasoning is that a person’s life is valuable and meaningful. Such a focus has led to a medical technology dedicated to sustaining physical life regardless of the expense or suffering involved. In view of today’s rising medical costs, and the insurance necessary to pay for it many segments of the private and public sectors are now considering various factors involved with aging and death.

A study of 1200 health care workers showed visible attitudes regarding the subject, with more than 65% of its respondents being anti-euthanasia and 35% being pro-euthanasia. Of the 65% against euthanasia, most were nurses’ aides and licensed practical nurses. The 35% favoring euthanasia were primarily doctors and registered nurses. The difference in attitudes shown by these results indicate that education and experience do appear to be factors in participant conclusions.

Several anthropological and sociological studies address euthanasia within broader contexts. A study of a 163-member Xhosa-speaking African tribe explored thoughts about death and dying. Respondents expressing the least fear of death were both older and less educated respondents; for it was the younger people who had the greater opportunity for education. Thus it was not possible, in this sample, to separate the effects of age and education from the reactions to fear of death or euthanasia.

In Columbia, Missouri, a study of abortion shows comparisons between 232 members of the Missouri Citizens for Life (MCL) and 282 members of the Abortions Rights Alliance (ARA). Members of the ARA were more inclined to favor equality of the sexes, especially in their approval of the Equal Rights Amendment. They were more politically liberal and more committed to free speech for social deviants. MCL members were much more conservative in their approach to matters of personal morality and regarded suicide and euthanasia as more objectionable than did their ARA counterparts.
In a 1987 study of abortion, researchers demonstrated that education has a significant effect in the polarization of attitudes. In this case, the greater a group's education, the greater their likelihood of consistently approving of legalized abortion. Adults with a grade school education were the least likely to consistently approve of legalized abortion, while college graduates were the most likely to consistently approve.

Hawaii Living Will Legislation

In Hawaii an initial living will law was passed in 1986. Following years of reconceptualization and debate, the revised statute contained the following elements:

1. A clear statement of the conditions under which life-sustaining medical treatment can be withdrawn. Unique among U.S. state laws, Hawaii permits advance directives from both terminal patients and those who have permanently lost the ability to communicate medical treatment decisions to their physicians.

2. A living will model that may be amended to individual preferences, providing the signer includes a specific check-off stating whether the person making the living will wants to have their life prolonged by tube or other artificial feeding or fluids.

3. Unlike more stringent laws in other states, Act 321 allows verbal or anecdotal evidence as well as written living wills.

This legislative revision resulted from a coalition of legislative, legal and medical authorities concerned with imprecision in the original statute. Expected negative response from Right-to-Life-Movement advocates, was overwhelmed by the oral and written testimony of governmental and professional organizations voicing support of this Act, including: American Civil Liberties Union of Hawaii; the Roman Catholic Diocese of Honolulu; the Hawaii Federation of Physicians & Dentists; Hawaii Health Care Association; Hawaii Long-Term Care Association; Hawaii Medical Association; Hawaii State Department of Health.

In 1992, the effectiveness of the Living Will Law in Hawaii was further strengthened by passage of an act providing for the Durable Power of Attorney for Health Care Decisions. As an amendment to the 1989 Durable Power of Attorney Act, this law allows a person to appoint someone to make health decisions for them, if their own decisions cannot be determined. Documents combining the language of a living will and a durable power of attorney for health care are now routinely provided by attorneys in the State of Hawaii.

Attorney Jeff Crabtree was a key proponent of these statutory amendments. He was propelled to an activist position by the experience of his mother who became comatose following an accident in 1986. With initial controversy within the family, and the ambiguous position of the 1986 law, Crabtree faced constructing a legally-acceptable argument for obtaining suspension of all life support aids to his mother.

Even with the eventual agreement by all family members, the process was arduous and expensive. Finally, after four and a half years, the State of Hawaii ruled that the mechanical life support systems could be disconnected and she would be allowed to die with dignity.

Focus

As of 1991, little national attention had been focused solely on euthanasia. The primary study to focus solely on attitudes regarding euthanasia was designed and administered in 1977 by sociologists David Jorgenson and Ron Neubecker. In their four-point response measurement they found that of the 1525 people surveyed, 50% were opposed to euthanasia. Seventy percent of white males were pro-euthanasia, contrasted to blacks and females who tended to be against euthanasia. The highest income group was also shown to be pro-euthanasia, as were those with the most seniority and education.

The latter two variables were the focus of the design and implementation of this sampling of societal views toward euthanasia. It compares attitudinal differences among: high school; college; working; and, retired persons. Specifically, this study sought to find whether the variables of age and education were measurably significant. It is hypothesized that life experience, as measured through age and education, tends to reflect a person's stand on euthanasia, with the older and more educated tending to reflect a more neutral or pro-euthanasia attitude.

Method

This cross-sectional study of four age groups sampled on the windward side of Oahu, Hawaii explores attitudes toward euthanasia with a 30-question survey of 185 people. The first 12 questions addressed the demographic profile of respondents. The remaining 18 questions focused on views of health and life including abortion, capital punishment, euthanasia, societal imposition of sterilization, and suicide.

Five areas of the opinion survey delineate the pro-euthanasia and the anti-euthanasia groups. The hypothesis is: The greater a person's life experience is (based on age and education), the more favorable will be his or her attitudes toward euthanasia. Structural, behavioral and attitudinal variables were cross-tabulated to measure the relationship between these variables.

Analysis of results concluded variables of religious and political affiliation and activism are not significant determinants of respondents' overall reaction to the concept of euthanasia. Age and education are found to be the two key relevant variables in this study.

Sample

The data base for this research draws on a total sample of 185 people in four research subgroups: students at James B. Castle High School; students of the University of Hawaii at Windward Community College; working adults; and residents of Pohai Nani Good Samaritan Kauhale, a retirement community.

Measurement of Euthanasia Attitudinal Variables

Euthanasia is often discussed in terms of the degree of active or passive involvement. The purpose of this study was to measure the overall reaction of respondents to the term itself. Except for consideration of self-induced death, suicide, neither qualification nor in-depth description were employed. This study focuses on respondents' agreement with five general conditions asking whether:

1. Euthanasia (mercy killing) should be legal.
2. Helping a terminally-ill loved one commit suicide is wrong.
3. Doctors should be allowed to end the life of a terminally ill patient upon request by the patient and his or her family.
4. A patient's life may be terminated if a court-appointed board determines the patient cannot be cured.
5. Euthanasia is wrong.

Independent Variables

Thirty variables were selected for this cross-sectional study of euthanasia of which 12 were structural and behavioral and 18 were attitude related. Structural variables included age, gender, place of
birth, number of years lived in Hawaii, ethnicity, education, occupation, and income. Behavioral variables were: mental outlook on life; political association; frequency of voting; religious affiliation; and, frequency of religious involvement.

Analysis
Response distributions were compared between groups utilizing the chi-square. In addition, mean scores were then compared between groups using Analysis of Variance. Each subject was given a score, coded from 0 to 4, with 0 being the most negative and 4 being the most positive. The Statistical Analysis System [SAS] program was used for statistical analysis.

Results
Condition 1 [overall probability of <0.01 to 0.57]. Legalization of euthanasia was favored by 56.2% of the entire sample of 185 individuals. 17.8% were opposed and 23.2% remained neutral. As noted throughout the study, receptiveness to euthanasia by high school students was notably low. Only 24% supported legalization, 42% remained neutral and 32% were negative to the idea.

Condition 2 [overall probability of <0.01 to 0.74]. This question drew a more positive response, asking if helping a terminally-ill loved one to commit suicide is acceptable. Of the total sample, 64.3% favored this proposal, 16.2% found it unacceptable, and slightly more (18.4%) remained neutral to the issue. Measurement of the 47 college students reaction to the subject of mercy killing was slightly less positive: 57.9% were pro-euthanasia; 19.6% were anti-euthanasia; and 24.4% were neutral.

High school students were also more positive in answering this question, but were nevertheless half as supportive as retirees. High school students responded with 38.8% in favor, 43.1% remaining neutral, and only 17.6% in opposition. In contrast, retirees, supported the question by 71.8%, with 23.1% in opposition and 5.1% being neutral.

Condition 3 [overall probability of <0.01 to 0.70]. Overwhelmed support was given the permisibility of doctors ending the life of a terminally-ill patient upon request by the patient and his or her family. 80.5% of the total sample were pro-euthanasia, 10.8% stated their opposition and only 5.4% of the respondents were neutral. The strongest support came from working adults, with a response of 91.5% positive, and 6.4% negative. It is interesting that none of this subgroup remained neutral on this question. While overall positive in their response, high school students were again notably less positive (60.7%) than other age groups in this study.

Condition 4 [overall probability of <0.01 to 0.68]. Asking whether a patient’s life may be terminated if a court-appointed board determines the patient cannot be cured, this issue drew the least support with only 37.7% of the sample responding favorably. The greatest sanction came from retirees (60.5% in favor, 26.3% opposed, 13.1% neutral). High school students were again markedly less enthusiastic (28.4% positive, 35.2% neutral, 35.3% negative). College students were even less supportive than high school students (17.1% in favor, 55.4% in opposition and 27.7% neutrally positioned). Working adults straddled the middle, with 44.7% favoring the question, 38.3% being opposed and 17% remaining neutral.

Condition 5 [overall probability of <0.01 to 0.67]. Addressing the overall acceptability of euthanasia, this condition received the greatest support from working adults (76.6% in favor, 14.9% opposed and only 8.5% neutral). A higher percentage of high school students remained neutral on the issue, with 32.6% favoring euthanasia and 24.5% being opposed. This compares with an overall approval rating of 66.7% by the other three subgroups and only 16.3% opposing the concept.

Summary
Retirees were the only subgroup consistently supportive of all conditions, including the least-favored Condition 4. The mean of their positive response to the five conditions was 70%. Only Condition 3, permitting physicians to terminate life, upon request by patient and family, drew positive support from high school students (60.7%).

The most pro-euthanasia age group were working age adults, 23 to 29 years old. Their overall agreement was 78.5%. The least supportive respondents were under the age of 18. This subgroup’s overall agreement with the issue of mercy killing was only 37.2%. With 46.7% support, young adults 18 to 22 years old were also less than positive about the subject.

In considering the variable of education, the most pro-euthanasia persons had attained a doctoral degree or its equivalent. None of this educational subgroup remained neutral on the issue of euthanasia. Their overall agreement with the concept of euthanasia was 80%. The remaining 20% were consistently negative in their overall response.

As the statistical analysis revealed in the mean scores, none of the five attitudinal conditions drew a level of significance. However, examination of percentages indicates that younger and less educated respondents tended to be less receptive to a pro-euthanasia stance as measured through each of the five conditions.

Discussion
The purpose of this research paper was to identify those variables most closely related to attitudes toward euthanasia in Windward Oahu. Structural, behavioral and attitudinal variables were chosen and cross-tabulated to see whether age and education were factors affecting euthanasia attitudes.

Comparison of the makeup of the total sample of this survey and that of the citizenry of the State of Hawaii demonstrates a degree of likeness. At the time this sample was taken, the median age was 31.9 years with the ratio between males and females roughly 1 to 1 (with 50.9% males and 49.1% females). The racial makeup of Hawaii was: Asian, 46.6%; Caucasian, 34.4%; and Polynesian, 13.9%. The State’s religious affiliation includes: Catholicism, 65.1%; Mormonism, 13.3%; traditional Protestantism, 10.7%; fundamental Protestantism, 7.9%; and Buddhism, 3.1%. Unfortunately, measurement of political affiliation was not provided in the State’s statistical analysis.24

The median age for participants in this study was 18 years, with a quarter of this sample being high school seniors. This sample includes a lesser proportion of males (35.2%) compared to females (59.4%). This deviation from the State’s average in gender, may be explained by the inclusion of 25% retired people, who generally include a higher percentage of females. When examining the gender breakdown between proponents and opponents of euthanasia, some variation is noticeable. For while those supporting euthanasia closely parallel the overall study, (57.7% being female and 36.5% being male), respondents opposing euthanasia included 76.9% women and 23.1% men.

Like the overall ethnicity of the State of Hawaii, this study’s participants are not an ethnically homogeneous group. Caucasians made up 44.9% of the sample, or roughly 10% more than the State’s ethnicity. Asians were underrepresented with only 20.4%, or less than half the state average. Polynesians were strongly represented at 24.1%. The ethnicity of pro- and anti-euthanasia respondents...
reflected a similar broad spectrum.

Although one might expect religiosity to be a deciding factor in determining an individual’s perception of the issue (as in the Jorgenson, Neubecker survey), the present study finds no such relationship. Respondents supporting euthanasia were as dedicated in their religious devotion as those of the opposite view and represented a wide spectrum of religious affiliation. The sample included traditional Protestants (28%), Buddhists (17.8%), fundamentalist Protestants (4.9%), Mormons (3.2%), and Catholics (2.4%).

Participants with both positive and negative views of mercy killing expressed generally liberal political beliefs. Of those supporting euthanasia, 36.5% described themselves as Democrats, 23.1% as Independents and 21.2% as Republicans. Respondents opposing euthanasia included 38.4% Democrats, 37% Independents and 15.4% who were non-affiliated. It is interesting to note that there were no Republicans among opponents of euthanasia.

As demonstrated in the results section of this study, life experience, as measured through age and education, does contribute to a more accepting view of euthanasia. Looking at the frequency of distribution of demographic characteristics of proponents and opponents of euthanasia, only measurements of age and education were noteworthy.

The sample of 51 Castle High School senior English students were the least positive toward the subject, with over a third indicating an anti-euthanasia view, and even more remaining neutral. Aside from age and education, the high schoolers deviated from their counterparts in few respects. They represented similar proportions of gender, race, religiosity and political orientation. The one noteworthy aspect of this group’s self description was their incomplete reporting of family income which may be reflective of the students’ lack of involvement in family finances.

The second group of 47 students at Windward Community College, were primarily in their first-year of college and therefore close in age to the first group. Yet they were more accepting in their overall response to the subject of mercy killing than the high school students. Nearly two-thirds of them indicated pro-euthanasia attitudes; one-fifth were anti-euthanasia; and only a quarter stayed neutral. Reporting of income was also incomplete and again may be attributed to non-involvement with family finances.

The sample of 47 working adults, from Castle High School and the general Windward Oahu community, was the most supportive of the concept of euthanasia. Over three quarters of these people were in favor of it, while less than one-fifth were in opposition and considerably less than a tenth expressed neutrality. These working adults differed from high school and college students in two meaningful ways; they were older, and had completed higher levels of education. Unlike their younger and less educated counterparts, it is likely they had had more experience with myriad life factors, including death and dying.

Occupation may be seen as another outstanding feature separating students from working adults. Over half of the 36 high school employees were teachers; the remainder included administrators, custodians, and teachers’ assistants. The 11 assorted adults participating in the survey represented a broader occupational range. This subgroup included workers from business, construction, government and food service.

The fourth category of respondents consisted of 40 residents of Pohai Nani Good Samaritan Kauhale. This evangelical Lutheran retirement center is part of a chain of 200 facilities around the United States. This particular sample consisted almost entirely of Caucasians, many having come as adults from the continental United States. This disproportionate ethnic representation may in part be explained by differences in family living between white and non-white cultures. For while the nuclear family arrangement predominates among whites in the United States, the extended family, has been more traditional among non-whites.

Conclusion

During the last three decades, considerable progress has been made in bringing the subject of euthanasia to the fore of public awareness. In the 1960’s Kubler-Ross brought attention to death and dying. The 1970’s saw an open interest in the subject of euthanasia. With today’s so-called “graying of America,” it is even more appropriate to look at many aspects of life for the aged and infirm, if the quality of life is to be enhanced for the nation’s aging populace.

Suffering, coupled with complex medical, moral and legal issues, is clearly perceived as a poignant social dilemma. Both private and public sectors are exploring economic and humanitarian issues in health care choices. Nearly half of the states in the U.S. permit the use of living wills. Organizations, like the Society For The Right To Die, are calling direct attention to euthanasia.

This study’s findings, like others, found that age and education can be key variables in exploring societal attitudes. The importance of political and religious association, race and level of income were not supported in the findings of this study. Gender was somewhat meaningful in that a higher percentage of males were supportive, rather than opposed to euthanasia. In short, the original hypothesis that age and education are determinant factors in a person’s view of euthanasia was born out. The greater one’s life experience, as measured in increasing age and level of education, the more favorable one’s attitude toward euthanasia will be.

While the health care providers contacted during this study concur in finding little change in the attitudes of staff, patients, and families since the passage of this statute, they concur that there is a clear need for legal guidelines on the issue of termination of life-supporting medical treatment. As a functional democratic society attempting to meet the needs of its myriad peoples, one must move beyond analysis in academia and the media. With the passage of laws providing for living wills and durable powers of attorney for healthcare decisions, Hawaii is reaching toward resolution of this area of social, medical and legal consideration.

But many socio-economic, legal, and medical questions will have to be answered before passive, let alone active, euthanasia can become an acceptable practice. As Dr Stephen Wallach observed, everyone is learning about this issue. In their desire to fulfill patient requests, courts must consider many complexities:

1) the extent of impairment of the patient’s mental faculties;
2) whether the patient is in the custody of a State institution;
3) the prognosis without the proposed treatment;
4) the complexity, risk and novelty of the proposed treatment;
5) its possible side effects [sic];
6) the patient’s level of understanding and probable reaction;
7) the urgency of decision;
8) the consent of the patient, spouse, or guardian;
9) the good faith of those who participate in the decision;
10) the clarity of professional opinion as to what is good medical practice;
11) the interests of third persons;
12) the administrative requirements of any institution involved.

As the United States stands on the threshold of health care reform, the issue of euthanasia is all the more relevant. What level of care
is appropriate to the various social classes? Who will have access to transplants and other life-sustaining medical technologies? The rich, the middle class, the poor? How long will patients be maintained on costly life support systems? At what point should a patient, their family and or health care provider be permitted to terminate costly medical care? Who will determine the fate of those who are not to receive continued care? Will passive, if not active, euthanasia become a wholly-accepted option in health care in America? Further study of this social dilemma will need to be undertaken before American society reaches a level of consensus sufficient to develop definitive public policies and guidelines.

References


Table 1.—Combined responses of total sample of 185 persons, in 9 age groups, to combined euthanasia conditions (expressed in overall acceptability of euthanasia, measured from positive to negative).

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Most Positive</th>
<th>Positive</th>
<th>Neutral</th>
<th>Less Positive</th>
<th>Negative</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
<td>18.4%</td>
<td>18.8%</td>
<td>34.9%</td>
<td>9.4%</td>
<td>17.3%</td>
<td>2.1</td>
</tr>
<tr>
<td>18-22</td>
<td>17.8%</td>
<td>28.9%</td>
<td>32.6%</td>
<td>9.6%</td>
<td>11.1%</td>
<td>2.3</td>
</tr>
<tr>
<td>23-29</td>
<td>52.3%</td>
<td>26.2%</td>
<td>4.6%</td>
<td>7.7%</td>
<td>9.2%</td>
<td>3.0</td>
</tr>
<tr>
<td>30-39</td>
<td>45.9%</td>
<td>28.2%</td>
<td>10.6%</td>
<td>9.4%</td>
<td>5.9%</td>
<td>3.0</td>
</tr>
<tr>
<td>40-49</td>
<td>46.1%</td>
<td>27.8%</td>
<td>9.6%</td>
<td>9.6%</td>
<td>7.0%</td>
<td>2.9</td>
</tr>
<tr>
<td>50-59</td>
<td>35.0%</td>
<td>30.0%</td>
<td>1.7%</td>
<td>21.7%</td>
<td>8.3%</td>
<td>2.6%</td>
</tr>
<tr>
<td>60-69</td>
<td>37.1%</td>
<td>37.1%</td>
<td>8.6%</td>
<td>17.1%</td>
<td>0%</td>
<td>2.9</td>
</tr>
<tr>
<td>70-79</td>
<td>43.1%</td>
<td>29.2%</td>
<td>7.7%</td>
<td>6.2%</td>
<td>10.8%</td>
<td>2.9</td>
</tr>
<tr>
<td>80+</td>
<td>42.9%</td>
<td>23.8%</td>
<td>7.6%</td>
<td>7.8%</td>
<td>9.5%</td>
<td>2.9</td>
</tr>
<tr>
<td>Probability</td>
<td>0.35</td>
<td>0.92</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2.—Combined responses of total sample of 185 persons, in 8 age groups, to combined euthanasia conditions (expressed in overall acceptability of euthanasia, measured from positive to negative).

<table>
<thead>
<tr>
<th>Education</th>
<th>Most Positive</th>
<th>Positive</th>
<th>Neutral</th>
<th>Less Positive</th>
<th>Negative</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>K-11</td>
<td>19.6%</td>
<td>19.3%</td>
<td>33.0%</td>
<td>9.6%</td>
<td>17.4%</td>
<td>2.1</td>
</tr>
<tr>
<td>High School or Ged</td>
<td>40.0%</td>
<td>22.9%</td>
<td>19.0%</td>
<td>12.4%</td>
<td>5.7%</td>
<td>2.8</td>
</tr>
<tr>
<td>Technical School</td>
<td>55.0%</td>
<td>10.0%</td>
<td>5.0%</td>
<td>15.0%</td>
<td>15.0%</td>
<td>2.8</td>
</tr>
<tr>
<td>Some College</td>
<td>33.7%</td>
<td>26.8%</td>
<td>20.5%</td>
<td>9.3%</td>
<td>9.8%</td>
<td>2.8</td>
</tr>
<tr>
<td>2 years of college</td>
<td>32.3%</td>
<td>23.5%</td>
<td>10.8%</td>
<td>7.7%</td>
<td>4.6%</td>
<td>2.9</td>
</tr>
<tr>
<td>4 years of college</td>
<td>36.3%</td>
<td>40.8%</td>
<td>7.4%</td>
<td>10.4%</td>
<td>3.7%</td>
<td>3.0</td>
</tr>
<tr>
<td>Master's Degree</td>
<td>44.0%</td>
<td>23.0%</td>
<td>3.0%</td>
<td>11.0%</td>
<td>13.0%</td>
<td>2.8</td>
</tr>
<tr>
<td>PhD or Equivalent</td>
<td>75.0%</td>
<td>5.0%</td>
<td>0%</td>
<td>5.0%</td>
<td>10.0%</td>
<td>3.4</td>
</tr>
<tr>
<td>Probability</td>
<td>0.40</td>
<td>0.96</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Euthanasia: Murder or Mercy?

Kenneth W. Phifer Senior Minister
The First Unitarian Universalist Church of Ann Arbor Michigan

Euthanasia has become one of the most urgent issues of our times. This has come about because of the development of technology that has enabled us to sustain our existence far beyond the "natural" course of life. Sometimes this extension of life involves an improvement of the functioning and the well-being of the patient. Not infrequently, though, it is only the dying process that is extended. The question this has forced upon us in the modern age, especially in the last several decades, is whether there is a point at which death is kinder than life. This is the issue of euthanasia, how we die: when, where, by what means, in whose presence, and by whose authority.

In dealing with this issue, it is advisable to declare one's personal involvement. Mine began in the first year of my ministry some 22 years ago. An older woman told me that she wanted to die. She was weary of pain and helplessness. She felt diminished by being a care-receiver rather than a care-giver. Life had no pleasure or purpose for her other than pain relief. She was without hope. She wanted the release of death, and was not even able to help herself to accomplish this. It took eight years of misery for her yearning to become reality. My efforts to comfort her were futile, even, as I look back now, cruel.

More recently I was involved with a congregant, Merian Frederick, who sought out the services of Dr. Jack Kevorkian. On October 22, 1993 Merian took her life in Royal Oak, Michigan, in the presence of her son and daughter-in-law, Dr. Kevorkian, and myself. Her choice was made after a struggle of several years with ALS (Lou Gehrig's Disease) and with the awareness that she would soon lose her only means of communicating with the world, the strength in her fingers to write her thoughts on a yellow pad or tap out a message on her computer.

I had known Merian for 12 years, worked with her in many capacities in the church, and counseled with her and her family on many personal issues. We had discussed euthanasia theoretically for many years before she first experienced the symptoms of ALS. Within a few days of her being diagnosed, that conversation became very practical and very personal. As her spiritual counselor, I worked with her to be sure that every possible option was considered and then considered again. Her family was intimately involved in this conversation and in the eventual decision which Merian made.

Had there been a better way for Merian to be relieved of what she viewed as pure hell—a good mind soon to be unable to communicate because of the ruined body in which it was housed—she would have chosen it. Having made her choice, she spent the last days of her life more happily and more purposefully than at any time since learning the name and nature of her disease.

One lesson from this experience is that suffering is easier to bear if there is a known terminal point to it. Two decades ago I felt helpless before a woman's request. Two years ago I was able to be helpful, though doing so meant a certain minor amount of legal risk. In between these benchmark experiences and after the second one, I have had many occasions to confront this issue of how we die. These experiences and much study and reflection have led me to support the moral right of competent adult persons at the end of their lives to choose death over continued suffering, and to seek the help of professionals and of loved ones in ending their lives if that is necessary.

I support euthanasia.

Like most individuals and most religions, I support passive euthanasia, allowing someone to die without taking heroic measures to save them.

Like a growing number of individuals but almost no religion except Unitarian Universalism, I also support active euthanasia, the right of a person to seek and obtain competent help to end a life that has become or soon will be unbearable.

If we choose active euthanasia, we should have the best available help to make the terminal point of life truly good and gentle for us. This may call for professionals in health care, like doctors and nurses. It may mean family or close friends. It may mean both.

We should not die in great agony or with doubt about whether we shall succeed in ending our lives or with concern for those who have helped us to die. We should die without pain, with certainty that death does await us as a relief from our suffering, and with confidence that our loved ones and care-givers will not be legally threatened because of their kindness to us.

If loved ones and professionals are able to cooperate with us, the moment of our death can be truly full of love.

At this time I am not prepared to defend such a choice for children, for non-competent adults, or for those who are comatose who have not given explicit instruction prior to their becoming unconscious.

Five principles guide my thinking and my acting

First, mere existence is not an absolute value.

That which exists changes, grows, deteriorates, becomes something quite different. Value is found more in the process than in the simple existence of any form of life. Conscious and articulate life, human life, sometimes can choose its changes, grounding that choice in values and meanings derived from it own life experiences. Sometimes the change that is made is death, an end to this existence being preferable to a continuation of it.

Every one of the religions and philosophies which have had major influence on our society argues this way. Socrates believed that death was better than violating the law of the city. Jews perished at Masada rather than be enslaved. Christians martyred themselves rather than betray their god by bowing to a Roman deity.

There are ideals, values, principles, and persons for which and for whom we would give up our lives if called upon to do so. What parent would not sacrifice their own life to save the life of their child? There are people who risk their lives, and sometimes lose them, in rescuing a stranger.

By making such a choice as this, we are at least implicitly saying that our death helps someone who is left behind. In certain circumstances, we may regard that way of helping another as being of higher value than our own existence.
To choose death sooner rather than later, actively rather than passively, can be an act of high moral stature.

Mere existence is not an absolute value.

The second principle is that we should respect life.

We should rejoice in life and be glad that we are alive. We should not give up life cheaply or quickly, our own or others. We should live as fully as we can for as long as we can. But there are different ways of doing this.

My friend Pansy respected life by defying her doctors when they declared that her 96 year old kidneys had shut down and were not going to function again. Three months after this diagnosis, she went home. She went back to her purposeful work of calling people who were house-bound or in nursing homes and hospitals to cheer them up. She kept this up until her energies gave out one year later and she died.

The Pitney VanDusens also respected life. They loved each other over many years. They made a pact as part of that love that they would die together. When both were of advanced age, and one of them was in very poor health, one day they simply lay down on their marital bed and he took her life and then his own. They made it clear that they did not wish to live under conditions in which they could not give but only take, conditions in which they would only be a burden to others, conditions in which they could only suffer. It was time for them to move on. They respected life by ending it and making room for someone else to enjoy life.

Sometimes choosing to die is as much a sign of respecting life as choosing to live.

A third principle is that suffering in and of itself has no moral worth.

Religions (like Christianity; see Augustine, Aquinas, et al) that include in their teaching the idea that the deity gives us pain in order to help us grow spiritually or to chastise us for our selfishness are missing the moral mark. How could anyone have confidence in a deity who would cause the kind of suffering that one can see daily in hospitals, nursing homes, and emergency rooms. My experience as a chaplain at the Massachusetts Hospital School for Handicapped Children revealed to me the enormous suffering through which some children must go. The various ailments of these youngsters were not the consequence of their moral failings. They were simply darnably bad luck. I could not imagine a divine figure who would bring such anguish to these gutsy boys and girls and their families. That they redeemed their suffering with courage and humor and hard work did not make me or them grateful for their pain and disability. It only made me and others more appreciative of their endurance and their achievements.

Suffering that we have not chosen does not in and of itself have any moral value. Disease, accident, decline, great age do not themselves have moral worth. How we face them does. One ethical way of doing that is by choosing not to let that suffering continue when it is of such magnitude that nothing else in life matters and there is no hope of relief save in death.

Suffering is not itself moral. Only our response to it can be moral.

The next principle is this: the autonomy of each individual must be respected.

Within the constraints of time and place and ability, each of us can choose how to live and each of us should be allowed to choose how we die. It is not that we have a right to die, as though there were an alternative to dying we must somehow resist. It is that, if death does not surprise us, we have a right to choose the moment of our letting go.

Autonomy is essential in moral action. Autonomy means that we are informed about the conditions in which we find ourselves and that we have legitimate options between which to choose. Autonomy does not mean that we are coerced subtly or overtly into one decision or another. It means that we freely make the choice we deem best.

Autonomy is necessary if we are to have meaning as moral creatures. It must be as applicable in our waning days and hours as it is when we are in full strength.

The fifth principle is that our individual lives are imbedded in community.

It is in the connections that we make to others that the deepest layers of meaning in our lives are revealed. We make these connections with families, friends, colleagues, neighbors, people who share our religious or political outlook or who enjoy the same sport or hobby. We also make connections with people who are different from us and who in their difference call upon us to enlarge our vision of the human collective.

In all the major decisions of our living, thinking about and sharing with a wider network of associations is important for understanding the larger meaning of what we are choosing to do. This is especially true when it comes to decisions about ending our lives. It is of great importance that we begin now to talk with those we care about regarding our feelings about death and dying. How long do we wish to live when our condition is terminal and our suffering great? Such talk helps us to know the impact of our decisions about how we want to die on those who survive us. In loving relationships, this knowledge may sometimes, and rightly, influence the choices we make.

Preparing Advance Medical Directives and a Durable Power of Attorney helps to clarify our views at this moment. Such documents announce to loved ones and strangers how we wish to confront our own ending. Together with conversation, these papers help others to understand, even if they do not agree with us, why we have made the decision we have made.

Death and dying are in one sense the most individual and isolating events of our lives. But in another sense these moments are very communal. The dying and death of any person we love touches us, changes us, alters the way life is for us.

The presence at memorial services of physicians, nurses, and other health care workers and care-givers testifies to the fact that those who are with us professionally in our last days are also part of our community.

No one is an island. The death of any of us affects all who know that person. How that death occurs is often as significant as the fact of death.

We live and we die in community.

These five principles are the basis of my support for passive and active euthanasia.

That support is not without an awareness of concerns raised by opponents of active euthanasia. Some of these concerns have more validity than others.

The concern that seems most valid to me is that when you move the line of what is permitted, you also sometimes move the line of what is expected. There is a danger that if active euthanasia (aid in dying) were legal, some who would not otherwise do so might be subtly coerced into choosing to end their lives.

It is easy to imagine a situation in which a member of a family that is already under great stress is given a particularly grim prognosis. However loving the discussion with that person may be, she may come to feel that dying sooner rather than later is what everyone really wants, even if that is not what she desires. Her choice of death...
Those who rely on the Hippocratic Oath read it selectively. They do not, for example, also call upon modern doctors to swear by the ancient gods dear to Hippocrates. They do not have protest marches outside of operating rooms, even though Hippocrates said that “I will not use the knife.”

More important than arguments about how to interpret ancient documents is the simple fact that doctors cannot always be healers. Each of us will come to a point in life when no medical treatment will help us, save perhaps to relieve our pain. At that point, when our condition is terminal, what we need more than anything else is intelligent compassion. We need people who understand the pain in our bodies and the suffering in our souls.

Compassion may well be to give us drugs and apply therapies to make our bodies feel better. But for some of us, compassion may well be to help ease us into death.

Doctors already do this, and do it legally and with the support of most religious communities. What they do is act under the principle of the double effect. The double effect is the principle by which doctors prescribe for pain even though they know that the level of medication prescribed will kill the patient.

This is a kindness for those whose bodies are racked with pain, whose spirits are sore with despair, who have no realistic hope this side of the grave, and who want relief from the pain. They want out of life. It is a kindness for the families who suffer watching helplessly as their loved ones wither in agony.

What I do not understand is why aid in dying is not also a kindness when performed with the full conscious participation of the dying person who has made repeated requests to die. To know that I can choose the moment that my anguish will be no more is to re-create hope within me. The only moral difference I can see between aid in dying and the double effect is that in the former it is the patient who is in control, who chooses the when and the where and the with whom, while in the latter it is the physician who is in control.

Morally the double effect and aid in dying are the same. In both cases, the patient, the families, and the doctor know that death will be the direct consequence of the actions taken. Indeed, that is the desired consequence. It is scandalous to me that the double effect is legal and aid in dying is a criminal act.

Ultimately the issue of how we die is a spiritual issue, not a medical or legal one. Religion has a vital role to play in this issue, though sadly many religious leaders have not been willing to assume that role.

Part of that role is to be a spiritual counselor to those who are confronted by death. Our task is to help people to think clearly about the options available. Our task is to give full emotional, moral, and spiritual support to whatever decision the person before us makes. Our responsibility is to be with people, not tell them what they must do or judge them because their decisions do not agree with ours.

Furthermore it is important for us to be a dynamic part of the societal conversation that is taking place right now. The best way we can do this is by discussing the issue as rationally as we are able to do, by encouraging discussion among our congregants and others, by writing and speaking and being active in seeking legislation that will defend a point of view consistent with our religious understanding.

Margaret Battin of the University of Utah some years ago was suggesting that churches and synagogues were likely going to be centers through which individuals would come to engage a physician who would assist them to die. She cited the work of many religious communities in the 1960s and early 1970s in helping...
Why I Do not Believe in Mercy-Killing

S.Y. Tan MD, JD*

I view with grave concern the gathering momentum towards the legalization of mercy-killing (physician-assisted suicide and active euthanasia) in this country. Prior efforts to legalize mercy-killing have been rebuffed. However, on November 8, 1994, Oregon’s voters narrowly approved Measure 16, which permits physicians to prescribe lethal doses of medication at the request of competent terminally-ill patients for the specific purpose of ending their lives. And earlier this year, appellate courts in the 2nd and 9th circuits found a constitutional right to physician-assisted suicide based on notions of equal protection and liberty. Although the final chapter of this debate is yet to be written (the U.S. Supreme Court will take up the issue in January 1997), one cannot help but be troubled by America’s increasingly fatal attraction to “managed-death.”

I do not believe in mercy-killing and I am not persuaded by the arguments advanced by its advocates. Here’s why:

The Mercy Argument

Ask any mercy-killing enthusiast, and he will tell you that physicians should, in the name of mercy, assist their terminally-ill patients to die. What is the point of forcing dying patients to bear unbearable pain and discomfort? We treat our suffering pets with greater compassion; we should therefore treat our loved ones no less. Medical science at any rate, appears more interested in high-tech than high-touch, often failing to provide effective pain relief and comfort care. Thus, it is merciful, and therefore right, to extinguish both indignity and infirmity upon request at the end-of-life.

These assertions, well-intentioned though they be, paint a mistaken and inaccurate picture of the dying patient, and are overly harsh on the medical profession. For one thing, the vast majority of patients do not die in unbearable pain and suffering. Secondly, even for the seemingly recalcitrant case, effective pain relief has become available, and better doctor education can be expected to dramatically improve this aspect of clinical care. Thirdly, physicians are now more willing and ready to prescribe narcotics in doses sufficient to effectively relieve pain, even if they should unintentionally hasten death. In a recent survey of 1,028 physicians in Hawaii, we found that 88% were willing to do so.

There are other measures that speak to compassion for the suffering. Palliative medicine is now a recognized specialty in Canada, and may soon be in the U.S. American medicine has embarked on a major initiative to improve end-of-life care which includes a curriculum for physician education in pain therapy. Medicare is responding as well: it now reimburses hospitals for specific palliative treatment that previously went unpaid.

Then there’s hospice — a compassionate home- or facility-based respite for the terminally-ill, where comfort care and psychosocial and spiritual support help soothe the final journey of life. Thousands of patients have benefited from hospice care, which has admirably delivered its promise of a gentler and more peaceful parting.

One can raise direct objections to the mercy argument. For example, who should be the “beneficiary”? Only the terminally-ill? How does one define the term “terminal,” knowing full well that doctors are notoriously inaccurate in their prognosis regarding time of death? Shouldn’t patients who are severely impaired neurologically (how about ‘modestly’ impaired?) or in a persistent vegetative state be treated mercifully as well, even if they are not terminal?

As for the “we treat our pets more compassionately” contention, I find it more specious than persuasive. Suffering, after all, is part of the human condition. To equate human life with animal life trivializes human dignity. Let’s carry this comparison to its absurd conclusion — we shoot horses, don’t we?

Incidentally, the mercy argument necessarily allows both doctors and non-doctors to help patients die. After all, it is the patient who “benefits”, and it should make no difference who does the assisting-in-death. On mercy, Shakespeare reminds us that “it is twice blessed; it blesseth him that gives, and him that takes.” If mercy is the raison d’être for legalizing mercy killing, then the law should not restrict its performance by the medical profession.

The Free-Choice Argument

This argument reminds us that patients have the right to decide what is done to their bodies (autonomy or self-determination), and they should therefore have the right to request assistance in dying as part of their medical care. After all, whose life is it anyway?

At first blush, this looks like a winning argument. We all value our independence, and being empowered to control the time, place and manner of death creates a definite if macabre appeal. The autonomy argument weakens, however, when we realize that it imposes the demand of one person upon another to terminate life. Additionally, mercy-killing undermines the integrity of the medical profession whose unchanging credo has always been to heal and comfort, not to kill.

The free-choice argument is further undercut by living-will statutes that allow terminally-ill patients to forgo life-sustaining treatment when they are no longer able to communicate their wishes. This allows the patient to die naturally without futile treatment. A durable power-of-attorney for healthcare decisions is even better.

* Professor of Medicine
John A. Burns School of Medicine
University of Hawaii

Continued on Page 303
Lethal Aid—Physician or Lawyer-Assisted Suicide?

James H. Pietsch JD*

This article will provide information about the current legal status of the right of a person to request physician-assisted suicide. It will provide a background on two appellate court cases which dealt with this issue and the significance of the U.S. Supreme Court's intervention.

When United States Supreme Court Justice Antonin Scalia was asked last Spring whether the Supreme Court should take on the issue of physician-assisted suicide after two appellate courts had ruled on the issue, he remarked, "Why would you leave that to nine lawyers, for heaven's sake?" Now that the Supreme Court has intervened, many continue to ask why lawyers need to be so involved in medical decisions to end life and where the legal system may be taking all of us in the area of self-determination, death and dying with dignity. We should not espouse what Shakespeare in Henry VI had Dick (the butcher) say, as he plotted a new government: "The first thing we do, let's kill all the lawyers." Instead, first let's review what the lawyers have done.

Two influential federal appeals courts, the 9th U.S. Circuit Court of Appeals in San Francisco and the Second U.S. Circuit Court of Appeals in New York, each ruled last Spring that terminally ill patients have the legal right to request physicians (and certain other health care providers) to assist them in killing themselves. Although the two circuit courts used different legal theories, they both expanded the ability of terminally ill persons to commit suicide and provided protections to physicians and certain others who help them. The 9th Circuit Court decision has a direct impact on residents of Hawaii since its rulings apply in Hawaii as well as several other western states. Coming from two traditionally influential circuit courts and coming so close in time, the two opinions put into question laws throughout the country which directly or indirectly may prohibit assisted suicide. In Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. (Wash.) March 6, 1996) three terminally ill patients (a 69-year old retired pediatrician who had suffered since 1988 from cancer which eventually metastasized throughout her skeleton, a 44-year-old artist dying of AIDS and a 69-year old retired sales representative who suffered from emphysema which caused him a constant sensation of suffocating), four physicians, and nonprofit organizations brought suit against the state of Washington. They sought a declaration that a statute that prohibited causing or aiding another person to commit suicide violated the Federal Constitution. The 9th Circuit Court ruled that the Washington statute which banned the promotion or assistance of suicide and which prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults violates the due process clause of the 14th Amendment of the United States Constitution. In its ruling, the court stated, "The decision how and when to die is one of the most intimate and personal choices a person may make in a lifetime, a choice central to personal dignity and autonomy."

Significantly, in a footnote in Compassion in Dying the court indicated that legally recognized surrogates (such as those appointed in a valid durable power of attorney) should also be permitted to carry out decisions for physician-assisted suicide when the patient is no longer able to communicate such decisions. The court indicated that the state's duty to preserve life is outweighed by the right to control "the time and manner of one's death." It also indicated that "a competent, terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diaped, sedated, incompetent." Compassion in Dying was the first right to die case that the 9th Circuit Court or any other federal court of appeals has ever decided.

On the East Coast, in Quill v. Vacco, 80 F.3d 716 (2nd Cir. (N.Y.) April 2, 1996), the 2nd Circuit Court ruled that two New York statutes penalizing assistance in suicide violated the equal protection clause of 14th Amendment of the U.S. Constitution. The action giving rise to this appeal was commenced by a complaint filed by three physicians and three individuals then in the final stages of terminal illness (a 76-year-old retired physical education instructor who was dying of thyroid cancer, a 48-year-old publishing executive suffering from AIDS and a 28-year-old former fashion editor under treatment for AIDS). Each of these plaintiffs alleged that she or he had been advised and understood that she or he was in the terminal stage of a terminal illness and that there was no chance of recovery. Each sought to hasten death "in a certain and humane manner" and for that purpose sought "necessary medical assistance in the form of medications prescribed by (her or his) physician to be self-administered."

The physician plaintiffs alleged that they encountered, in the course of their medical practices, "mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life." Many of these patients apparently "experience chronic, intractable pain and/or intolerable suffering" and seek to hasten their deaths for those reasons. Each of the physician plaintiffs has alleged that "under certain circumstances it would be consistent with the standards of (his) medical practice" to assist in hastening

---

* William S. Richardson School of Law
University of Hawaii Elder Law Program
2515 Dole Street
Honolulu, Hawaii 96822
Ph (808) 956-6785
Fax (808) 956-9439

This article will provide information about the current legal status of the right of a person to request physician-assisted suicide. It will provide a background on two appellate court cases which dealt with this issue and the significance of the U.S. Supreme Court's intervention.
death by prescribing drugs for patients to self-administer for that purpose. The physicians alleged that they were unable to exercise their best professional judgment to prescribe the requested drugs. The other plaintiffs alleged that they were unable to receive the requested drugs, because of the prohibitions contained in sections of the New York Penal Law. All plaintiffs were residents of New York.

In Quill v. Vacco, the 2nd Circuit held that the New York statutes criminalizing assisted suicide violated the Equal Protection Clause of the Federal Constitution because, to the extent they prohibited a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they were not rationally related to any legitimate state interest. In this case the court did not find that assisted suicide is a constitutional right. Rather it found that the New York law failed to uphold the constitutional guarantee of equal protection of the law. Patients on life-support equipment are allowed to hasten their deaths by instructing their physicians to withdraw or withhold life-sustaining treatment but patients desiring lethal doses of medication to hasten their deaths are denied that right. In its decision the court stated: “What interest can a state possibly have in requiring the prolongation of life that is all but ended? And what business is it of the state...to interfere with a mentally competent patient’s right to define (his) own concept of existence, of meaning, of the universe, and of the mystery of human life?”

Just when it seemed that the medical and legal communities had exhausted their respective predictions on what would happen next, the U.S. Supreme Court did what nobody seems to have predicted. First, Associate Supreme Court Justice Sandra Day O’Connor temporarily blocked the 9th Circuit Court’s ruling that struck down Washington state’s ban on physician-assisted suicide. Justice O’Connor’s order was to remain in effect until her further order or a subsequent order of the U.S. Supreme Court or at least until all briefs related to an expected appeal to the full U.S. Supreme Court had to be submitted. Then, in what would be called Washington, et al.,applicants, v.Harold Glucksberg, et al.No. A-974, the Supreme Court of the United States on June 10, 1996 issued the following unusual subsequent stay:

Application for stay of issuance of mandate of the United States Court of Appeals for the Ninth Circuit, case No. 94-35534, issued on May 29, 1996, presented to Justice O’Connor and by her referred to the Court is granted pending a timely filing and disposition by this Court of a petition for writ of certiorari. Should the petition for a writ of certiorari be denied, this stay terminates automatically. In the event the petition for a writ of certiorari is granted, this stay shall continue pending the sending down of the judgment of this Court.

In October the court decided to grant Certiorari. Clearly, we are in a new environment when it comes to dealing with the issues of self-determination, death and dying with dignity. Ultimately, the issue of physician-assisted suicide will be decided by the United States Supreme Court. The Supreme Court may be interested in consistency in dealing with this issue or it may leave the issue to be decided by the respective states. Whether the decisions are permitted to stand or not, many questions must still be resolved. If it is permitted, will physician-assisted suicide be limited to terminally ill patients? If so, who will decide whether a person is terminally ill and how will the term be defined? Who will determine if a person is of sound mind and not, for example, clinically depressed? Who determines if a person is making a request voluntarily and whether the person is “competent” to make decisions? What are the limits, if any, to a person’s right to self-determination—to refuse unwanted treatment or to seek relief from pain or to commit suicide? May a person designate a surrogate to carry out his or her decisions? What safeguards will patients have and what standards will medical personnel need to follow, if any? What interests do the states have in this area?

Until we get more guidance from the court, the dilemma of how to approach physician-assisted suicide will continue to face the medical profession. Even after the courts have ruled, guidelines will have to be established to reflect a new environment with respect to self-determination, death and dying with dignity. In seeking to regulate what may appear to be unregulated, a multi-disciplinary approach will serve to protect the legal interests of the entire community while taking into consideration important medical, religious, moral and ethical concerns. While lawyers may not seem to be the most likely profession to deal with medical matters of life and death, fundamental constitutional interests and legal protections are involved. The medical profession may have no choice but to include the legal profession, along with legislatures and others concerned with the welfare of our community in addressing these grave issues. Lawyers should be seen as assisting physicians to assist their patients with decisions about their own lives.

Editor’s Note:

James H. Pietsch, JD, is the Director of the University of Hawaii Elder Law Program (U.H.E.L.P.) and Associate Professor of Law at the U.H. William S. Richardson School of Law. He received his B.A. at Georgetown University and Juris Doctor degree at the Catholic University of America in Washington, DC. He is very active in our University, serving on the Council on Aging, the Center on the Family Advisory Committee and the Committee on Human Studies.

Jim is also a very active member of Ah Quan McElrath’s Ad Hoc Committee on Death with Dignity. Thank you, Jim, for reviewing the complicated legal aspects involved with “lethal aid.”

The issue of Death with Dignity is the ultimate example of medical teamwork—not just physicians, but attorneys, legislators, the clergy, social workers, family members and the general public must work together to develop sensible and compassion-ate guidelines for those who need our help when they cannot help themselves.
St. Francis Hospice: Medicare and Health Care Reform

Michael A. Warren RN, BSN, MA

The St. Francis Hospice Program is symbolic of more than 100 years of Franciscan dedication to the people of Hawaii. Since Mother Marianne’s arrival in November of 1883, the Sisters of the Third Franciscan Order Syracuse, New York have responded to the calling; “the charity of Christ impels us.” It is through this calling that care and comfort for the terminally ill is a part of the mission of St. Francis Healthcare System. The magnificent spirit through which Hospice services have been made possible, is a reflection of God’s great generosity to us throughout the years.

Background

Originally, hospice was a medieval name for a way-station for weary travelers, where they could be cared for, replenished, and refreshed. In 1967, Dame Cicely Saunders MD, founded the first modern day hospice, St. Christopher’s Hospice in England. The mission of St. Christopher’s Hospice was to use palliative care as a focus in providing for pain and symptom management. Comfort care was to be focused on the patient and family, thus providing dignity at the end of life.

Historically, dying had been a natural process in which families, friends and care givers were intimately involved. In previous centuries, the majority of people died in their homes. However, advances in modern technology extended the dying process far beyond the normal limits of the body. Until recently, more than 90 percent of deaths were occurring in the hospitals and other institutional settings. In the 70’s and 80’s, the impetus for the development of hospices grew out of the recognition that the needs of terminally ill patients and their families were not being met effectively, by the existing health care system, and of the need to reduce medical costs, which often skyrocketed during this period.1

In 1974, the first hospice in the United States was begun in New Haven, Connecticut. Today, there are over 2,700 hospices located throughout the United States. Here in Hawaii, there are eight hospices:

1) St. Francis Hospice - Oahu
2) Hospice Hawaii - Oahu
3) Hospice of Hilo - Hawaii
4) Hospice of Kona - Hawaii
5) North Hawaii Hospice - Hawaii
6) Ka Ea Hou Mahelona Hospice - Kauai
7) Kauai Hospice - Kauai
8) Hospice Maui - Maui

Today, the term hospice is used to describe a program that assists terminally ill patients and their loved ones, in facing impending death with dignity and meaning. Hospice care focuses primarily on the care of the patient and family and not on the disease and its treatment. At the point in which a terminally ill patient and his/her family chooses hospice care, it becomes more than just philosophy or theory. Rather, it becomes a unique approach in providing care for both the patient and family, either at home or in an inpatient facility.

Terminal cancer is the leading diagnosis of hospice patients. Approximately a sixth of our patients have diseases other than cancer, including ALS (Lou Gehrig’s Disease), Alzheimer’s Disease, Chronic Lung Disease, Parkinson’s Disease, Chronic Kidney Failure, AIDS, and End Stage Heart Disease.

St. Francis Hospice

St. Francis Hospice was begun in 1978 and is today the oldest and largest hospice program in the state, with an average daily census of 70 -75 patients. This program supports families and other care givers by providing skilled assistance in the home, which allows patients to remain with their loved ones, rather than be institutionalized in an acute care facility for the final months of their lives.

St. Francis Hospice provides a choice to the terminally ill patient for whom the traditional medical approach may no longer be appropriate. The hospice philosophy emphasizes palliative care rather than curative treatment, and has developed in response to growing concerns that medical care, with its technological emphasis, has become increasingly insensitive to the needs of terminally ill patients and their families.

Although we continued to focus and promote hospice home care services, it soon became apparent that as the population of patients grew in the home setting, so too, would the need for a hospice inpatient setting grow. Thus it was that the St. Francis Hospice - The Sister Maureen Keleher Center, a 12-bed inpatient facility was opened in 1988. This facility provided a home like setting for both the patient and family, where the acute care needs and the respite needs of the patient and their family could be met.

As the aged population continues to increase, so does the terminally ill population. This particular population requires more health care, as well as supportive care. Many cannot rely on their children for care and support. The very old have children who are also old and in today’s society children, because of economics tend to be engaged full time in the work force, leaving no one at home to tend to the terminally ill. Those who are able to help at home, often find that the nursing care needs are so skilled and demanding that the only alternative is taking their loved one back to the emergency room or to an acute hospital. Recognizing both the current and the future needs, a 24-bed hospice inpatient facility, St. Francis Hospice - EWA, is being built in order to meet the hospice needs of the West Oahu population.

St. Francis Hospice provides a comprehensive medical/social model of providing care for terminally ill patients experiencing a life limiting and irreversible disease. An interdisciplinary team approach aimed at controlling physical, emotional, spiritual, and social pain affords the patient the opportunity for reconciliation and life fulfillment. The following bundle of services are included in the
Medicare Hospice Benefit

In 1982, the Medicare Hospice Benefit was first funded through the Tax Equity and Fiscal Responsibility Act (TEFRA). Through the Consolidated Omnibus Budget Reconciliation Act of 1985, the benefit became a permanent part of the Medicare program. Certified hospice providers are payed a per diem payment based on four defined levels of care: Routine Home Care, Inpatient Respite Care, General/Acute Inpatient Care, and Continuous Home Care. Patients may elect hospice care but must meet the following criteria:

- Medicare Part-A eligibility,
- voluntary election of the hospice benefit, and
- physician certification of an anticipated prognosis of less than six months.

Patients who elect their hospice benefit continue to receive services for other diagnoses unrelated to the terminal illness. Medicare uses the hospice benefit as a mechanism to transfer care/care management and cost risk to the hospice organization. While Medicare pays the per diem rates, the hospice is responsible for providing the services needed by the patient. The following is taken from a hospice article written by Lubash and Dunn:

The per diem reimbursement provides incentive for the hospice organization to manage costs by minimizing the use of acute and inpatient facilities, maximizing the contribution of available family members and other volunteers, and negotiating prices with all providers.

The Medicare Hospice Benefit covers the full cost of standard hospice services in the home. Many other forms of insurance reimburse all or part of the cost of hospice care. In the event the patient is not insured and the cost of care causes family hardships, hospice services will be provided, based on sliding-scale eligibility. Table 1 gives a comparison of the Hospice Medicare Benefit and Standard Medicare Coverage.

How patients gain the most from the Medicare Hospice Benefit:

- It eliminates the financial strain of costly drugs.
- It gives the hospice interdisciplinary team freedom to make more frequent visits when needed.
- It eliminates the financial burden of medical equipment.
- It allows the family respite care when a break is needed.
- Bereavement services are provided for up to one year after the death of the patient.

Health Care Reform

The need to control the rising cost of health care is a key element in health care reform. Studies have demonstrated that hospice care reduces the cost of insurance and private costs in the terminal phase. Hospice changes the focus of care from aggressive, curative treatment and technology to palliative intervention. This shift in focus results in substantial cost savings, a key element in health care reform. Shifting the focus results in substantial cost savings because of the use of managed care, lower use of costly technology and the absence of acute hospitalizations of a dying patient as compared to those who are not receiving hospice care.

Table 1. Comparison of the Hospice Medicare Benefit and Standard Medicare Coverage.1

<table>
<thead>
<tr>
<th>Hospice Services</th>
<th>Medicare Hospice Coverage</th>
<th>Standard Medicare Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy/Drugs</td>
<td>95-100%</td>
<td>0</td>
</tr>
<tr>
<td>Inpatient Respite</td>
<td>5 days</td>
<td>0</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Intermittent Nursing</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>services</td>
<td>Unlimited period</td>
<td>Coverage only while</td>
</tr>
<tr>
<td></td>
<td>regardless of level of care</td>
<td>strictly defined skilled</td>
</tr>
<tr>
<td></td>
<td></td>
<td>nursing care is required</td>
</tr>
<tr>
<td>Extended Nursing visits</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>Intermittent home</td>
<td>Same as coverage of</td>
<td>Same as coverage of</td>
</tr>
<tr>
<td>health aide visits</td>
<td>nursing services</td>
<td>nursing services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended home</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>health aide visits**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>(In hospice inpatient or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>contracted hospital)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bereavement</td>
<td>100%</td>
<td>0</td>
</tr>
</tbody>
</table>

**Extended visits are longer than regular visits

Hospice care currently is available to many, but not all terminally ill patients. In Hawaii, hospice care is available to all Medicare and Medicaid Beneficiaries, through most Health Maintenance Plans (HMOs), such as Kaiser and Hawaii Medical Service Association (HMSA), and through a growing number of private insurance plans.

Under both Federal and State Health Care Reform proposals, it will be essential that hospice care be included in the basic benefit plan. Rather than waiting for some direction to emanate from Washington in the form of health care reform, St. Francis Hospice is taking a pro-active role to embrace these uncertainties and to work towards defining the role of hospice in the future.

Although anxiety about health care reform is very high, hospices are finding themselves extremely well positioned as a viable alternative to acute hospital care. St. Francis Hospice finds itself growing as its target population, the elderly, increases and as hospice services become more acceptable as a viable health care alternative. St. Francis Hospice continues to take strides towards helping more terminally ill patients and their families achieve quality of life during the last six months of life; a viable alternative to the very controversial 'physician assisted suicide' as advocated by Dr. Jack Kevorkian. By reducing the overall cost in health care, we also become a major player in health care reform.

References

1. Warren M. Attitudes of Family Members Toward Hospice Care of the Terminally Ill; research project, University of Phoenix, 1985.
Life and Death in Hawaii: Ethnic Variations in Life Expectancy and Mortality, 1980 and 1990

Kathryn L. Braun DrPH*, Haiou Yang PhD**, Alvin T. Onaka PhD***, Brian Y. Horiuchi MPH****

Life expectancy in Hawaii is among the highest in the nation. Past research, however, found significant ethnic differences in longevity. This study presents life expectancy estimations for 1980 and 1990, along with ethnic differences in mortality rates for specific causes of death. The findings suggest that ethnic differences continue, with Chinese and Japanese having the longest life expectancy and Native Hawaiians having the shortest.

Introduction

Past research found significant differences in life expectancy and mortality rates among Hawaii's major ethnic groups.1,7 To what extent do these differences exist today? To address this question, this paper presents updated life expectancy and mortality rate estimates by gender for the five major ethnic groups in Hawaii—Caucasians, Chinese, Filipinos, Japanese, and Native Hawaiians (full and part Hawaiian). Based on Department of Health statistics, of the state's 1990 population of 1,108,229, about 208,653 (19%) were Native Hawaiian, 285,524 (26%) were Caucasian, 259,465 (23%) were Japanese, 161,063 (15%) were Filipino, and 67,386 (6%) were Chinese.8

Ethnic differences in health status has been a long-standing concern of local researchers. Focusing on life expectancy, Park, Gardner, and Nordyke presented life tables by ethnicity over the century.4 While they found that life expectancy for the total population of Hawaii had improved from 45.69 years in 1920 to 74.20 years in 1970, they also found ethnic differences at each time point. In 1920, for example, Caucasians had the longest life expectancy (56.45 years), followed by Chinese (53.80 years), Japanese (50.54 years), Hawaiians (33.56 years), and Filipinos (29.12 years). By 1970, the pattern had changed, with the longest life expectancy seen among Japanese (77.44 years), followed by Chinese (76.11 years), Caucasians (73.24 years), Filipinos (72.61 years), and Hawaiians (67.62 years).4 In 1984, Gardner constructed life tables based on 1980 data, finding that life expectancy was still longest for Japanese and Chinese and shortest for Native Hawaiians.6

Among published reports of ethnic variation in mortality rates, a good overview of the 1980-1986 data was provided by Johnson.7 It showed a remarkable similarity in leading causes of death across ethnic groups, i.e., for all five major ethnic groups, heart disease was the leading cause of death, cancer was the second, and cerebrovascular disease (CVD) was the third. For all groups, accidents, influenza/pneumonia, and diabetes appeared as either fourth, fifth, or sixth leading cause of death. Cross-ethnic comparison of these mortality rates showed that individuals with Hawaiian ancestry had the highest overall death rates, as well as the highest death rates for the major causes of death.7 Focusing specifically on Native Hawaiian mortality across the century, a 1982 study by Look found significantly higher mortality rates among full Hawaiians compared to part Hawaiians and to the general population.9

This paper presents a summary of the life expectancy estimates and age-standardized mortality rates for the five major ethnic groups in Hawaii. These findings are from a program of research being undertaken by the authors and associated researchers to expand and update work in comparative mortality and longevity in Hawaii. Our earlier work updated the 1982 Look study, finding that 1990 mortality rates were still significantly higher among full and part Hawaiians compared to non-Hawaiians.10,12

Methods

This paper reports findings of two studies, one of comparative longevity and another of comparative mortality rates. In both studies, mortality rates were estimated by dividing the number of deaths by the population at risk for each age-gender-ethnic category. In estimating mortality rates, the death data were derived from vital records maintained by the Department of Health. Population estimates were based on Hawaii Health Survey estimates, as adjusted by the Cancer Research Center of Hawaii,13-14 rather than on U.S. Census estimates. These two data sources differ in their classification of ethnicity, resulting in the enumeration of 30% fewer Native Hawaiians by the U.S. Census compared to the Hawaii Health Survey in 1990. Because the ethnicity classification procedure of the Hawaii Health Survey more closely matches that of the death record, we consider the Hawaii Health Survey the better of the
two sources of population data.

In the comparative life expectancy study, age-gender-ethnic-specific mortality rates were estimated and used to construct life tables. The life table procedure generates a measure of life expectancy, denoting the average number of years that would be lived by members of a newly born group given the current age-gender-ethnic-specific mortality rates. In order to compare findings of this research with previous studies, we followed the technique used in Gardner’s 1984 publication with some modifications (e.g., longer life expectancy overall allowed us to use age 85+ as the terminal age category, rather than age 75+, in our calculations). Because of this, we recomputed the 1980 life tables using the modified method. While this provides a set of 1980 findings with which to compare our 1990 findings, it also means that our 1980 results differ slightly from the 1980 findings published by Gardner. A full description of the modified methodology is presented elsewhere.15

In the comparative mortality study, 1980 and 1990 mortality rates were estimated for specific age-gender-ethnic categories by major causes of death. Because of small numbers of deaths in some cells, rates were based on data from 5 years around each decade. (In contrast, rates estimated in the life expectancy study were based on data from 3.5 years around the decade, as done by Gardner). This “averaging” procedure is necessary to help smooth fluctuations of deaths that occur year-to-year. Rates were standardized to the 1940 U.S. population using the indirect method and 95% confidence intervals were estimated using a method developed by Mantel.16-17

While our study produced age-gender-ethnic-specific mortality rates, presented here are mortality rates and 95% confidence intervals by gender and ethnicity only.

Findings
Life Expectancy
Life Expectancy over the Century. Table 1 shows findings from our life expectancy study (1980 and 1990), combined with findings of Park, Gardner, and Nordyke (1920-1970).4 These data indicate that, overall, life expectancy in Hawaii has improved tremendously over the century, from 45.69 years in 1920 to 78.85 years in 1990.

<table>
<thead>
<tr>
<th>Period</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920*</td>
<td>45.69</td>
<td>45.64</td>
<td>45.75</td>
</tr>
<tr>
<td>1930*</td>
<td>53.95</td>
<td>52.70</td>
<td>55.86</td>
</tr>
<tr>
<td>1940*</td>
<td>62.00</td>
<td>59.92</td>
<td>64.86</td>
</tr>
<tr>
<td>1950*</td>
<td>69.53</td>
<td>67.77</td>
<td>71.67</td>
</tr>
<tr>
<td>1960*</td>
<td>72.42</td>
<td>70.29</td>
<td>74.75</td>
</tr>
<tr>
<td>1970*</td>
<td>74.20</td>
<td>72.12</td>
<td>76.44</td>
</tr>
<tr>
<td>1980*</td>
<td>77.87</td>
<td>74.54</td>
<td>81.51</td>
</tr>
<tr>
<td>1990*</td>
<td>78.85</td>
<td>75.90</td>
<td>82.06</td>
</tr>
</tbody>
</table>

* Park, Gardner, & Nordyke (1979)
** Yang, Braun, Onaka, & Horluchi (1996)

While dramatic improvements occurred earlier in the century, improvements between 1980 and 1990 were also noted. Specifically, Hawaii’s life expectancy in 1990 (78.85 years) was almost a full year longer than in 1980 (77.87 years). The improvement in life expectancy at birth between 1980 and 1990 was greater for males (from 74.54 to 75.90 years, a gain of 1.36 years) than for females (from 81.51 to 82.06 years, a gain of .55 years). The difference in life expectancy between men and women, which became apparent in 1930, is still evident in the 1990 data, with females “outliving” males by 6.16 years.

Life Expectancy by Ethnicity. As shown in Table 2, ethnic variations in longevity continued to exist in 1980 and 1990. Specifically, the 1990 life expectancy was 82.93 years for Chinese, 82.06 years for Japanese, 78.94 years for Filipinos, 75.53 years for Caucasians, and 74.27 years for Native Hawaiians. Although ethnic difference still exist, looking across the century (see Figure 1) suggests that life expectancy among the ethnic groups is continuing to converge. In fact, while the 1920 discrepancy between the longest and shortest lived groups was 28 years, the 1950 discrepancy was only 10 years, and the 1990 discrepancy was only 8.7 years (Table 2).

| Table 2.—Life Expectancy by Birth by Gender and Ethnic Group, 1980 and 1990, State of Hawaii |
|-----------------------------------------------|------|------|------|
| Ethnicity       | Total | Male | Female |
| Caucasian       | 1980  | 75.79 | 72.80 | 79.28 |
|                 | 1990  | 75.53 | 72.90 | 78.60 |
| Chinese         | 1980  | 81.65 | 78.91 | 84.51 |
|                 | 1990  | 82.93 | 79.76 | 86.11 |
| Filipino        | 1980  | 79.32 | 76.61 | 83.36 |
|                 | 1990  | 78.94 | 77.63 | 81.51 |
| Japanese        | 1980  | 80.91 | 77.75 | 84.09 |
|                 | 1990  | 82.06 | 79.49 | 84.49 |
| Native Hawaiian | 1980  | 71.83 | 68.18 | 75.63 |
|                 | 1990  | 74.27 | 71.48 | 77.20 |

Fig 1.—Expectancy at Birth by Ethnicity, 1920-1990, State of Hawaii

The gender differential is also apparent by ethnicity. Looking at the 1990 data, for example, the gender difference is most pronounced among Chinese (with women living 6.35 years longer than men) and least pronounced among Filipinos (with women living 3.88 years longer than men). The life expectancy for Hawaiian males (71.48 years) is the lowest among all groups.

The changes in life expectancy between 1980 and 1990 were not
consistent across gender-ethnic groups. Looking by gender, it appears that males made more gains than females between 1980 and 1990. For example, Native Hawaiian men gained 3.30 years compared to 1.57 years for Native Hawaiian women. Japanese men gained 1.74 years while Japanese women gained only 0.40 years. Filipino men gained 1.02 years while Filipino women lost 1.85 years. Caucasian men gained 0.10 years while Caucasian women lost 0.68 years. The exception is among Chinese, with women gaining 1.60 years compared to 0.85 years for men.

Comparative Mortality

Leading Causes of Death. Table 3 shows the top ten causes of death by gender and ethnicity. Heart disease, malignant neoplasms, and cerebrovascular disease (CVD) were the top three causes of death in 1990, regardless of ethnicity or gender, except for Caucasian males, for whom HIV was the third leading cause of death and CVD was the fourth. In contrast to the 1980 data, cancer (rather than heart disease) was the leading cause of death for females in all ethnic groups except Native Hawaiians in 1990.

The next three leading causes of death differed by ethnic group. Ranked as either fourth, fifth, or sixth leading cause of death were: diabetes (for Native Hawaiians and for Filipino and Japanese females); motor vehicle accidents (for Chinese and Filipinos and for Caucasian females and Native Hawaiian males); suicide (for Caucasian, Filipino, and Japanese males and for Chinese females); COPD (for Caucasians, Japanese, and Native Hawaiian females); influenza/pneumonia (for females in all groups and for Chinese and Japanese males); and other accidents (for Chinese, Filipino, and Native Hawaiian males). This is in contrast to Johnson’s 1980 finding that the second three leading causes of death were the same across ethnic groups—accidents, diabetes, and influenza/pneumonia.

Table 4 ranks 1990 age-adjusted mortality rates across the five ethnic groups. It shows that, of the five groups, Native Hawaiians had the highest mortality rates for heart disease, cancer, MVA, other accidents, and diabetes. Caucasians had the highest mortality rates for HIV, Suicide, COPD, and influenza/pneumonia. Filipinos tended to have intermediate rates compared to the other groups. Overall, Chinese and Japanese had the lowest mortality rates of the five ethnic groups with a few exceptions: Chinese females ranked second in age-adjusted rates of suicide for women; Chinese males ranked second highest in death from diabetes among males; Filipino men led in CVD deaths; and Japanese ranked relatively high in death from influenza/pneumonia. The actual age-standardized mortality rates for all causes of death and for death from heart disease and cancer are provided below.

Figures 2-11 display the mortality rates for the leading causes of death for each gender-ethnic group. Even-numbered figures show rates for males while odd-numbered figures show rates for females. The scale is constant across graphs so that the relative magnitude of mortality rates can be assessed at a glance. The exception is for Native Hawaiians (Figures 10 and 11) whose exceptionally high mortality rates for heart disease necessitate a different scale.

continued on next page
Fig 3.—Mortality rates per 100,000 Population for Top Ten Causes of Death for Caucasian Females, State of Hawaii

Fig 4.—Mortality rates per 100,000 Population for Top Ten Causes of Death for Chinese Males, State of Hawaii

Fig 5.—Mortality rates per 100,000 Population for Top Ten Causes of Death for Chinese Females, State of Hawaii

Fig 6.—Mortality rates per 100,000 Population for Top Ten Causes of Death for Filipino Males, State of Hawaii

Fig 7.—Mortality rates per 100,000 Population for Top Ten Causes of Death for Filipino Females, State of Hawaii

Fig 8.—Mortality rates per 100,000 Population for Top Ten Causes of Death for Japanese Males, State of Hawaii
Mortality Rates for Heart Disease, Cancer, and all Causes of Death. Although not shown in the tables, we tested the inter-ethnic differences in mortality for statistical significance by estimating each mortality rate's 95 percent confidence intervals and checking for overlapping intervals. (Where intervals do not overlap, the differences in mortality rates are significant.) Using this method, we found that the all-cause mortality rates for males were significantly higher than for females within each ethnic group in both decades. Within gender categories, mortality rates for Native Hawaiians were significantly higher than for all other ethnic groups. In addition, Caucasian mortality rates were significantly lower than Native Hawaiian mortality rates but significantly higher than Chinese, Filipino, and Japanese rates.

The same pattern appeared for heart disease, i.e., male mortality rates were significantly higher than female rates within each ethnic group and, within gender categories, Caucasian rates were significantly lower than Native Hawaiian rates but significantly higher than the Chinese, Filipino, and Japanese rates. A different pattern emerged for cancer mortality. Here, the gender differential appeared only among Japanese, with significantly higher cancer mortality rates for Japanese males than Japanese females. Within gender categories, the difference in rates between Caucasians and Native Hawaiians was not significant; however, rates for both of these groups were significantly higher than for Chinese, Filipinos, and Japanese.

Discussion

The life expectancy findings suggest that ethnic differences in longevity continued to exist in 1990, with Japanese and Chinese having the longest life expectancy and Native Hawaiians having the shortest. Of particular interest is the relative ranking of the Filipino group; while they had the shortest life expectancy in 1920 and the second shortest from 1930 to 1970, they ranked third longest in life expectancy in 1990, behind Chinese and Japanese. Gender differences in life expectancy also continued, with women outliving men in every ethnic group.

Although life expectancy among ethnic groups continued to show convergence, differences were still apparent. The obvious question is “why the differences?” To test the possible explanatory value of “cause of death,” this paper includes findings from our mortality study, which also showed ethnic differences. As expected from the longevity study, the three Asian-American groups—Chinese, Filipino, and Japanese—had significantly lower overall mortality rates than did Caucasians and Native Hawaiians in 1980 and 1990.

Unexpectedly, differences were also seen among the groups in leading causes of death. For the first time, HIV was among the top three causes of death (for Caucasian males), COPD and suicide were among the top six causes of death (COPD for Caucasians and Japanese, and for Native Hawaiian females; suicide for Caucasian, Filipino, and Japanese males and for Chinese females). Certainly, lowering mortality from HIV would increase life expectancy for Caucasians, for example, as the HIV deaths were among individuals age 25 to 54 (not shown in tables). It is doubtful, however, that differences in causes of death explain much of the variance in life expectancy because, overall, heart disease, cancer, and cerebrovascular disease still account for between 60 and 70 percent of the deaths for all of the gender-ethnic groups (not shown in tables).
A laundry list of other factors have been shown to influence longevity and health status, including genetic predisposition to certain diseases, residency, individual diet and exercise patterns, individual socio-economic status, exposure to environmental hazards, and the general condition of society (e.g., its infrastructure for water, sanitation, and education). While there are some genetically-linked diseases among certain ethnic groups (e.g., sickle cell anemia among individuals of African ancestry), not much is known about genetic susceptibility to disease among Asians and Pacific Islanders. Studies of heart disease, however, have found that residence plays a role in longevity and disease. For example, 1990 life tables from Japan suggest that Japanese Americans in Hawaii have longer life expectancy than Japanese nationals in Japan. On the other hand, investigators have found that Japanese residing in California have higher rates of heart disease than Japanese residing in Hawaii who, in turn, have higher rates of heart disease than Japanese in Japan. This finding supports the lifestyle origin of disease, as the diets of these immigrants have become more western as they moved from Japan to Hawaii to California. Ethnic differences in lifestyle have also been documented in Hawaii. For example, data from the state’s Behavior Risk Factor Survey suggest that Native Hawaiians have the highest rates of obesity and smoking, that Native Hawaiians and Caucasians have the highest rates of binge and chronic drinking, and that Caucasians have the highest rates of driving and driving of all ethnic groups. In terms of socio-economic status, federal and state publications include data that suggest that Native Hawaiians are socio-economically disadvantaged compared to other groups (e.g., they have lower income and less education and are more likely to receive government assistance). In addition, Native Hawaiians are more likely to live in rural areas with less access to health services. Lack of access may help explain the fact that while overall cancer incidence is similar for Caucasians and Native Hawaiians, cancer mortality is significantly higher for Native Hawaiians, suggesting delays in the detection and treatment among Native Hawaiians. Regardless of cause, ethnic differences in mortality rates continue to exist. In addition, variation appears to be increasing among groups in terms of their leading causes of death.

In the interpretation of our findings, several methodological caveats must be considered. First, these data cannot be used to predict individual life span, which is influenced by one’s personal genetics, lifestyle, and environment. These data are based on current age-gender-ethnic-specific mortality rates to give an estimate of the average longevity of a specific gender-ethnic group who was born in 1990. Life expectancy estimates are useful, however, in that they provide information about the population at large which is critical for projecting population growth, determining service needs for a population, and allocating resources. For example, these data suggest that health programs that reduce the incidence of HIV, accidents, and suicide and programs that target Native Hawaiians may help lower mortality and improve life expectancy for the state as a whole.

Second, caveats concern data comparability. In the life expectancy study, we modified the method used by Gardner because we had better data available to us. Thus, the 1980 figures that appear here will not match the 1980 figures in earlier reports of life expectancy in Hawaii. In terms of source of population data, this study used data from the Hawaii Health Survey as modified by the Cancer Research Center of Hawaii. A few studies of life expectancy and mortality have used the U.S. Census data set instead. Because the method of classifying ethnicity in the Hawaii Health Survey more closely matches the method of classifying ethnicity in the death record, we feel strongly that the Hawaii Health Survey is the preferred source of population data in studies of mortality and life expectancy. It should be noted, however, that its use results in higher estimate of life expectancy among Native Hawaiians (74.27 years vs. 67.95 years based on U.S. Census data) and a lower estimate of life expectancy for Caucasians (75.53 years vs. 78.86 years based on U.S. Census data).

In addition to the differences in the way ethnicity is classified on state and federal surveys, there are other concerns about ethnicity as a measure. For example, all coding methods still depend on individual reports of ethnic heritage, and incentives to report one’s ethnicity have changed over the century. While there were true disadvantages for reporting Hawaiian ancestry for much of the century, growing tolerance of diversity, local sovereignty movements, and programs that give Hawaiians increased access to education and help have changed that. With high inter-marriage rates in the state (about 40%), classification by ethnicity will become even less clear. Finally, the variable “ethnicity” is confounded by socio-economic status; because U.S. data sets rarely include a standard measure of socio-economic status, ethnicity is often used as a proxy. Future research by the authors is proposed that will examine socio-economic status as a predictor of longevity in Hawaii.

Caveats aside, this paper presents the updated life expectancy estimates, by gender, for the five major ethnic groups in Hawaii. These data suggest that: 1) life expectancy in Hawaii increased by almost a year between 1980 and 1990; 2) women continue to have longer life expectancy than men (regardless of ethnicity); 3) the Chinese, Japanese, and Filipino populations have longer life expectancies than do the Caucasian and Native Hawaiian populations in Hawaii; 4) while the leading causes of death in 1990 were still heart disease and cancer, cancer became the leading cause of death for non-Hawaiian females; and 5) Native Hawaiians have the highest age-adjusted mortality rates overall and for heart disease, cancer, MVA, other accidents, and diabetes. While overall improvement in life expectancy continues, ethnic differences in health status remain.

Acknowledgements

Acknowledgments are tendered to funders of this program of research, including the Hawaii Department of Health, the Queen’s Health Systems, the Straub Foundation, and the University of Hawaii Office of Research Administration. Thanks also to the staff of the Office of Health Status Monitoring at the Department of Health and the Cancer Research Center of Hawaii for providing access to the necessary data, to Carol Matsumiya and Kim Sugawa-Fujinaga for their editorial assistance, and to Virgina Tanji, MSLS for her assistance with the literature review.

References

Models of Physician-Assisted Dying

Faye Girsh EdD
Executive Director, Hemlock Society USA

Repeated surveys have shown that more than 70% of Americans support physician aid in dying for terminally ill mentally competent adults. Recent polls of physicians in Oregon and Michigan demonstrate majority support of those doctors for such a law while 25% of physicians surveyed in Washington admitted to already providing help. Models of how that would work have been spelled out in proposed legislation in the United States since 1988, other models come from the Northern Territory in Australia, and from Holland, and from Jack Kevalik’s writing and actions as well as from other writers such as Dr. Timothy Quill.

In this article I will review some of the main features of these models in an effort to find common elements. In July the U.S. Supreme Court will decide on the constitutionality of this issue; it is likely they will turn it back to the states or the voters to develop guidelines. It is, therefore, helpful to examine the elements that could be included in future proposals.

Holland, of course, is the oldest model having evolved over 23 years of judicial guidelines. The scope of assisted dying is not limited to the terminally ill but includes hopelessly ill people, a tiny minority of whom have had psychiatric conditions which they and their doctors see as hopeless. A small number of patients who received help were not competent and the assistance was provided at the request of the family or on a decision by the physician who had known the patient’s wishes. Usually the patient is mentally competent. Assistance is sometimes provided to minors.

Doctors will not be prosecuted if they observe the following guidelines:

1. The request must come from the patient; it must be made freely and voluntarily
2. The request must be well-informed and considered
3. The request must have been made over a period of time
4. The patient must experience unacceptable and hopeless suffering which cannot be satisfactorily relieved
5. The doctor must consult with a second doctor to confirm the decision
6. Only a doctor can assist and must be present

The method is either through lethal injection or a lethal dose of medication self-administered; the death usually occurs at home. The doctor is present as is the family and often a nurse and a clergyman. In the hospital a team of two doctors, a nurse, and a spiritual caregiver evaluate the request.

Doctors report the death to the local medical examiner with comprehensive details covered in a 60 item questionnaire. The coroner views the body, verifies the facts and files a report to the public prosecutor. An investigation occurs if the guidelines do not appear to have been followed, which is relatively rare. Not every request is honored; the Members Aid Society of the Dutch Voluntary Euthanasia Society helps match patients with doctors when there is no help available.

Palliative care is integrated into the delivery of health care generally. Dr. Peter Admiraal, a noted Dutch physician who has been assisting patients in a Delft hospital since 1973, notes that to “fail to practice voluntary euthanasia under some circumstances is to fail the patient.” He regards it as “the last dignified act of terminal care.” The majority of the Dutch population supports the practice although it is not governed by an actual law.

The Northern Territory in Australia is the only jurisdiction in the world in which physician aid is dying occurs under a law, the Rights of the Terminally Ill Act, which went into effect July 1, 1996. The first person in the world to die using voluntary euthanasia legislation was Bob Dent, a 66 year old prostate cancer patient who was helped to die at his home by Dr. Philip Nitschke on September 21 with Mrs. Dent present.

Terminal illness is a requirement as defined as one that will lead to death. The competent, adult patient who makes the request must have the diagnosis and prognosis confirmed by the treating physician and by a specialist in the disease. In addition, there must be a psychiatric evaluation certifying the competency to make the decision and an absence of clinical depression. There is a nine-day waiting period after the initial request. Although the law does not require it, Mr. Dent died from a self-administered lethal dose of barbiturates administered by a machine invented by Dr. Nitschke. The physician inserts the IV then the patient pushes the button starting the lethal drip after answering three questions on a laptop computer. Death occurs in a few minutes.

There is an effort to rescind this law in Australia; Dr. Nitschke has had difficulty finding specialists because of the opposition of the Australian Medical Association. In a letter to members of the Australian parliament a few days before he died Mr. Dent, in describing his deteriorating condition over five years, wrote, “If I were to keep a pet animal in the same condition I am in, I would be prosecuted.” Dr. Nitschke said, “I was left with the overwhelming feeling that I had done the right thing, done something good by being able to end the suffering of this brave man.”

The Oregon Death with Dignity Bill was passed by 51% of Oregon voters in November 1994. At this writing no deaths have occurred because of an injunction issued by Judge Michael Hogan at the instigation of the National Right to Life Committee. Were it to go into effect it would apply only to terminally ill, mentally competent adults. Doctors would only be allowed to assist by prescribing a lethal dose of medication to be self-administered by the patient. Safeguards include: a written, witnessed directive; examination by an independent physician; an optional request by the treating physician for a psychological or psychiatric evaluation to determine the patient’s competence; and reporting by the hospital to the State Department of Human Resources without using the patient’s name. The doctor does not have to be present. The appeal of the judicial injunction will be heard by the 9th Circuit Court of Appeal.”
Dr Jack Kevorkian is apparently engaged in legal aid in dying in more than 40 cases since he has been acquitted three times in five deaths and is not currently being prosecuted. He has helped competent terminally and hopelessly ill adults who are suffering greatly or, in the case of his first patient, Janet Adkins, anticipate a greatly reduced quality of life and incompetence, and who make the request. There is some question about the subjective quality of the suffering in a few cases but Dr Kevorkian has not been able to use consultants and is not a treating physician.

He has used a “suicide machine” in which he puts an IV in the person’s arm then the patient her/himself actually starts the lethal medication. Since he lost his license, Kevorkian has mostly used carbon monoxide. The patient tapes an interview with Kevorkian and a family member is generally present. Recently there have been other health care professionals present and with whom Kevorkian apparently consults. In his book, Kevorkian proposes another model in which physicians are trained as obituarists; a patient could go to an obituarist in which requests are screened and medicide is administered.

A thoughtful article in the Harvard Journal of Legislation in the Winter of 1996 by nine authors proposed guidelines for a model state act to authorize and regulate physician-assisted suicide. They recommend a prescribing-only model because it accentuates the voluntariness of the patient’s decision and it would be more acceptable to the public.

Those eligible would have an incurable illness and subjectively feel that the accompanying suffering is worse than death. There should not have to be a demonstration that the suffering is unbearable. Because the person would have to be competent, someone who is clinically depressed or mentally ill would not qualify. The request must be stated to the physician on at least two occasions that are at least two weeks apart. Information is supplied to the patient in the presence of two witnesses. The physician is allowed but not required to be present at the time of death. The physician’s report is confidential and the patient’s name is not used.

The decisions of the 9th and 2nd Circuit Courts of Appeal have declared that state assisted suicide laws which prohibit doctors from helping competent terminally ill patients die by prescribing a lethal prescription of medication are unconstitutional. The Supreme Court has agreed to hear the appeals of these decisions in January, 1997, and to give an opinion in July. They may accept the constitutionality of physician aid in dying and allow the states to draft the safeguards and conditions.

These are just a few of the proposed models from the United States and elsewhere. It is now a question of what form the legalization of physician aid in dying takes and when, not if, it will be permitted. The issues are whether only terminally ill patients would be eligible, as in the Supreme Court cases, or whether it would extend to hopeless illnesses. A doctor may be able to provide direct help (voluntary euthanasia) or just give the patient the means to accomplish it (physician assisted suicide.) The Supreme Court will hear the prescribing only model. The mandatory or optional use of a mental health professional’s evaluation will probably be decided in each state’s statute. It is likely that two independent doctors will have to evaluate the patient, that there will be a witnessed written request followed by a waiting period, and that the patient will be required to be competent (at least at the time of the first, witnessed request.) In all cases participation of the doctor and the patient would be voluntary; a hospital will probably be able to refuse to have this procedure administered.

The process from a physician’s point of view is summarized by Australian urologist, Dr Rodney Syme:

Medical assistance in suicide means that the doctor assists patients with advice, and through the prescription of drugs, enables them to end their lives in a dignified way. This involves the doctor in dialogue to inform the patients of their diagnosis prognosis and treatment options. It involves ensuring that suffering in each case is significant and unalterable, that the patient is rational and not under duress, and that the request is sound and enduring....If the doctor is satisfied beyond reasonable doubt of the bona fides of the request then she or he should be able, after confirmation of the facts by a second doctor, to proceed to assistance without threat of legal sanction.

Or, to quote Dr Timothy Quill:

By exploring our hopes and fears about our own death, and by listening and learning from the stories about those who have directly faced death, we will hope to learn how to use medicine’s power judiciously to achieve two of its most important objectives: prolonging a meaningful life and humanizing the process of dying.

References

5. Humphry, D. Lawful Exit. Norris Lane Press, Junction City OR, 1993
6. The Rights of the Terminally Ill Act, Northern Territories, Australia
13. The Oregon Death with Dignity Act 1994

Editors Note:
Dr Faye Girsh is Executive Director of the Hemlock Society USA, a national right to die organization founded in 1980 and based in Denver, Colorado. Prior to accepting this position in August, 1996, she had been a clinical and forensic psychologist in private practice in San Diego for 18 years. She received her doctorate from Harvard University and was in the field of psychology for almost 30 years. Her research was cited by the U.S. Supreme Court and she has testified in ten states. She was a faculty member in the Department of Psychiatry of the University of Chicago, and chair of the Psychology Department at Morehouse College in Atlanta.

She has served on the Boards of several ACLU affiliates, was the founder and president of a nationwide professional organization Psychologists in Addictive Behavior — and is Past President of the San Diego Psychology-Law Society.

Her interest in the right to die began in 1983 she was asked to evaluate Elizabeth Bouvia — a young quadriplegic woman who wanted the right to refuse food at Riverside Hospital. In 1987 she founded and became the first president of the Hemlock Society of San Diego and editor of their Newsletter, offices she held for nine years. She has written articles on the right to die for medical, legal and psychological journals and has appeared on national TV and radio speaking on the right to die.
A View of Death and Dying Among the Chinese and Japanese

Donald F.B. Char MD*, K.S. Tom MD**, George C.K. Young***, Rev. Toshio Murakami****, Roger Ames PhD*****

The practices of medicine around the world have been fused into that of faith and religion. In serving our patients’ need to accept death, physicians must also be sensitive to this underlying basic human concern as they prepare for this final journey. The Chinese and Japanese, reflecting their belief in Buddhism, perceive death as a natural part and an extension of life itself.

The practices of medicine have been integrated with that of religion from time immemorial. The forerunner of all physicians today were the shamans, witch doctors, or medicine men of the preliterate peoples. Three civilizations developed and went on to document a sophisticated, integrated, tightly reasoned, and comprehensive system of medicine, the ancient Greeks of the West and the Indians and the Chinese of Asia. These medical concepts were inextricably bound to their native precepts of the supernatural forces ruling over their cosmos. Unable to adequately define where human rationality melds into that of faith and trust and belief in their spiritual creators, these earlier medical care systems may have been more acceptable for assisting their suffering patients to accept their limited capacity for healing. Perhaps more importantly, they could better support them in the time of their greatest crisis for coping with death.

Modern biomedicine, rooted in the breakthroughs of rational thinking led to science and technology. It has come to stand out above all other forms of medical care around the world. In extending the domain of human rationality to challenge concepts of nature itself, the mysteries of what was formerly considered to be supernatural have been revealed. Forces of secularism inevitably have arisen to challenge the role of faith and religion in the lives of humankind everywhere.

Biomedically educated and trained physicians in science and its technology have not only learned to cure many diseases that were once thought to be fatal, but have greatly contributed toward extending the lifespan for all who live within the reach of its practices.

In spite of the greatly expanded benefits that can be attributed to the accomplishments of biomedicine, it has not been free from criticism. Much controversy has arisen in many communities regarding its widespread practices. A most distressing dilemma revolves around the question of the use of life support technology for prolonging lives. Perhaps the paramount quandary for everyone involves the question of what constitutes a life of sufficient quality with deeper meaning for the individual if the life is saved but the individual remains infirmed or continues to suffer severe pain. In this problem, physicians must obviously move beyond the question of treating to merely prolong the life of the sufferer. What is the good to be achieved for the patient if the life that is saved becomes so diminished and unthinkable? Physicians are being confronted with this existential nightmare in their practices more frequently today and must learn how better to cope with these critical needs of their patients.

At present, as physicians are being reminded to consider the bodymind connections in caring for the total needs of their patients, questions about the existence of a soul, a spiritual or metaphysical nature of all human beings, are once more being openly discussed for biomedicine.

Faith and religion have always been assumed to be an important factor for coping with the pain and suffering of the patient. Over the past several decades, biomedical researchers began to study human behavior and its relationship to health and concluded that much of human illness and disease result from a person’s careless habits and unhealthy lifestyles. The initial research involved questions of excessive stress causing disease, but recently, the question of faith and religion in promoting health and well being and preventing illness has been explored.

Research in the neurosciences using the most advanced technology is producing newer conceptualizations of the brain and its involvement in consciousness, as manifested by thought, perception, feeling, will, memory, or imagination. These newer insights as to how the brain works may well pave the way toward a better understanding of the contributions of faith and belief in health and illness.

Benson, a physician researcher, claims to have uncovered a faith factor that works to heal and prevent diseases. Over two decades ago, he described the Relaxation Response, a hypometabolic physiological state of the body that resulted from a deep self-induced state of meditation. Subsequent research documented that this Relaxation Response could also be “evoked by any of a large number of techniques including meditation, certain types of prayer, autogenic training, progressive muscular relaxation, jogging, swimming, Lamaze breathing exercises, yoga, tai chi chuan, chi gong, and even knitting and crocheting.” He proposes that if this state of deep relaxation is combined with the placebo effect, the body’s intrinsic capacity to heal itself that he calls “remembered wellness”, this faith factor can be produced to heal the body. A strict, regular disciplined
practice of the Relaxation Response is necessary, whether induced by prayer, exercise, meditation or other means. A belief and abiding faith in such devoted practices may be essential for maintaining health.

Should the faith factor suggested by Benson be important for achieving and maintaining health and combating illness, it would appear to be as valid for the healing of those who are encountering severe diseases and facing death.

Hawaii is a state made up of diverse, multicultural and multiethnic communities in which many differing faiths, beliefs, and religious practices find acceptance. Unlike most other states in the union, the majority of its residents are linked to an Asian heritage. Very private and much more tolerant in their behaviors and character, they often appear to be a shy and inhibited group, rarely revealing their innermost thoughts to others. Highly disciplined and mindful of the needs of others, they are loath to speak about their personal social needs and problems, feeling that help and assistance can generally be met through personal families and kinship. It is understandable that other cultural groups in the community often know little about their traditions, habits and practices in their unique faith and religions.

The United States, rooted in Western European civilization, is built around Judeo-Christian values and faith. Too often, it is assumed that they speak for all other groups. To ensure that other faiths and beliefs systems are recognized, we hope that this cursory overview of the Chinese and Japanese in regard to their faith and beliefs and practices will sensitize physicians and others in the helping professions to approach their critical problems of sickness and dying with fuller and deeper compassion for their unique needs. We may be addressing these problems too simplistically, and although we are listing some of the sources of our information we suggest that there are much more detailed and scholarly writings on these subjects.

We hope that others more knowledgeable about different ethnic-cultural groups will join us in sharing their unique viewpoints and practices for these critical medical problems.

The Chinese

The first Chinese arrived in Hawaii more than 200 years ago, but it was not until the latter half of the 19th century that they came in significantly large numbers. Predominantly from the poor farming villages of the Kwangtung Province along the coastal areas of Southeast China, they came to seek their fortunes in the land known to them as the Sandalwood Mountains.

It is this Chinese cultural legacy and hardy adventuring spirit that took root and flourished. It has been renewed and nourished by the successive waves of Chinese migrants that followed.

The Chinese civilization has a continuing history of over 5000 years, but it is deeply rooted and clearly identified with the philosophies of Confucius, Lao Tzu of Taoism and Buddha. Coexisting during the epochal period of the 6th century BC, these sages developed their unique social insights relating to humanity and its social problems just as the ancient Greek civilization began to flourish in the West.

All of these philosophies ultimately became integrated and fused in the minds and activities of the Chinese. Confucius taught them a way to be rationally human; Lao Tzu, the acclaimed leader of Taoism, bestowed upon them a sense of intuitive mysticism and awe of nature that permitted them to connect to the metaphysical world and Buddha granted them insight into the hereafter.

These philosophies are frequently discussed separately as distinctive religions, but one must appreciate that these ideas have become inextricably bound to each other in shaping the life and culture of the Chinese. While recognizing and accepting the daily problems for life on earth, they also explain how the Chinese believe in supernatural, spiritual forces that appear to motivate them.

Confucianism unifies the Chinese on a foundation of unique rational humanism. Promoting peaceful and virtuous social intercourse and concern for others, it is rooted in soil that recognizes the need for social discipline and responsibility, advocating proper social etiquette and protocol. Emphasizing harmony, not necessarily truth, as the goal for human interrelationships, it presumes that personal gain must always be balanced against the needs and desires of others. Each individual is born into a nexus of human relationships and these are all ranked in a predetermined order of importance in social obligations. It creates a selfless society in which the individual’s interest must be considered subservient to that of the family, which in turn is subservient to that of the community, then the country beyond, the world beyond the country and ultimately, to the hereafter. Any breach of this social protocol may result in rejection and shame for the individual.

Known popularly for its advocacy of concepts of filial piety and ancestor worship, Confucianism is much more involved and complicated, requiring reciprocity in its applications. There is a heavy burden for everyone if it is to work properly. Regarding filial piety, the offspring must not only respect and honor the wishes of the parents, but the latter must be deserving and merit this respect, to stand out as a moral example. All human intercourse is to be distinguished by a sense of humility and responsibility for others, regardless of one’s ranking.

Confucius wrote of the five universal obligations and the three moral qualities required to carry them out. The duties recognize those between ruler and subject, parents and children, husband and wife, elder sibling to younger, and between friends. The moral qualities involve wisdom, compassion and courage. The Golden Rule of Confucius states that, “Never do to others what you would not like them to do to you.”

For example, in discussing a gentleman, Confucius wrote: “In him were to be found four of the virtues that belong to the way of the true gentleman. In his private conduct he was courteous; in serving his master he was punctilious; in providing for the needs of the people he gave them even more than their due; in exacting service from the people, he was just.”

Taoism is the countervailing force to the sobering teachings for the Chinese. The word Tao means the “way,” “road” or “path”. Philosophically, the Tao is the origin for everything in this world. “Tao produced the One; the One produced the Two; the Two produced the Three; and the Three produced ten thousand things.” Tao is the primal source, the One is the primordial essence or the chaos from which the universe is created, the Two being Yin (female or negative) and Yang (male or positive), the Three representing Yin, Yang and their unity, from which the abundance of our world is created. This appears to be the story of creation for the Chinese.

The chaos of the universe is organized around contrasting bipolar concepts called Yin and Yang. The darkness of the shadows found on one side of the mountain, the Yin, must be contrasted to the brightness on the opposite side, the Yang; night is contrasted to day, female to male, wet to dry, negative to positive. Eschewing all sharp dichotomies, Taoism seeks moderation in all things and rejects extremism. There can be no pure goodness which is not touched with some evil, and vice versa. Somewhere between the bipolar opposites lies the essence of reality.

It was Taoism that gave rise to the conceptualization and practices of traditional Chinese medicine. Invoking the concept of qi (chi), the vital force for life, health resulted if qi flows normally within fixed channels of the body. Treatments using herbs or acupuncture can be useful to correct the obstructed flow of qi when illness strikes.
Linked to these thoughts for saving lives and preventing illness, Taoism also became enshrined as a religious practice. Based upon an acceptance of animistic beliefs in which all natural phenomena and objects, animate or inanimate, are held to have an innate soul or spiritual essence, Taoism is polytheistic. It reveres a pantheon of hundreds of gods or spirits for worship. There are heaven gods such as the sun and moon, earth gods such as rivers, mountains and grains and human spirits or ghosts such as ancestors or sages.

With divine reverence for all of nature, the rituals and practices of Taoism are clearly evident in the customs and behaviors of the Chinese. There is the common practice of burning of firecrackers to celebrate and to chase away the evil spirits, the practice of Feng Shui, a form of geomancy, in building homes, the offering of food and the burning of “money” at the gravesite of one’s ancestor during Ching Ming.

The Tao Te Ching, the bible of Taoism, consists of only 5000 characters or words. Written in poetic verse, appearing to be light-hearted statements on one hand, it expressed profoundly deep thoughts. For example:

A man is born gentle and weak
At his death he is hard and stiff
Green plants are tender and filled with sap
At their death they are withered and dry.
Therefore the stiff and unbending is the disciple of death
The gentle and yielding is the disciple of life.

Buddhism entered China from India in the century following the birth of Christ. Part of the Mahayana tradition, it accepted cosmic grace and the greater role of lay persons in its religious activities. It soon became entangled with Taoism and Confucianism. It came to be known as Chan Buddhism because of its emphasis upon meditation (called Zen Buddhism in Japan).

A manifestation of the acceptance of Buddhism in daily Chinese living is the worshipping of Kuan Yin, the Goddess of Mercy. She is derived from Avalokitesvara, an Indian Bodhisattva (or “Saint”). Chinese revere her and beautiful statues of Kuan Yin can be regularly found in their homes.

Buddhism is built upon the foundation of the Four Noble Truths. First, one must acknowledge life as suffering; second, the source of suffering is craving or desire; third, to relieve suffering, one must give up desire; fourth, the path leading to giving up desire involves being right in ideas, feelings, speech, actions, livelihood, obedience, mindfulness and meditation. Successfully accomplishing these Four Noble Truths, one could achieve Nirvana, a state of utmost peaceful bliss, “incomprehensible, indescribable, incomprehensible and unutterable”.

The Japanese

The Japanese came to Hawaii for the same reasons that most other Americans did, to escape a life of impoverishment in their native homeland. However, this migration largely involved labor contracts sanctioned by the Japanese government, set up with the American sugar planters of Hawaii. Approximately 200,000 Japanese entered Hawaii between 1885 and 1924. This immigration was finally discontinued through the action of the U.S. Congress which barred further entry of Japanese into the United States. Many women were brought into Hawaii as laborers, and later the “picture bride” program enabled many Japanese men to begin their families in Hawaii.

Most of the Japanese laborers were recruited from the rural farming areas of Southwestern prefectures of Hiroshima, Kumamoto and Fukuoka. Others were recruited from Okinawa, which had recently been reunited with Japan.

Highly disciplined, peace abiding, hard working and concerned with improving upon their lives, they proved to be excellent workers. Sharing many of the characteristics of the Chinese, due to their common cultural history, the Japanese are an eclectic, pragmatic, highly motivated people. Confucianistic in their outlook and habits, strongly centered around supporting their parents and family, they practiced ancestor worship. The Okinawans, due to their trading relationships with Ming China and their relative isolation from Japan proper, spoke a dialect that made it somewhat difficult to communicate with other Japanese.

The Japanese Shinto religion appears to replace the Taoism of the Chinese. They too believed that a spiritual essence, a Kami, resided in all animate and inanimate objects. The emperor is viewed as a Kami, being derived from the sun, but it is a mistake that Westerners assume that he is the Supreme God. Shinto religious practices permeate much of Japanese life.

Buddhism stands out much more and is actively practiced as a religious force among the Japanese in Hawaii.

Death and dying and successful survivorship are of great concern in this life and it is to the teachings of the great teachers of the past that we can turn for wisdom concerning these issues. In his last words, the Buddha emphasized the Dharma (his teachings) and the Dharma would act as our teacher after his death. His words are documented by his disciples in the sutra (Collected sayings of the Buddha) as follows:

“My disciples, my last moment has come, but do not forget that death is only the end of the physical body. The body was born from parents and was nourished by food; just as inevitable are sickness and death.

But the true Buddha is not a human body: it is Enlightenment. A human body must die, but the Wisdom of Enlightenment will exist forever in the truth of the Dharma, and in the practice of the Dharma. He who sees merely my body does not truly see me. Only he who accepts my teachings truly sees me.

After my death, the Dharma shall be your teacher. Follow the Dharma and you will be true to me.

During the last forty-five years of my life, I have withheld nothing from my teachings. There is no secret teaching, no hidden meaning; everything has been taught openly and clearly. My dear disciples, this is the end. In a moment, I shall be passing into Nirvana. This is my instruction.”
We realize the truth of the transient nature of life by carefully reflecting our own lives which are changing constantly as we move towards the unknown realm beyond our preconception of life and death. This changing nature of existence itself, therefore, is an important part of the process of realization of the true nature of life. Basically the sense of Buddha-dharma is not trying to find something one does not have, but simply to discover what one already has, but does not know it. The sense of Buddha-Dharma, therefore, is a matter of discovering and realizing the true nature of life as it manifests itself in its entirety. To Buddhists, life, death and dying take place within a cycle which dynamically refuxes between the realm of the finite and that of the infinite. The teaching of "reincarnation" is conducive of the Buddha-Dharma that we come back again and again into physical existence to find out what is really going on. Everything is in the state of flux until they become infinite or Enlightened. The reality of death and dying which occurs in the dynamic reflux of circumvita proposes that human life is to be projected as 'dangerous opportunity' towards awakening (bodhi) of true spiritual healing.

The following is a classical prescription for a mother who survived the death of her child and gained deeper insight by gradually realizing and accepting the dharma medicine of the transient nature of life:

A young woman, Kisagotani, the wife of a wealthy man, was suffering profound grief at the death of her child. She took her child from house to house begging for people to heal him. Nobody could do anything for her, but finally, a follower of the Buddha advised her to go see the Blessed One, who was staying at a nearby temple. So she carried the dead child to the Buddha. The Buddha looked upon her with compassion and said, "To heal the child I will need some mustard seeds. Go and ask for four or five mustard seeds from some home where death has never entered." So the poor, demented woman went out looking for a house where death has never entered, but in vain. At last, she was obliged to return to the Buddha. In his quiet presence, her mind cleared and she understood the meaning of his words.

This classical description implies that through personal experience and accepting the truth of these basic dharma of the changing nature of existence and interdependency of life one is faced with the possibility of living life in a true and real way in the reflux of circumvita. Human perception of the flux of life has been projected in a classical denotation of a symbolic letter in Chinese 瞳 ho in Sino-Japanese. It is composed of two radicals: the left radical 瞳 signifies either vertical or horizontal flux of water that constantly moves towards its fountain; the right radical is composed of two indicative parts 干 and 木, to mean human life to be completed by natural as well as necessary consequences of having infinite life. 瞳 is the translation of dharma as the primordial power to help all sentient beings attain the infinite life. Dharma flows into the finite life, such as humans, to lead to his ultimate destination of Enlightenment. The Buddha "wishing to expound the Dharma, he smiles and so cures the three pains with various Dharma-medicine." (The Three Pure Land Sutras; the Sutra on the Buddha of Infinite Life delivered by Shakyamuni Buddha).

This flow of dharma fills and permeates our life and beyond our temporary existence. The relationship between man and the Buddha as the medicine king is interdependent and works throughout our transient life. The human side of existence, or as it is popularly referred to this shore, to be crossed by dharma wisdom to get to the other shore, that of the Buddha. The other shore, inconceivable touts, is the realm of Enlightenment, which has been referred to as Pure Land. So, from this other shore of the Buddha, we are made to awaken the compassion of the Buddha who embraces us and is leading us to the Buddha's realm of Enlightenment beyond this life and death. When we realize the compassion of Buddha as it has been manifested in the name of compassion, it is called, Namo Amidabutsu.

Through the profound meaning of the name, we realize that our life has always been and is now supported by this compassion. The true realization of our life has always been and is now supported by this compassion. The true realization of our life as the recipient of dharma-medicine prescribed by the Buddha spontaneously characterizes the way of life in accordance with the flux of infinite dharma that moves one to oneness of life and death.

The Buddhist culture, the dharma of oneness of life and death has been popularly celebrated by the traditional celebration of Bon festivals in China, Japan, Canada, and the Mainland U.S. and Hawaii.

The origin of Bon stems from the Ullambana Sutra, in which the well-known story of Mokuren, a disciple of the Buddha, is related. Mokuren was very devoted to his mother who had died at an early age. He had been apprehensive of where she had gone after her death. With his extrasensory power of clairvoyance, he found his beloved mother in the world of hungry devils, painfully emaciated as a result of her being miserly in her previous life. Astounded and saddened by the discovery, Mokuren attempted to relieve her pains by taking her some food in a bowl. But no sooner had the mother touched the bowl, then the food turned into a mass of flames. Unable to bear the sight of his mother's pitiful plight, he went to the Buddha for instruction on how to save her. The Buddha said, "The self-centered deeds that your mother committed are so grave that it is beyond our power to extricate her from her state. If you should give offerings to one thousand monks, they would gladly accept your offerings. The effect of your pious offerings to the monks who have done pure deeds will be great, indeed. By the merit of your virtuous deed, you mother will be relieved from the pains of the world of hungry devils. Mokuren followed the Buddha's instruction and the mother was immediately freed from the suffering world. Mokuren and the disciples of the Buddha clapped their hands and began dancing in joy. This is the origin of the Bon Dance. In Japan, Bon service was held in the palaces of the Emperors and temples of the nobility. During the reign of Emperor Saimyo, Bon services were held at the Asuka Temple in Nara, during the month of July. During the Heian Period (900-1200) Bon was widely observed by the masses. Until this time it was only among the upper class that Bon Services were held. In the Muromachi Era (1400-1430), the Nembutsu (Namo Amidabutsu) Odori (dance) was first introduced during the service.

Immigrants from Japan (the first generation Japanese) transplanted the tradition of Bon festivals to Hawaii one hundred years ago. Bon is the time for visiting graves. When life is so mobile and transient as it is today, there is hardly a place where one may call his permanent home. But the graves are the places of permanent rest for the physical remains of the dear ones who are no more. The cemetery may be considered as a spiritual abode where all members of the family, some living in distant places, return at least once or twice a year. Thus, Bon is also a time for the reunion of family members and kinsmen. The thoughts that come to us are the memories of those who are no more with us physically. But perhaps because of their bodily absence, we appreciate what they had done for us and their memories become precious all the more.

Bon reminds us also of the importance of charity. It was because of Mokuren's offerings of the Buddha's disciples, that his mother was released from her greed and the resulting hunger and thirst. To undo the wrong, something positive had to be done. Greed stems from ignorance and delusion. As we fail to see that, we are part of the
whole and that we came into mere temporary beings by concurrence of causes and conditions, we are predisposed to cling to ourselves as an abiding, stable and unchanging existence. We become egoistic, self-centered and selfish. We feel as though the whole world evolves around us. ‘Ullumbana’, the transliteration of which become ‘Urabon’—Bon for short—means “being hung upside down”. Physical pains may result from bodily inversion. But the delusion of inverted views is the more fundamental cause of all evils and sufferings. The deeds of pure dana (absolute altruism) perform a double purpose of helping others and purging oneself of egoism. Mokuren’s dana from the purohness of his heart to the great assemblage of monks did serve these purposes.

Bon tradition is the Dharma-medicine that individually as well as collectively, heals grief and lamentation derived from profound experiences of transient existence of human life and it leads us to the realization and awakening to the world of infinite life, ever reflecting upon the temporary life here and now.

**Biomedical Ethics**

The field of biomedical ethics is not new. Most biomedical physicians have been taught that they should practice according to the moral precepts of the ancient Greek Hippocratic oath. Approximately thirty years ago however, many became aware of the serious shortcomings of its teachings.

Pellegrino, a leading physician bioethicist, stated: “In biomedical ethics, this transcultural challenge is vastly complicated because medical science and technology, as well as the ethics designed to deal with it, currently are Western in origin. They are deeply ingrained with three sets of values distinctly Western—the values of empirical science, principle-based ethics, and the democratic political philosophy. Such values are often alien, and even antipathetic, to many non-Western world views”.

It is this foundation of biomedical ethics that needs to be challenged. Western assumptions that all human beings are circumcribed, independent and rational individuals is not strongly shared with non-westerners. For example, the Confucianist person tends to look at the world and life much more through a sense of well being and happiness of others, particularly those of parents and others in the family. This built-in perception of selflessness for many Asians makes it truly difficult to deal with and accept western concepts of autonomy, truth telling, even confidentiality. Altruism for the Asian must concern itself much more with concepts of paternalism. American’s notion of justice must be tempered and moderated to deal with its unique concept of the relatively selfless “non-western” person. It is interesting to note that one is currently seeing increasing attacks upon contemporary biomedical ethical practices. Medical dilemmas related to managed care, commodification of human life, medical rationing, even human dignity and rights require that non-western perspectives and views involving alternative ethical principles must be promulgated and promoted to join the essentially western voices heard today.

Physicians around the world must deal with the terminal stages of life, when death occurs. Science will continue to contribute newer approaches for relieving pain and suffering and to prolong the life of the patient but it will never be able to deny death. All physicians are taught to recognize when death becomes inevitable and further medical intervention is futile.

Nuland, a physician and writer, points out that:

- Each one of us needs a guide who knows us as well as he knows the pathways by which we can approach death.
- There are so many ways to travel through the same thickets of disease, so many choices to make, so many stations at which we may choose to rest, continue, or end the journey completely — until the last steps of that journey we need the company of those we love, and we need the wisdom to choose the way that is ours alone. The clinical objectivity that should enter into our decisions must come from a doctor familiar with our values and the lives we have led, and not just from the virtual stranger whose superspecialized biomedical skills we have called upon. At such times, it is not the kindness of strangers that we need, but the understanding of a longtime medical friend. In whatever way our system of health is reorganized, good judgment demands that this simple truth be appreciated.

Acting to prolong the life, by attempting to relieve the pain and suffering of the patient, what are the physician’s ethical responsibilities during this end stage for life? For those Chinese and Japanese patients steeped in their traditional beliefs and practices, the physician may find it easier for them to confront and accept the inevitability of death. For Buddhists, life-death exists on a continuum, for the person merely passes from the physical state of being into another, from nature into that of the supernatural. Freed of another human desire, the Buddhist can readily “give up” life to move onward.

Even regarding questions of euthanasia, traditional Chinese and Japanese patients can find solace and comfort in their traditional native belief systems. Letting die or refraining from taking action, passive euthanasia, should pose no ethical problems for most physicians, for when it is undertaken to induce the painless death of a person for reasons assumed to be merciful, it represents one of the traditional responsibilities of all physicians.

However, the concept of active euthanasia, taking action to promote and hasten the death of an individual would appear to be an act of killing. However, in contemporary medical practices, the patient may be suffering so much pain that death may in fact be the only merciful recourse remaining. Not uncommonly, the request for death may be initiated by the patient, the so called plea for assisted suicide. Again, these Asian belief systems would not prohibit the physician in supporting these activities, if this act is based purely upon what the patient needs or requests.

Any death invariably involves survivors. It is extremely important for families to be involved in many of the medical decisions regarding the dying patient. The question of a living will to define what limits are to be set on the medical support and treatments and a durable power of attorney for healthcare, permitting an agent to make medical decisions for the patient should he or she become incapacitated, may be useful, but should never overlook the importance of the extended family involvement in these crucial matters during the terminal period of life. Concepts of family and filial piety must be promoted throughout this period to ensure that these needs are fulfilled for those who are surviving.

This family centered decision sharing process is especially critical for these Confucianistic people. Physicians must ensure that critical information is widely communicated and shared with the survivors. This is especially true, for acknowledging the stoicism and laconic nature and personalities characteristic of these Asian people, one cannot assume that all of the critical medical information will be freely shared and discussed among them. Each member of the surviving group may have distinctly separate and deeply personal and heartfelt needs to address during these crucial days of dying. Physicians must recognize their responsibility toward ensuring that other resources to assist and support the survivors must be involved.

Continued on Page 295
Death with Dignity: There's Plenty More that We Can Do

R. Gary Johnson MD*

The medical profession has seen an accelerated interest in end of life decision making and terminal care. The growing need for attention in these areas requires more of the art of medicine - the human and compassionate side of medicine as opposed to the high technology side.

Everyone knows or at least has heard the facts and statistics. The population of the United States and most other "developed" nations is aging. The group eighty-five and older is growing at an unprecedented rate. Control of certain infectious diseases and public health measures over the last half century are largely responsible for this demographic shift.

The challenge to the medical profession now and in the immediate future is to better respond to the needs of an elderly population with chronic debilitating and endstage conditions. The financial and societal implications of this challenge were addressed by Dr. Patricia Blanchette in the April 1995 issue of the Hawaii Medical Journal. The points raised in that article are even more compelling a year and a half later. The frail elderly with chronic and terminal medical conditions can be cared for in ways that are both fiscally sound and personally satisfying, tailored to meet the individual's needs.

For physicians to manage these chronic problems well requires a change in approach. The traditional 10 to 15 minute office visit is not adequate to meet the needs of this population. The scope of care is expanded to include the office, hospital, nursing home, hospice, and most importantly, the home. The physician becomes less the autonomous decision maker and more a team member, communicating with various professional disciplines and caregivers. The ability to be a good team member and to balance the expertise of different people is a crucial part of caring for people with chronic and terminal conditions.

Many physicians, some may argue, the majority, do not handle this end of the continuum of life well. There are many reasons for this. There is real paucity of formal medical education in the areas of death and dying, not to mention the management of chronic conditions generally. The advent of so much new technology so rapidly and the emphasis on this in medical education leads many physicians to feel that they should be able to fix anything. High technology should be used to the very end and if this fails, it is time to walk away. Residency programs are great in teaching how to run an intensive care unit, but what happens beyond the hospital door remains, for many, a big mystery. Even in an office practice, once a diagnosis of a chronic incurable condition is made, frequently the physician-patient interaction stops at this point. An example: a patient, after a complete and thorough workup, is diagnosed with Alzheimer's Disease; the family is told this, given a couple of pamphlets, but no follow up is scheduled because "there is nothing more that we can do." Experience in working with elderly people with chronic and terminal conditions shows that the point where "there is nothing more that we can do" is actually where the real work begins.

Communication and availability are crucial to successfully take care of a terminally ill person. It is important for the physician to communicate clearly with the patient and family what to expect and what can be done. Often the patient is told "I'm sorry, you have (for instance) cancer, we have no treatment to offer." A better approach is to say "I'm sorry, you have a condition that we can't cure. However, there are many things that we can continue to do to make sure that you can be comfortable and pain free."

There are many issues to address at the beginning as well as during the course of a terminal illness. First, if no previous discussion has occurred, an active discussion about life sustaining measures needs to be addressed. The general public usually has little understanding of what the implications of resuscitation, hydration, and tube feeding are. Asking only "do you want us to do everything if an emergency occurs?" will not lead to an informed response. Giving the family solid information about the futility of resuscitation and tube feeding in such conditions will permit much better decision making. Obviously it is much better to face these issues early rather than when the crisis occurred. All too often patients with advanced metastatic cancer end up in an intensive care unit being intubated and resuscitated because no one had discussed the options beforehand.

The case of a patient with advanced Alzheimer's Disease illustrates this well. Once the patient starts to develop dysphagia, families are confronted with having to decide whether to tube feed or not. One approach is to explain to the family that artificial feeding will not reverse the underlying process and in fact will increase the likelihood of suffering by interfering with the natural process and in fact will increase the likelihood of suffering by interfering with the natural process of death. Many families have the misconception that without artificial feeding or hydration, the patient will experience a slow, painful death. Explain that the opposite is true and that the patient will have a comfortable and dignified death without artificial support. Often families do not want to pursue aggressive measures but are afraid to speak out. When the physician speaks to these issues directly, providing more guidance and education, this puts the family more at ease to make choices. Families are already stressed: they need more direction from the physician than being asked "do

* Chief, Department of Geriatric Medicine
Straub Clinic & Hospital, Inc.

HAWAII MEDICAL JOURNAL, VOL 55, DECEMBER 1996
you want this treatment or not?"

Most people are taken care of in the home; patients and families generally prefer this to institutionalization. Making use of community resources during this period is great help to both the family and physician. A hospice program is extremely beneficial. Often hospice is equated with cancer care; however the same philosophy applies to any endstage condition, such as advanced dementia or Parkinson’s disease. A hospice can provide skilled nursing services; nurses aid services, respite care, social services as well as coverage for medications and certain supplies. Nursing services are especially helpful in working with the physician to modulate medications for pain.

Patients at this point rarely fear death itself. They fear more the potential of having pain and suffering during the dying process. Unfortunately, many patients do not have these fears addressed and do not receive the necessary medications to relieve their pain. A recent article in the New England Journal of Medicine describes this well. Adequate treatment of pain in terminal conditions is not given sufficient attention for many reasons: lack of education, inappropriate concern about the effects of narcotics to name two. Concern about addiction in a patient with a terminal illness really approaches the absurd.

Depression as a co-morbid condition in a chronic disease and terminal illness is also under recognized and treated. Depressive symptoms are often dismissed as being an accepted part of the condition thus not meritng attention. In many cases an antidepressant can be very beneficial in improving the quality of life and as an adjunct to treating pain.

The following illustrates a “best case scenario.” An 80-year-old man with endstage Parkinson’s Disease and dementia is cared for at home by his wife and a hired caregiver. The physician makes routine home visits to provide support and guidance in the day to day care. As the disease progresses, the patient develops symptoms of dysphagia. Discussions between the wife and physician on previous occasions have led to the decision not to tube feed or do other aggressive measures. As the dysphagia represents a significant change in the prognosis, a referral to Hospice is made to assist with the terminal care. The physician prescribes liquid morphine to have on hand in the event of respiratory distress probably due to aspiration. Visits are made by both the hospice nurse and the physician to provide additional support. The wife is instructed to give as much morphine as is necessary to relieve the respiratory distress. After several days, the patient passes away quietly at home with the wife during the days that follow. A much preferred passing to what could have happened without adequate preparation: years of meaningless existence in vegetative state with a feeding tube in a nursing home.

The need for this kind of care will only grow in the future. Physicians can and should play such an important part in the care of dying patients. Despite the availability of excellent paraprofessionals, patients and families ultimately look to the physician for real guidance and decision-making. There is so much to do medically during the dying process: aggressive relief of pain, aggressive treatment of depression, aggressive use of community resources. Being at the bedside of a dying patient, if to do nothing else but listen, can be the greatest practice of the art of medicine.

References

Euthanasia: Murder or Mercy?
Continued from Page 272

women to find doctors who would perform abortions in those days before Roe vs. Wade. Battin saw religious institutions as the right place for people to come. A religious community is the only place whose central focus is the meaning and value of life, and the disturbing fact of death which challenges all claims to meaning and value.

The work of Ralph Mero and others clearly indicates that some of our clergy are hearing the call to respond to those suffering people in need of aid in dying. Such work is to be highly commended and extended by others of us as we are able.

The ultimate goal is to enable every person not carried away by sudden death to make informed choices about what happens to them in the last stages of life. We will not all choose the same way. There must be room for those who choose to live even in the face of frightful pain and suffering and for those who choose an earlier point of death.

The Greeks gave us the word euthanasia. It is a lovely word that means simply, good death. Only if we are given the full legal right to make the choice of how we shall die, and to get the assistance of our physicians in carrying out that choice—for existence to continue by every means possible or for death to take us out of our misery—does the good death, euthanasia, become possible for all of us. It is my hope that every person will be able to have a good death.

Editor's Note:
Ken Phifer now serves as Senior Minister at First Unitarian Universalist Church in Ann Arbor. He received a B.A. in history at Harvard and attended the University of Chicago Divinity School. He served as Scholar in Residence at the Ecumenical Institute for Jewish Christian Studies, as well as teacher, advisor and Minister at several institutions on the mainland. But, Ken Phifer has firm connections to Hawaii: he taught at Mid-Pacific Institute, has lectured at the Pal Unitarian Church and his parents live in Hawaii at Pohai Nani. Mahalo, Ken for sharing your words of compassion with us.

Healthful Eating

Fruits and vegetables are important components of a healthful diet. Here’s why:

• They are easy to fix and serve
• There are so many choices
• They are the original “fast food”
• They taste great
• They are good for your health

©1996, American Heart Association

HAWAII MEDICAL JOURNAL, VOL 55, DECEMBER 1996
In the first year of medical school, our students spend one-half day a week (15 weeks) in a community hospice experience. They go through a 20-hour orientation program, either at St. Francis Medical Center or at the Queen’s Medical Center. They are then assigned their own patient, whom they visit once a week for the 15-week period. Often, students develop strong relationships with terminally ill patients and continue the hospice experience until the patient dies. It is a rich and touching experience for some students, coming early in their medical education.

During the first two years, students meet in tutorials and study a total of 70 different health care problems. Among these problems are patients and their families who must deal with death and dying. Some examples of these situations are a 50-year-old nurse with breast cancer, an adult male with transitional cell carcinoma, and a lone immigrant to Hawaii with colon cancer.

In these tutorials, the students are encouraged to discuss not only the biological and clinical aspects of the problems, but the population and behavioral aspects of the case, including death and dying. Many of these discussions are truly profound. Some are superficial, depending on the makeup of the tutorial as well as the maturity and readiness of the student to discuss these issues, and the ability of the tutor to facilitate discussion.

Our medical school has also offered colloquia by Max Botticelli, MD, S.Y. Tan, MD, Mitsuo Aoki, DD, and Kenneth Kipnis, PhD on subjects such as “Death and Dying,” “Palliative Care,” and “Ethical Issues in Death and Dying.”

While we have no formal courses on “Care of the Dying” or “Choice in Dying,” our students are exposed to these problems by the methods described above. Whether or not these experiences are effective is unknown at this time.

Editor’s Note:
Beginning this fall, ten medical schools across the country will develop and test models that will integrate death and dying into their existing programs. Regrettably, the University of Hawaii is not one of these participating schools. At the end of the five-year project, Choice in Dying, the funding agency based in New York City, will compile the results into a technical manual that will then help other schools integrate similar death and dying teaching into their programs. Further information can be obtained from Choice in Dying, 200 Varick Street, New York, NY 10014. Fax 212-366-5337. Phone 212-366-5540.
To Die or Not to Die - Is that the Question? Educating Physicians About End-of-Life Care

Richard MacDonald MD

Introduction
The past three decades of technological advances in medicine have produced many benefits in the way of curing illness and prolonging quality life, when applied appropriately in acute injury for disease. However, some of these same developments, when used inappropriately in those conditions associated with degenerate processes without possibility of cure, can lead to prolongation of the dying process associated poor quality of life. Little is taught in medical and nursing schools, or in residency programs, about end of life care. The difficult decisions to be made by the patient, her or his loved ones, and the medical care team present personal, ethical and emotional quandaries. If physicians are to provide patients with informed answers to questions about avoidance or withdrawal of treatment, palliative care, refusal of hydration and nutrition, as well as discussing options open to the patients wishing to hasten death, much more education in these areas must be included in the training of those who will be treating terminal illness. Many physicians and patients now share the opinion that the continuum of care for such hopeless situations should include physician assisted death as one of the options to be considered.

Discussion
The twentieth century has seen many remarkable advances in technology, most notably in the field of medicine. Much of the progress has taken place in the past 25 years, altering the entire approach to many medical conditions. With these changes, the venue for caring for those with terminal illness has changed from the home to the intensive care units of tertiary care hospitals. Due to this medicalization of dying, it is estimated that over 80% of patients are hospitalized at the time of death, in sharp distinction to the 25 to 40% just four decades earlier.

Since the early 1970's, when ventilators became available to maintain life in cases that, without such advanced life support technology, would have little or no possibility of survival, the approach to end of life care dramatically changed. The opportunity to save many patients suffering acute trauma or illness, with accompanying cardiopulmonary compromise, was welcomed. Numerous patients have survived serious illness and injury, returning to active lives, with longevity and quality of life that was close to that expected prior to hospitalization.

There was an insidious development secondary to the rapid number of inventions in the medical sphere. Prior to the advent of this technology, it was usual to care for terminally ill patients in the home surrounding, after exhausting the limited armamentarium of life-sustaining therapies then available. If life expectancy was measured in only weeks or months, compassionate attention to comfort of the patient was the norm, with analgesics freely prescribed to ensure adequate pain control. However, in the effort to prevent death in those for whom there was "no more to be done," the technology that had been developed for short term use in acute, remedial situations, was increasingly applied to patients suffering terminal malignancies with widespread metastases and those with severe neurological damage. The latter included cerebrovascular accidents and head trauma with deep, permanent coma, in what came to be called persistent vegetative state. This misapplication of technology lead to an ever increasing number of patients totally dependent on ventilators and/or other life-supporting medical devices, with no hope of recovery.

As life expectancy increases due to improved nutrition, health habits, and medical progress in available treatments for preventing or curing many infectious illnesses, the number of older Americans who suffer malignant disease has also increased. When in terminal stages of cancer, as well as with some neurological conditions, such as Alzheimer’s disease and amyotrophic lateral sclerosis, it appears that the patient is frequently ready to accept the inevitable conclusion of such illness before the physician may be willing to discontinue efforts to extend life. Technology may be applied to these chronic disease states when it is clear that no cure is expected, and that no possibility exists of the individual returning to a quality of life acceptable to her or him.

Unfortunately, little in the medical curricula of most universities helped prepare physicians for these situations. In reviewing textbooks considered to be the best available in their fields, there is great attention paid to details of diagnosis, prognosis, medical and surgical treatment, and technological applications for even the rarest of conditions. There is, however, virtually nothing included about what to do for the patient when further curative efforts are futile. Personal investigation and conversations with faculty of medical schools and residency programs revealed that few medical schools have any required courses dealing with dying and death. Some have a few "interest" lectures on the subject, but required courses are rare. Similarly, very few residency programs expose the young physicians to such rotations as long-term facilities or hospice care.

There are a few that have the opportunity to follow a patient or two in a hospice program, but no compulsory exposure to terminally ill patients in long term care facilities or home hospice care is found in the vast majority of residents training, even in the oncological specialties. Until very recently there were few continuing education programs sponsored by organized medical groups, or by hospital staffs, that included presentations discussing end of life care. In November, 1996, the AMA ethics division announced that a program to teach physicians skills for quality end-of-life care is being organized. This appears to have happened only after that organization became alarmed at the success of grass roots efforts to effect changes in laws that would permit some patients, with no hope for recovery, the option of requesting assistance in shortening the time of dying.

As a result of the paucity of efforts to teach physicians about dying and death, the numbers of patients who died while still connected to life-supporting equipment seemed ever-increasing. The SUPPORT
study reported in *JAMA* confirmed much of what is wrong with the care of terminally ill patients.\(^4\) Physicians either did not know, or failed to follow, the wishes that patients had expressed verbally or in advance directives. As a result, many of the cases followed revealed continued application of technology not desired by the patients, yet with a surprisingly high percentage suffering pain in the last week of life. Even with the expenditure of millions of dollars of grant money in an effort to intervene, with specially trained nurses advising the physicians as to patient preferences, no improvement in physician behavior or in the dismal results occurred.

Clearly, those in didactic medicine need to redirect some of their efforts to teaching appropriate care for those with incurable illness. It is the opinion of many physicians and the majority of patients that those who are dying with chronic disease, for which all available methods of treatment have been considered and/or undertaken, and for whom the very best in palliative care has failed to provide the quality of life that the patient finds acceptable to continued existence, that another option could and should be offered. That option, as an alternative to continued suffering secondary to the prolongation of the time of dying due to the application of various futile treatment modalities, is physician assisted death. The few patients for whom palliative and hospice care does not suffice deserve this consideration. The United States Court of Appeals for the Ninth Circuit, which encompasses all nine western states, agreed with this contention, by a majority vote of 8 to 3, in a decision filed on March 6, 1996. The final paragraph of the majority opinion states succinctly that an individual has the right to make decisions affecting life and death. That Court also dealt with the prescription placed on such action as hastening the time of dying by those with strong religious beliefs that “only God can take one’s life.” The Justices stated that “Those who believe strongly that death must come without physician assistance are free to follow that creed, be they doctors or patients. They are not free, however, to force their views, their religious convictions, or their philosophies on all other members of a democratic society, and to compel those whose values differ with theirs to die painful, protracted, and agonizing deaths.”

Although there is much to be done in the way of improving teaching about end of life care and decisions, there is some recent improvement apparent in the awareness of physicians about patient preferences with regard to terminal care. It is my belief that the increasing dialogue in our society, and in medical circles, regarding terminal illness, has resulted from the demand, by certain patient advocacy organizations, that more autonomy in decision making be offered to patients. It has been reported that more attention to teaching about palliative care, pain management and the need for earlier and more frequent hospice referral, is occurring in Oregon. This may be attributed to the extensive exposure of all the citizens in that state to the arguments, both pro and con, preceding the passage of Measure 16 in November 1994. When the injunctions preventing implementation of that law are finally resolved, there will be an opportunity to establish guidelines and safeguards for physician aid-in-dying. Hopefully, with improved teaching about end of life care for all health care professionals, the number of patients who fail to have a quality of life deemed by them to be commensurate with continued life, will be minimal.

---

**A View of Death and Dying Among the Chinese and Japanese**

Continued from Page 290

in these final days of life, such as the need for spiritual, legal and other counselors. The medical services represent only a portion of what each patient needs in navigating this final passage of life.

To ensure satisfactory closure involved in this process of letting go for everyone, it is critical that the physician spend sufficient time to advise, reassure, support and comfort not only the patient, but must also extend these services to the family and other survivors as well.

**Suggested Reading**


---

**References**


---

**Editors Note:**

Richard MacDonald, MD, since his 1993 appointment as Medical Director of the Hemlock Society USA, researches and writes on medical aspects of physician aid-in-dying, provides guidance on medical matters to the National Board of Directors and to local chapters, and creates dialogue and increases communication between Hemlock and the medical community. Born and educated in Canada, he has practiced family medicine in Canada and California for over forty years. Extensive experience in communications has included his "Doctor of the Air" program on the Canadian Broadcasting Corporation and, more recently, on KPAY, Chico, California, and a "Health Break" series for local television. Participation in many national medical organizations meetings will advance the mission of Hemlock by educating the medical and allied health professionals in the concepts of appropriate end-of-life decisions to provide their patients with the choice of death with as much comfort and dignity as possible. Included in his current memberships are the Society of Teachers of Family Medicine, The Gerontological Society of America, the American Association of Bioethicists and the Society for Health and Human Values. He has traveled extensively for Hemlock, speaking to both medical and lay audiences, concentrating especially on delivering presentations to medical students and residents who will be involved in treating patients with terminal illness. As this "most important bioethical issue of the 1990's continues to be debated in both medical and lay circles, he will be expressing the philosophy of the Hemlock Society USA and hopes to see improved care and caring for those with terminal illness, with more adequate pain control, earlier and more frequent referral for hospice and palliative care, and the possibility of the choice of physician aid-in-dying for those few patients for whom even the best care fails to provide a quality of life acceptable to the dying patient.

Richard MacDonald, MD and Faye Girsh, executive director of the Hemlock Society USA, attended the 9th annual meeting of Hemlock USA in Denver, November 9-11. The Conference on Physician Aid in Dying presented the latest developments from legal, medical, legislative, nursing and family perspectives. More on this in later issues of the Journal. Thanks to Dick and Faye and the wonders of e-mail and faxes, we have their manuscripts for this special issue. Mahalo again, Dick and Faye.
How Hawaii’s Doctors Feel about Physician-Assisted Suicide and Euthanasia: An Overview

Lorene K. Siaw* MD and S.Y. Tan MD, JD**

We polled, by questionnaire, all doctors and medical trainees in Hawaii (n=3,017) to determine their attitudes towards physician-assisted suicide, euthanasia and other end-of-life medical issues. One thousand and twenty-eight (34.1 %) responded. Medical trainees did not differ significantly from practicing physicians. Only a minority of respondents (15.6 %) were willing to assist a terminally-ill patient to commit suicide. An even smaller number (9.8 %) would perform active euthanasia. On the other hand, an overwhelming majority would withhold (97.6 %) or withdraw (78.6 %) life-support upon request. Most doctors (88.0 %) were also willing to administer high doses of narcotics for pain relief, even if such therapy hastened death. About half the doctors felt that physician-assisted suicide and active euthanasia may be justified under some circumstances, although most were unwilling to personally carry out these acts. Catholic, Filipino and Hawaiian/Polynesian doctors were statistically less likely to approve of or perform physician-assisted suicide or active euthanasia.

For much of this decade, both the medical and lay communities have actively debated the ethics of “mercy-killing”. In November 1994, voters in Oregon voted to legalize physician-assisted suicide, after previous initiative votes failed in Washington and California.1 Earlier this year, two appellate courts separately held that mentally competent patients who were terminally-ill had a constitutional right to physician assisted suicide.2,3 Going one step beyond, the Northern Territory of Australia recently legalized the practice of euthanasia,4 thereby joining the Netherlands5 in allowing physicians to actively end, with consent, the lives of terminally-ill patients.

Are doctors for or against such practices? Published surveys6-11 have generally found that a substantial minority in the medical profession is supportive of physician-assisted suicide and a smaller number of active euthanasia. To date, no data are available on the opinions of Hawaii’s physicians. We therefore undertook such a survey concerning various end-of-life medical issues, including physician-assisted suicide and active euthanasia. Given Hawaii’s limited and diverse population, we were able to mail questionnaires to all the physicians in the state, and to analyze the results for ethnic and religious differences.

Methods

We mailed an anonymous questionnaire to all physicians, residents and medical students in Hawaii in September 1995. The questionnaire was patterned after that used in a recently published survey of Rhode Island physicians.11 Two months later, we completed a second mailing. All results were entered into a computer data base and analyzed by SAS statistical analysis program. Chi-square testing was performed to determine statistical significance among the various demographic groups.

The questionnaire consisted of two main parts. In the first part of the questionnaire, we posed several clinical scenarios involving a hypothetical terminally-ill competent patient with lung cancer. A simple yes/no response was sought. In scenario 1, the patient requests not to be intubated, although it appears he will not survive otherwise (withholding treatment). Scenario 2 describes the same patient who requests narcotics for pain relief in doses that might hasten death through respiratory depression. In scenario 3, the patient, having been emergently intubated by another physician, now requests that the endotracheal tube be removed (withdrawal treatment). Scenario 4 describes the patient’s request for a medication prescription with the specific intent to end his life (physician-assisted suicide). In the 5th and last scenario, the patient seeks death via a lethal injection to be administered by the physician (active euthanasia).

For each yes/no response, the surveyed physicians were asked to select, in rank order, various reasons why they so decided. The analysis of these results will be reported in a later communication.

In the second part of the questionnaire, we asked about general attitudes towards physician-assisted suicide and active euthanasia. We asked whether physicians would approve of these practices in some circumstances (unstipulated), and whether they would personally perform such acts. We also asked whether they had actually performed these acts in the past.

Results

Three thousand and seventeen physicians, residents and medical students were polled. Of these, 1,028 responded for an overall response rate of 34.1 %. Two hundred and seventeen (21.1 %) of the respondents were trainees. There were 139 medical students and 78 residents. Their views did not differ significantly from those of practicing physicians.

Demographic data of the respondents are shown in Table 1. The responses of physicians (this term is used to include residents and medical students) to the five described clinical scenarios (Part 1 of questionnaire) are tabulated in Table 2 and shown graphically in Figure 1. The vast majority would withhold (97.6 %) or withdraw (78.6 %) treatment, or give narcotics for pain relief even if they hastened death (88.0 %). However, only a minority would perform physician-assisted suicide (15.6 %) or active euthanasia (9.8 %).

Table 3 tabulates the general attitudes of the respondents (Part 2 of
A slight majority would approve of physician-assisted suicide (60.0%) or active euthanasia (58.6%) under some unspecified circumstances. A much smaller percentage would personally perform these acts (28.8% and 27.6% respectively). Four percent of respondents indicated that they had assisted their patients to commit suicide, and 3.5% said they had personally performed active euthanasia.

Table 4 depicts ethnic and religious differences. Catholics (n=195) were the only religious group that consistently showed a statistically lower rate of support for physician-assisted suicide or active euthanasia. Among the various ethnic groups, Filipino (n=41) and Hawaiian/Polyesian (n=35) doctors showed a definite trend towards being less likely to approve of or perform these acts. This trend persisted even after removing Catholic religious belief as a confounding variable. Non-Filipino Catholics appeared more likely than Filipino Catholics in their approval of physician-assisted suicide (45.3% vs 30%) and active euthanasia (42.3% vs 24.1%). In contrast to the religious and ethnic differences observed for physician-assisted suicide and active euthanasia, there were no differences observed for withholding and withdrawing life-support, and prescribing narcotics for pain relief.

No statistical differences in physician response were detected for subgroups classified by age, sex, specialty, years in practice, and place of practice.

**Discussion**

1,028 physicians participated in this survey, making it one of the largest series, second only to Oregon’s. This figure represents 34.1% of Hawaii’s entire physician population. Unfortunately, we were unable to obtain reliable data on the demographics of Hawaii’s physician population so that we could ascertain and confirm sample-match.

The results of our survey, the first carried out in the state of Hawaii, indicate that the vast majority of physicians would withhold or withdraw treatment in accordance with the request of a terminally ill patient. Likewise, Hawaii’s physicians are quite willing to administer narcotics for pain relief, even in doses that may hasten death. These practices comport with generally accepted ethical precepts set forth by professional organizations such as the American College of Physicians and by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

Our results closely parallel those obtained in the 392 physicians of Rhode Island who were surveyed using a similar questionnaire.

Regarding assisting a patient to commit suicide, our figure of 15.6% is virtually identical to that obtained in a much smaller and defined group in Florida. There, 16% of physicians (360 medical faculty and trainees at the University of Miami) stated that they would perform the act, compared to 15.6%-28.8% of our physicians. In Rhode Island, only 9% would do so. In contrast, the figure was a third in Michigan, 40% in the state of Washington, and nearly one half in Oregon.

Fewer than 1 in 10 physicians in the state of Hawaii would personally perform active euthanasia when faced with a hypothetical patient making such a request. Published figures from other surveys range from 1% in Rhode Island to 33% in Washington.

Oregon’s physician survey on physician-assisted suicide is the largest yet published, and involved 2,761 physicians who were deemed eligible to prescribe a lethal dose of medication. Sixty percent thought such an act should be legal in some cases; 46% might be willing to prescribe, and 31% were unwilling on moral grounds. Although a similar percent of our respondents would approve of physician-assisted suicide under some unspecified circumstances, Hawaii’s physicians appear much less likely to become personally involved, especially when confronted with a specific case scenario. These differences appear to be real; 36 physicians in Hawaii reported that they had performed physician-assisted suicide (4%), a frequency almost half that of Oregonian physicians (7%).

Why is it that under some unspecified circumstances, slightly more than half of our physicians could approve of both physician-assisted suicide and active euthanasia, yet only about a quarter would personally perform these acts? This disparity between “general approval under some circumstances” and actual performance has been noted in other surveys. We attribute the reluctance of personal involvement to cultural and religious factors, prior medical teaching, the lack of knowledge of how to proceed, the fear of criminal liability, and insecurity regarding the true meaning of such patient requests. This last factor may prove determinant. In a recent survey of oncologists, for example, Emanuel et al found that 45.5% agreed with physician-assisted suicide for cancer patients with unremitting pain, but this figure dropped to 35.5% for patients with functional debility, to 22.9% when the reason was burden on family, and to only 18.1% when life was viewed as meaningless. We identified ethnic and religious differences in our study. Catholic physicians as a group were consistently less likely to approve of or carry out physician-assisted suicide and active euthanasia. The same generally held true for Filipino and Hawaiian/Polyesian doctors, although with somewhat less statistical confidence. The ethnic differences appear real, persisting even after removing Catholic religious belief as a confounding variable. On the other hand, the views of these doctors did not differ from the entire group on the issues of withholding and withdrawing treatment, and prescribing narcotics for pain relief. Given Hawaii’s heterogeneous population, divergent views are not surprising, especially since attitudes towards life, death and the dying process are deeply rooted in one’s heritage and upbringing, and susceptible to both cultural and spiritual influences. Our results, however, do invite the inquiry into whether other end-of-life issues, e.g., hospice care and cardiopulmonary resuscitation, are race- and religion-sensitive, and whether these views are comparably shared by doctors as well as their patients.

How physicians in Hawaii feel about physician-assisted suicide and euthanasia is highly relevant, since they will be the ones called upon to effectuate such acts. Will Hawaii legalize these acts? At the federal level, appellate courts in the second and ninth circuits have recently ruled that competent terminally-ill patients have a constitutional right to physician-assisted suicide. These cases have been appealed to the U.S. Supreme Court, which has agreed to hear oral arguments in January 1997. Its decision may well be a landmark in the annals of medical jurisprudence. Or it may take a neutral stance by deferring to the states for individual adjudication or legislation.

In 1993, state representative Terrance Tom, then chair of the House Judiciary Committee, conducted public hearings on these issues. Based on his findings, he rejected any form of euthanasia for the State of Hawaii, and instead introduced legislation to ensure that knowledge of modern pain-management therapy and comfort care was made available to every terminally-ill patient in need of such relief. Given Hawaii’s heterogeneous population, divergent views are not surprising, especially since attitudes towards life, death and the dying process are deeply rooted in one’s heritage and upbringing, and susceptible to both cultural and spiritual influences. Our results, however, do invite the inquiry into whether other end-of-life issues, e.g., hospice care and cardiopulmonary resuscitation, are race- and religion-sensitive, and whether these views are comparably shared by doctors as well as their patients.

How physicians in Hawaii feel about physician-assisted suicide and euthanasia is highly relevant, since they will be the ones called upon to effectuate such acts. Will Hawaii legalize these acts? At the federal level, appellate courts in the second and ninth circuits have recently ruled that competent terminally-ill patients have a constitutional right to physician-assisted suicide. These cases have been appealed to the U.S. Supreme Court, which has agreed to hear oral arguments in January 1997. Its decision may well be a landmark in the annals of medical jurisprudence. Or it may take a neutral stance by deferring to the states for individual adjudication or legislation.

In 1993, state representative Terrance Tom, then chair of the House Judiciary Committee, conducted public hearings on these issues. Based on his findings, he rejected any form of euthanasia for the State of Hawaii, and instead introduced legislation to ensure that knowledge of modern pain-management therapy and comfort care was made available to every terminally-ill patient in need of such relief. Interestingly, Oregon’s healthcare systems have responded to its 1994 pro-suicide vote, currently challenged in court, by instituting these same measures. If Hawaii’s healthcare professionals would heed this “wake-up” call, they too can provide better comfort care to their patients at the end-of-life.

**Acknowledgments**

We thank Dr T. Fried and Dr M. Stein for allowing us to use their questionnaire in this survey, Dr Helen Petrovitch and Clifford Li of the Honolulu Heart Program for helping us with the statistical analysis, and Gary Belcher for the art work.
Table 1.—Demographics of Respondents (n=1,028) by Percent

<table>
<thead>
<tr>
<th>Age:</th>
<th>Years in Practice:</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40 years</td>
<td>&lt;10 years - 28.4</td>
</tr>
<tr>
<td>40-59</td>
<td>10 - 19 years - 26.3</td>
</tr>
<tr>
<td>60+</td>
<td>20+ years - 45.4</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex:</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Caucasian - 48.5</td>
</tr>
<tr>
<td>Female</td>
<td>Japanese - 17.3</td>
</tr>
<tr>
<td></td>
<td>Other Asians - 10.2</td>
</tr>
<tr>
<td></td>
<td>Hawaiians/Poly - 3.4</td>
</tr>
<tr>
<td></td>
<td>Other - 2.3</td>
</tr>
<tr>
<td>Level:</td>
<td></td>
</tr>
<tr>
<td>Residency</td>
<td>Catholic - 19</td>
</tr>
<tr>
<td>Education</td>
<td>Protestant - 14.1</td>
</tr>
<tr>
<td>Specialty</td>
<td>Christian - 13.8</td>
</tr>
<tr>
<td>Practice</td>
<td>Buddhist - 5.6</td>
</tr>
<tr>
<td></td>
<td>Jewish - 4.4</td>
</tr>
<tr>
<td></td>
<td>Episcopal - 4.2</td>
</tr>
<tr>
<td></td>
<td>None - 18.1</td>
</tr>
<tr>
<td></td>
<td>Other - 20.8</td>
</tr>
</tbody>
</table>

Table 2.—Survey Results of 1,028 Hawaii Physicians* Regarding a Hypothetical Terminally-Ill Patient

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withhold treatment</td>
<td>97.6%</td>
</tr>
<tr>
<td>Use narcotics to relieve pain</td>
<td>68.0%</td>
</tr>
<tr>
<td>Withdraw treatment</td>
<td>79.6%</td>
</tr>
<tr>
<td>Participate in physician-assisted suicide</td>
<td>15.6%</td>
</tr>
<tr>
<td>Participate in active euthanasia</td>
<td>9.8%</td>
</tr>
</tbody>
</table>

*There were 139 medical students and 78 residents in the group. Separate analysis of the data from these trainees yielded differences that were statistically insignificant (data compared to those of practicing physicians).

Table 3.—Survey Results of General Attitudes of 1,028 Hawaii Physicians

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approve physician-assisted suicide</td>
<td>60.0%</td>
</tr>
<tr>
<td>Would personally perform physician-assisted suicide</td>
<td>28.6%</td>
</tr>
<tr>
<td>Approve of active euthanasia</td>
<td>58.4%</td>
</tr>
<tr>
<td>Would personally perform active euthanasia</td>
<td>27.6%</td>
</tr>
</tbody>
</table>

Note: 4% of respondents indicated they had personally assisted a patient to commit suicide; 3.5% said they had personally performed active euthanasia.

Table 4.—Ethnic and Religious Differences in Physician Response

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>All Doctors (n=1,028)</th>
<th>Filipino (n=41)</th>
<th>Haw/Poly (n=35)</th>
<th>Catholic (n=195)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician-assisted suicide</td>
<td>160 (15.6%)</td>
<td>2 (4.9%)</td>
<td>1 (2.9%)</td>
<td>13 (6.7%)</td>
</tr>
<tr>
<td>Active euthanasia</td>
<td>101 (9.8%)</td>
<td>2 (4.9%)</td>
<td>2 (5.7%)</td>
<td>11 (5.6%)</td>
</tr>
</tbody>
</table>

Hypothetical Scenarios in a Terminally-Ill Patient

<table>
<thead>
<tr>
<th>Scenario</th>
<th>All Doctors</th>
<th>Filipino</th>
<th>Haw/Poly</th>
<th>Catholic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withhold Life-Support</td>
<td>617 (60%)</td>
<td>13 (31.7%)</td>
<td>5 (12.2%)</td>
<td>83 (42.6%)</td>
</tr>
<tr>
<td>Use High Dose Narcotics To Relieve Pain</td>
<td>206 (19.8%)</td>
<td>5 (12.2%)</td>
<td>5 (14.3%)</td>
<td>27 (13.6%)</td>
</tr>
<tr>
<td>Withdraw Life-Support</td>
<td>600 (58.4%)</td>
<td>11 (26.8%)</td>
<td>7 (17.1%)</td>
<td>33 (16.9%)</td>
</tr>
<tr>
<td>Physician-Assisted Suicide</td>
<td>294 (27.6%)</td>
<td>7 (17.1%)</td>
<td>6 (22.9%)</td>
<td></td>
</tr>
<tr>
<td>Active Euthanasia</td>
<td></td>
<td>1 (2.4%)</td>
<td>1 (2.4%)</td>
<td></td>
</tr>
</tbody>
</table>

(*) denotes p<0.01; (**) p<0.05; (+) p=0.1. No statistical significance was found for other ethnic or religious categories.

Fig 1.—Medical Decision in a Hypothetical Terminal Patient

- Withhold Life-Support
- Use High Dose Narcotics To Relieve Pain
- Withdraw Life-Support
- Physician-Assisted Suicide
- Active Euthanasia
Aloha Dearest Hemlock Member,

First, as a fellow member of our Hemlock Society ohana here in Hawaii, I write to you with an update on some of the most recent developments within the US Court system regarding important Right to Die issues that are presently before the Courts.

Second, as an individual with an untreatable and ‘terminal’ neuromuscular illness—commonly known as Lou Gehrig’s Disease—I’d like to personally encourage you to support our efforts across the Hawaiian Islands to create a heightened level of public awareness for the desperate plight of the terminally ill in gaining our freedom and civil rights.

Today, this struggle has now escalated into a war within the US legal system for our Constitutionally guaranteed right to Die with Dignity, rights that have currently been abridged by US Supreme Court Justice Sandra O’Connor’s injunction order of May 29th.

Background

March 6th, San Francisco, US 9th Circuit Court of Appeals — following years of contested legal wrangling throughout the courts of Washington and Oregon states, the 9th Circuit Court upheld the Constitutional Rights of the terminally ill, and ruled in favor of physician-assisted life termination for mentally competent, terminally ill persons. This ruling frees medical practitioners to legally prescribe and administer lethal drugs to terminal patients.

March 14th, New York, US 2nd Circuit Court of Appeals — following years of contested wrangling throughout the courts of New York and Vermont states, the 2nd Circuit Court upheld the Constitutional Rights of the terminally ill and ruled in favor of physician assisted life termination for mentally competent, terminally ill persons.

May 29th, Washington DC, US Supreme Court—The Hon. Justice Sandra Day O’Connor, the Supreme Court judge immediately responsible for the 9th Circuit issued a stay against the Circuit Court’s rulings until she and her fellow Supremo’s decide whether or not they might care to spare the time to review the 2nd and 9th decision. This review process will drag on into 1997 and possibly into the next century!

Meanwhile, the urgent and pain-filled agonized cries from hundreds of thousands of Americans who are forced to suffer the daily torture of terminal illness . . . goes totally unheeded by a legal/medical establishment more concerned with bureaucratic paper-shuffling and maintaining its power over the mass of society than clearly showing moral leadership or human compassion.

Lives in the Balance ‘96 — I appeal to you, the members of my Hemlock ohana, to please contact your elected representatives both here in Hawaii and in Washington DC, together with all nine Supreme Court Justices, and beseech those in power to regard the review of the 2nd & 9th Court rulings to decriminalize physician-assisted euthanasia by order of the nation’s highest legal body . . . as an extremely urgent matter. Mahalo a Nui. A hui hou, malama pono.

Mikki Lawson, Hemlock Hawaii Member (July 15, 1996)
with the, also standard, set of medical disclaimers—of between 3-5 years of degenerative life expectancy.

Today, almost eleven years later, apart from two brief periods of catastrophic muscular weakness and temporary confinement to a wheelchair for a few months ... I have been able to overcome most of the challenges and have managed to regain some strength ... but since July of '95 I’ve been mostly disabled and dependent. However, I remain confident at overcoming this neuromuscular killer and leading as near a “normal” life soon.

Like most people, I’ve made some serious mistakes in my life. However, I consider myself as relatively ‘normal’ and, because of my recent brushes with terminal neuromuscular illness, I know how important it is to enjoy whatever time is available.

Current Objectives: Since July of 1995, I’ve been severely disabled. During this time of declining health, I’ve been given the unique opportunity to reflect for long periods of time in a wheelchair and isolated confinement on the Quality of my life ... past, present and, perhaps, future?

I’m acutely aware of the grim and terminal prognosis for most ALS/MND victims. However, I do believe in miracles and the healing power of love to conquer all. It is my fervent wish to be happy until the end ... and to die happily.

Activist: Director, Hawaii Macintosh & Apple Users’ Society; Member, Hemlock Society; Member, ALS Association; Member, Hawaii Gay/Lesbian Coalition; Member, Hawaii Transgender Outreach Support; Member, MDA; Supporter, ERGO. Sysop: Surfboard BBS.

I’m active in ALS support and research activities as well as being and active and vocal proponent for the ‘right-to-die’ movement. I’m interested in any and all info/help on ALS/NMD that’s out there. Still learning.

As yet, I can still use my PowerPC pretty good to do DTP and Pre-Press work and some WWW pages. I like to feel I can still make a positive contribution... I’d welcome any ideas, thoughts, advice, direction or morale support anyone can offer.

You can reach me directly at osiris@tapa.com or 808-922-1801. My personal struggles can be accessed at http://www.tapa.com/ohana/MMM/purgatory.html

Aloha a Nui, a hui hou, malama pono, Mikki

Editor’s Note:
(Part II) — I then met Mikki in person at a Board meeting of Hemlock Hawaii. Mikki doesn’t get out very much now, but the Handi-Van did bring him to the meeting at Straub. This man has an unbelievable amount of courage and drive — to keep busy and make the best of life — and he does keep busy at his computer using a mouth-held probe. Hopefully, a new voice-activated computer, “Dragon Dictate” will enable him to be even more productive and faster using voice commands. On September 27, 1996, I received the most exciting message ever transmitted via E-mail: Subj: Where’s My Red Shoes?

“Hello!!!... For the first time in 15 months of being confined to a wheelchair ... I walked over a dozen paces without ANY assistance and without pain this morning... Well, so much for incurable terminal neuromuscular illness.....and...moving right along...we’ll be back after this.....never discount the existence of miracles or underestimate the healing power of prayer... Oh Toto! Are we in Kansas yet?”
The Friday and Saturday morning programs October 18-19, 1996, were designed to bring primary care physicians up-to-date on a variety of specialties, emphasizing how to evaluate and treat and when to refer. Six speakers each morning delivered information-packed 30 minute talks. The program was truly excellent, and I hope that the speakers will comply with the Journal editor’s request for manuscripts so that physicians who did not attend may have the benefit of their expertise. It is not possible to report it all in the limited space available here.

Dr Melvin H.C. Yee spoke about “worrisome” and “non-worrisome” headaches. Worrisome headaches are new onset headaches, those described as “the worst headache of my life” and those accompanied by focal neurological signs, meningeal signs, increased intracranial pressure, or a history of trauma or AIDS. Non-worrisome headaches are the benign recurrent headaches such as tension headache, classic migraine, common migraine, cluster headache, caffeine withdrawal headache and analgesic dependent headache. He discussed causes and treatment of each.

Dr Rhoads Stevens discussed common eye problems, beginning with a list of those which should be referred to an ophthalmologist: sudden loss of vision, eye pain not due to corneal abrasion, corneal opacity, pupillary abnormality, significant trauma, rapidly worsening acute conjunctivitis, chronic conjunctivitis lasting over one month; soft contact lens wearers because they are prone to pseudomonas infection which can lead to perforation in 24 hours; anyone with a history of previous eye surgery. Conditions which the primary care physician can treat: subconjunctival hemorrhage, chalazion, seborrheic blepharitis, classic adenoviral conjunctivitis, acute bacterial conjunctivitis, acute allergic conjunctivitis, corneal abrasion.

Dr Alfred J. Liu described approaches to allergic and non-allergic rhinitis, acute and chronic sinusitis, and workup of the patient with vertigo.

Dr John McDonnell described asthma as characterized by reversible airway obstruction, airway inflammation, and increased airway responsiveness to inhaled allergens and a variety of other stimuli. 75-85% of patients have positive skin tests. Airway inflammation is a major problem. Inhaled steroids are used to prevent symptoms, not to treat them, in patients with persistent asthma. Bronchodilators and beta-agonists are used to treat symptoms.

Dr Edward Chesne discussed the evaluation and treatment of the patient with hypertension. Many who have hypertension are unaware and many who are being treated are not adequately controlled. People with high normal BP (systolic 130-139, diastolic 85-89) are at increased risk for developing hypertension. Other coronary risk factors are common in those with hypertension, and treatment should begin with lifestyle modification. If response in 3-6 months is inadequate, drug treatment with diuretics or beta-blockers should be started. If BP control is still inadequate, dose should be increased or another drug substituted. If these fails the addition of a third drug may be indicated. If hypertension is severe (systolic 210, diastolic 120) prompt and aggressive treatment is necessary.

Dr Mari Nakashizuka described the evaluation of breast masses and abnormal mammograms. 80% masses are benign. Fine needle aspiration is used to distinguish cyst from solid mass. If the mass is not cystic, material should be withdrawn for cytology. Surgical consult should be sought if there is a residual mass after a cyst is evacuated or if the fluid is bloody. 80% with breast cancer have no known risk factors; 1:1000 men have breast cancer.

Dr Erlaine Bello’s topic was the choice of antibiotics for respiratory tract infections in outpatients. Otitis media is the most common infection for which antibiotics are used. Most common agents in otitis media and bacterial sinusitis are pneumococcus and H. influenza. Strep pyogenes and rhinovirus are most often implicated in pharyngitis. Penicillin VK is the cheapest for strep pharyngitis. Amoxicillin is effective against hemophilus as well as the gram-positive organisms. Third generation cephalosporins are the best gram-negative agents and have the longest dosing intervals. Erythromycin is inexpensive but has to be given QID. Compliance depends upon dosing frequency, length of treatment and side effects.

Dr Norman Goldstein provided guidelines for the treatment and referral of common skin problems: acne should be referred if response to 6-8 weeks of treatment with OTC preparations such as desquamex is poor; psoriasis if inadequate response with 3-4 weeks of topical steroids or tar preparations; warts and molluscum contagiosum if the physician does not have the facilities or training for treatment; moles and keratoses should be referred if malignancy is suspected, if there is a personal or family history of melanoma, or if the lesion grows, changes color or shape, bleeds, ulcerates or is subject to irritation; herpes simplex and zoster if there is no response to treatment in 5-7 days; impetigo and pyoderma if unresponsive to antibiotics after 2-3 days; fungal infections if they do not respond to topical antifungals; alopecia if the cause is not obvious or if the physician lacks experience for managing.

Dr James Scooggins discussed the diagnosis and treatment of common athletic injuries: dislocations and subluxations of the shoulder, rotator cuff strain or tear, acromioclavicular joint separation, lateral epicondylitis (golfer’s wrist), skier’s or gameskeeper’s thumb, ulnar nerve compression (distance cyclists), extensor synovitis of radial wrist extensors (oarman’s wrist), trochanteric bursitis (female runners usually), hamstring pain (football and soccer), chondromalacia patella (runner’s knee), iliotibial band friction syndrome (runners and cyclists), shin splints (runners), ankle sprains.

Dr William Yarbrough discussed the evaluation and treatment of impotence. Causes include many drugs, a wide variety of diseases, surgical procedures and traumas. Treatment is based on determination of the underlying cause and its elimination if possible. Some oral and intercavernosal medications may be helpful. Prostheses are a last resort.
Dr William Haning, III, covered the outpatient evaluation and management of substance abusers. He described screening instruments used to assess abusers of alcohol and other drugs and criteria for deciding whether outpatient treatment is appropriate.

Dr Gerald McKenna discussed sources of physicians' stress and the impact on physicians' families. Stresses may come from the training experience, the demands of practice, failure to forgive oneself for mistakes, and the physician's personality. Stress may result in physical illness, depression, anxiety, and chemical dependence. Families may experience alienation from the physician, feel abandoned, and they often suffer in silence. Chemical abuse/dependence is common; divorce and separation rates are high. Possible solutions are physician support groups, physicians health committees, psychotherapy (usually rejected), medication, or mentoring to improve practice management.

The Sunday morning session dealt with managed care. Robert C. Nickel (HMSA) gave an overview of managed care in Hawaii. Dr John Berthiaume discussed how physicians are selected, deselected, evaluated and compensated in managed care programs. Dr George Bussey described the effects of managed care on doctor-patient relationships and the ethical dilemmas which may arise. Dr Michael Nagoshi discussed practice guidelines and problems which may be associated with their use. Finally attorney Peter C. P. Char talked about medical-legal aspects of managed care and the potential liability of physicians. He emphasized the importance of careful documentation of the decision-making process and of discussions with the patient regarding informed consent.

Continued From Page 283


Counted among the January 1997 issue, is a new Publication entitled: "The Hawaii Medical Journal September Special Issue on Domestic Violence are available at HMA"

Copies of the Hawaii Medical Journal September Special Issue on Domestic Violence are available at HMA

Please call 536-7702, ext. 2239 for more information

Classified Notices

To place a classified notice:
HMA members.—Please send a signed and typewritten ad to the HMA office. As a benefit of membership, HMA members may place a complimentary one-time classified ad in HMA's newsletter is available.

Nonmembers.—Please call 536-7702 for a nonmember form. Rates are $1.50 a word with a minimum of 20 words or $30. Not commissionable. Payment must accompany written order.

Positions Available

Johnston Atoll.—Unaccompanied physician with U.S. license required for general practice, 48 hr week. Housing, food, and transportation is provided. JA is a friendly community with recreational opportunities including diving, sailing, and a 9 hole golf course. Please respond to Pam Cooper, Holmes & Harver, PO Box 6240, Orange, CA 92663-6240.

Immediate Opportunities available at Family Practice Clinics. Honolulu, Oahu, Waikiki, Maui, and Kailua-Kona, Hawaii. Spectrum Healthcare Resources offers: Permanent full or part-time positions, independent contractor or employee status available, flexible hours, competitive salary/benefits. For more information, please contact: Mike Dominguez at 800-288-6044 ext. 2305 or fax your CV to 719-589-7947, or Paula Wilson at 800-325-3892 ext. 8315 or fax your CV to 314-919-8191.

Looking for board certified Ophthalmologist licensed to practice in Hawaii to join a group practice. A & B scans, office lasers, ERG, VER, optical dispensaries, and full office equipment available. Interested, call Traci at 677-7400 for information.

Office Space

Ala Moana Bldg.—Office space available immediately. Completely furnished, 2 exam rooms and consultation room. Best reasonnable offer. Call 955-6666.


Kapolei Medical Park.—Tenants include HMSA, Kapiolani, Straub, & Queens. A limited amount of custom designed space will be available for private practices in this exclusive first-class building. For info call (800)-537-6329.

Services Available

CPA specializing in Medical Profession. Books, payroll, taxes—Big Six experience, honest & reliable. Call Rose Chan at the Financial Advantage 262-0877 or e-mail cpa@aloha.net.

For Sale

This instrument, commonly used in conjunction with a living will, authorizes a designated trusted individual to decide on the patient’s behalf, including the refusal of treatment. These are legitimate examples of patient autonomy at work. Allowing death to occur naturally by withholding ineffective and non-beneficial treatment is fundamentally different from the deliberate termination of life. In the former case, the underlying terminal condition is allowed to take its natural course; in the latter, a positive act is performed with the specific intent to kill.

Unfortunately, only a minority, perhaps 15% of the public, has executed such advanced directives. One reason—fear that they may be prematurely ‘done-in’ if they are hospitalized with living wills. Continued educational efforts should allay these fears; permitting mercy-killing, on the other hand, can be expected to have the opposite effect.

But most of all, legalizing mercy-killing will lead us down the slippery slope, with inevitable abuses. What begins as allowing free-choice would slide into subtle encouragement to end life; mental coercion and involuntary euthanasia without explicit patient requests lie short steps away. Relieving a burden and saving the healthcare dollar are the unspoken rationalizations. Who is most imperiled? — the handicapped, the poor and the aged. The right to die now becomes a duty to die.

Incidentally, the free-choice argument, extended to its logical conclusion, should not require the pre-requisite of a terminal illness.

When caring becomes more important than curing, St. Francis Hospice offers...

- an alternative to expensive hospitalization during the final phase of life
- respite care for the family when a break is needed
- help to the patient and family in dealing with physical, emotional, spiritual and social pain
- interdisciplinary care including nursing, social work, nutrition, home health services, chaplain services, bereavement support, durable medical equipment, pharmacy services, medical supplies, laboratory services and counseling

Or for that matter, any illness. Remember, whose life is it anyway?

History, religion and sociology are all on the side of banning mercy-killing. Since the dawn of history, society has always forbidden the taking of lives by physicians. The Hippocratic oath bears such testimony. All religions of the world consider mercy-killing to be sinful, immoral, or just plain wrong. And experiences from the Dutch, who have condoned the practice for some time, tell us that nearly 90% of patients rescinded their initial death request, most often after having had the opportunity to resolve feelings of depression, helplessness, and fear of abandonment. Most tellingly, in some 1,000 deaths, there was no explicit request by the patient for mercy-killing.

The views of advocates of “managed-death” are wrong because they cheapen human life, misconstrue and oversimplify the clinical context of the dying patient, and underestimate the fatal impact mercy-killing will wield on society’s voiceless and vulnerable. I concede there may be an extreme case of intolerable unremitting pain in an absolutely clear-minded individual who pleads for a merciful end. How could one not feel compassion and empathy in such a rare example? I frankly do not know how I would react to such a request by my patient. But I do know this: America is currently squeezed by rising healthcare costs, and is experiencing mindless violence, increasing discrimination, family rupture, and the secularization of the medical profession into a business. In this environment, a thumbs-up for legalized mercy-killing will work to produce a more dangerous, impersonal and uncaring society.
INDEX to the Hawaii Medical Journal
Volume 55, 1996
Compiled by Carolyn S.H. Ching and Christine Sato of the Hawaii Medical Library

Keyword Index

ACADEMIC MEDICAL CENTERS. Trispler graduation [Military medicine], 55(8):133
ACCURACY. Medical insurance claims as a source of data for research: accuracy of diagnostic coding, 55(1):95
ACSCLOVIR. Herpes zoster at school age: a case presentation and discussion of the unique aspects within the pediatric population, 55(7):118
ADOLESCENCE. When children witness domestic violence, 55(9):162
— Teen perspectives on HIV and the relevance of Hawaii’s health providers, 55(10):205
SUMMARY. Kahuna lapaau, 55(1):237
ADVANCE DIRECTIVES. The need to live right, the right to die [President’s message], 55(6):96
— Cultural issues in death and dying, 55(12):260
AGE FACTORS. A new, standardized approach to fracture risk interpretation, 55(8):141
— Attitudinal survey of euthanasia in Windward Oahu: a cross-sectional pilot study of four age groups, 55(12):265
AGED. First case report of spontaneous pulmonary hemorrage following hepatic transplantation in acute myocardial infarction, 55(5):63
— elderly and disabled in Hawaii, 55(12):258
AIR AMBULANCES. Preparation of the injured patient for aeromedical evacuation: environment and physiology [Military medicine], 55(11):226
AIR MOVEMENTS. Airflow over the island of Hawaii [abstract], 55(3):44
AIR POLLUTANTS, ENVIRONMENTAL. Vog in Hawaii [Editorial], 55(3):41
— Guest editor, 55(3):41
— Vog overview and background [abstract], 55(3):44
— Atmospheric structure around the Big Island and how it affects vog flow [abstract], 55(3):45
— Vog concentrations from satellite [abstract], 55(3):45
— vog size distributions, optical effects, and spatial variability [abstract], 55(3):46
— Volcanic emissions from Kilauea and their effect on air quality [abstract], 55(3):46
ALZHEIMER’S DISEASE. “Controversies in medicine,” highlights of the HMA scientific session, 55(1):14
AMERICAN MEDICAL ASSOCIATION. Re: AMA/Federation of Medicine re-organization [HMA president’s message], 55(8):132
— HMA president’s message, 55(9):155
ANTIVIRAL AGENTS. “Controversies in medicine,” highlights of the HMA scientific session, 55(1):14
— Herpes zoster at school age: a case presentation and discussion of the unique aspects within the pediatric population, 55(7):118
ANXIETY, SEPARATION. When children witness domestic violence, 55(9):162
ASIAN-AMERICANS. Barriers to mammography in a low income, multiracial clinic population, 55(8):136
ATMOSPHERE. Atmospheric structure around the Big Island and how it affects vog flow [abstract], 55(3):45
ATTITUDE. Domestic violence...myths and barriers, 55(9):159
ATTITUDE OF HEALTH PERSONNEL. Letters to the editor, 55(7):112
— Domestic violence...myths and barriers, 55(9):159
— Teen perspectives on HIV and the relevance of Hawaii’s health providers, 55(10):205
— Attitudinal survey of euthanasia in Windward Oahu: a cross-sectional pilot study of four age groups, 55(12):265
— ATTITUDE TO HEALTH. Barriers to mammography in a low income, multiracial clinic population, 55(8):136
— Teen perspectives on HIV and the relevance of Hawaii’s health providers, 55(10):205
— Attitudinal survey of euthanasia in Windward Oahu: a cross-sectional pilot study of four age groups, 55(12):265
— AUDILOGY. Roles of speech language pathologists and audiologists in medicine [Medical school hotline], 55(1):16
— AUSTRALIA. Models of physician-assisted dying, 55(12):284
— BATTERED WOMEN. Domestic violence...myths and barriers, 55(9):159
— PTSD among women survivors of domestic violence in Hawaii, 55(9):164
— Pandora’s box: open it and pass it on! Victim advocates can bring relief to busy physicians, 55(9):166
— BEHAVIORAL AND MENTAL DISORDERS. When children witness domestic violence, 55(9):169
— Multidisciplinary evaluation of preschool children in a military psychiatry clinic: a 10-year comparison and a brief outcome study, 55(11):231
— BIOMEDICAL. Transient blindness in a preeclamptic patient secondary to cerebral edema, 55(7):116
— BONE DENSITY. A new, standardized approach to fracture risk interpretation, 55(8):141
— BOTTICELLI, MAX. A doctor’s advice on choosing how to die. 1995 [classical article], 55(9):182
— BRAIN EDEMA. Transient blindness in a preeclamptic patient secondary to cerebral edema, 55(7):116
— BREAST NEOPLASMS. New method for breast cancer detection using TC-99m sestamibi scintimammography, 55(2):26
— Barriers to mammography in a low income, multiracial clinic population, 55(8):136
— Cultural issues in death and dying, 55(12):260
— view of death and dying among the Chinese and Japanese, 55(12):258
— view of death and dying among the Chinese and Japanese, 55(12):286
— CROSS-CULTURAL STUDIES. An attitudinal survey of euthanasia in Hawaii: a cross-sectional pilot study of four age groups, 55(12):265
CULTURE. Identifying family violence: a community prototype incorporating native Hawaiian values and practices, 55(9):169
— Native Hawaiian culture across the curriculum at the John A. Burns School of Medicine [Medical school hotline], 55(11):227
— Cultural issues in death and dying, 55(12):260
— view of death and dying among the Chinese and Japanese, 55(12):258
CURRICULUM. Native Hawaiian culture across the curriculum at the John A Burns School of Medicine [Medical school hotline], 55(11):227
— Care of the dying at the John A Burns School of Medicine University of Hawaii, 55(12):293
DATA COLLECTION. Medical insurance claims as a source of data for research: accuracy of diagnostic coding, 55(1):9
— view of death and dying among the Chinese and Japanese, 55(12):286
DEATH. Cultural issues in death and dying, 55(12):260
— view of death and dying among the Chinese and Japanese, 55(12):286
DETECTION. View of death and dying among the Chinese and Japanese, 55(12):258
DEPRESIVE DISORDER. PTSD among women survivors of domestic violence in Hawaii, 55(9):164
— DEVELOPMENTAL DISABILITIES. Multidisciplinary evaluation of preschool children in a military psychiatry clinic: a 10-year comparison and a brief outcome study, 55(11):231
— DIABETES MELLITUS. National diabetes awareness month [Editorial], 55(11):225
— DIAGNOSIS. Medical insurance claims as a source of data for research: accuracy of diagnostic coding, 55(9):19
— DIAGNOSTIC TESTS, ROUTINE. “Controversies in medicine,” highlights of the HMA scientific session, 55(1):14
— New method for breast cancer detection using TC-99m sestamibi scintimammography, 55(2):26
Nancy Dickey, MD
AMA Board Chair discusses Physician-Assisted Suicide

What is the AMA's overall position on the issue of physician-assisted suicide?

Physicians are devoted to healing and to relieving suffering. As your doctor, I am obligated and committed to helping you in your remaining days. I cannot be the cause of your death, nor can I assist you in causing your own death.

What is the AMA's underlying concern on this issue?

The heart of our concern is placing physicians in the position to actively end their patients' lives. My patients must know wholeheartedly that I am devoted to their health and welfare, not deciding their fate based on what I, or others, might perceive to be the value of their remaining life. Make no mistake, when it comes to caring for my patients' health and welfare, I am their trusted ally.

How do you respond to critics who say the AMA's position on physician-assisted suicide does not consider patient fear and desire for dignity at the end of life?

Fear associated with physical suffering, with losing control, with being a burden to or dependent upon family members, and with losing dignity is an understandable reality. The medical profession has not concentrated on these issues to the necessary degree. But, we feel the appropriate alternative to physician assisted suicide is improved care through a better informed medical profession and public, working together to ease the dying process. I will use all of my skill and knowledge to relieve your suffering, I will get you the help you need to come to terms with death. But, I cannot help you kill yourself.

How does the AMA distinguish between controlling pain even if it causes death and assisted suicide?

The distinction is based on the intent of my actions. I am acting in the best interests of my patient if, while attempting to control suffering and maximize his or her comfort, death is hastened. However, if the intent of my actions goes beyond comfort and focuses specifically on causing death, I am either assisting in suicide or performing euthanasia, both of which are unethical.

How does assisted suicide through pain medication differ from death caused by removal of treatment/life support? In the case of a patient whose life is artificially extended by technology, they and their family, in consultation with their physician, may decide to withdraw that life support. The patient's ability to remove the technological barriers to natural death is paramount to their autonomy and dignity. Again, the issue is one of intent. By removing artificial life support, I am honoring my patient's wish to allow natural death to occur. My intent is to avoid prolonging artificially sustained life, not to cause death.

Will the AMA appeal these and other Court decisions?

We will do whatever is necessary to ensure that physicians are not put in a position to kill, and that patients die in comfort and with dignity. If this means appealing directly or submitting amicus briefs or offering verbal or written testimony in support of an appeal, we will do so. In addition, the AMA is mounting a major information based campaign to educate and inform the courts, the media, physicians and the general public about the alternatives to physician-assisted suicide, including hospice care.

Will the AMA consider changing its policy regarding physician-assisted suicide?

We will continue our discussions with those whose opinions differ from ours. We will aggressively increase our efforts to educate physicians at all levels in treating physical pain and the psychological needs of patients at the end of life. We will work diligently to enlighten patients on the alternatives to physician assisted suicide, including hospice care. However, the related ethical opinions developed by the AMA's Council on Ethical and Judicial Affairs will remain unchanged.

Interview by Mark Wolfe
Only in America.

This corny story is about oily Stefano Mazzola, CEO of TriCon Associates of Hasbrouck Heights, N.J. who was arrested on racketeering charges. Allegedly, Mazzola, a reputed mafia enforcer and other members of the Genovese crime family, were paying unnamed individuals $100 for each new member signed to the HMO or PPO clients of Tri-Con. As a side action, by using his brokerage contacts, he was able to provide free medical coverage for mobster associates. What a guy; a fraudulent medical enrollment plan, free heath care for the Don and family, plus a lottery, book-making, and sports betting on the side.

There Ought to be a Law- and Now There is!

In a truly landmark legal decision, a state court in Idaho ruled that laser surgery is actually surgery. The outcome of this action is that wannabe eye surgeon optometrists will not be able to perform photorefractive keratectomy (PRK) just like real doctors do. Additionally, the court stated that the Idaho State Board of Optometry does not have the power to enlarge the scope of the practice of optometry. The logic of this patient protection decision will not be limited to eye surgery, but should establish a precedent for all areas of medical practice where pretenders could invade with lasers. If the wannabes had been supported by the court, we would soon see beauticians performing laser blepharoplastics, and naturopaths and chiropractors doing laser removal of varicose veins and treating skin disorders.

There is no Underestimating the Intelligence of the American Public.

Apparently the reason Joe Camel is wearing dark glasses is because the poor old dromedary is blind. The discovery that the use of tobacco increases the incidence and severity of age-related macular degeneration was big news for the media. Reporting in the October 9, 1996, JAMA, Seddon, et al. at the Mass. Eye and Ear Infirmary, in an epidemiologic study, found that women smokers had an AMD occurrence roughly 2.4 times that of women who never smoked. The data were slightly less provocative for males.

Showing up is 80% of Life.

The recent Hawaii Medical Association annual meeting at the Kauai Marriott was a very productive gathering of the members, visiting MDs, Delegates to the House, and spouses. If you failed to attend, you missed a fascinating and inexpensive, highly relevant educational and social event. Also, the HMA is in the process of restructuring in order to provide a leaner and more relevant organization to tighten expenditures, and provide more action. An interesting and frightening sidelight was the allegation that a physician assistant (PA) on Kauai is openly practicing medicine by using an electronic communication with a distant physician for his umbrella. Delegates were alarmed to learn that an unscrupulous doctor can lend his license to PAs, apparently without regulation, while he claims to be supervising the PA through electronics. This disgraceful medical license abuse must be investigated and prosecuted by RICO and the Board of Medical Examiners. This is still another example of incompetent pretend- ers not bothering with the challenging experience of earning a medical education.

Information Deteriorates Upward Through Bureaucracies.

If you didn’t already know, the Corporation for Enterprise Development in Washington D.C. surveyed the fifty states for business employment, earnings, job quality and economic performances, and Hawaii finished—dead last. That’s right, number five-oh, and that’s not a TV show. Keep that in mind when you head for the polls, and remember also that small business employs 54% of the private work force, contributes 52% of all US sales, and was responsible for 50% of the private GNP.

Everyone is, in his Own Way, Vulnerable.

A family physician in Arkansas examined a 13 month old infant and found a forearm fracture of both bones and bruises on the baby’s head. Suspecting child abuse, the doctor inquired if anyone deliberately injured the baby. The mother said no one was abusing the child, and the doctor dropped the issue and did not report her suspicions to the state Human Services Department. Three months later, the 16 month old girl was brought to a Lime Rock hospital and was pronounced dead of massive head injuries. The mother’s boyfriend was arrested and convicted of first degree murder and sentenced to life in prison. Subsequently, in a civil suit, a jury determined that the doctor had committed malpractice for failure to pursue the original suspicions, and awarded $200,000 to the baby’s estate.

We Must Live with the Ambiguity of Partial Knowledge.

In the spring of the year, a patient was experiencing dizzy spells and difficulty closing her right eye. In November, she consulted a neurologist who diagnosed Bell’s palsy. Because the condition was still present three months later, he admitted her to the hospital for diagnostic tests which revealed no abnormality. The patient did not return until the following year, at which time the doctor modified his diagnosis by saying the condition was “a bit more routine than Bell’s palsy,” but he ordered no further tests. The patient did not return to his care, but 18 months later underwent surgery to remove a tumor from her facial nerve. Because the nerve was destroyed, the patient brought a successful lawsuit against the neurologist claiming that his delay prevented any possibility of saving nerve function. The jury awarded her $800,000.

Addenda—

郧 Percentage of Americans who didn’t know Serbs were the groups that attacked Bosnia: 79%; who didn’t know the reason for the fighting: 68%; who didn’t know the meaning of ethnic cleansing: 66%.
郧 People who read the Packwood dairies can’t wait to get to the bottom of the page, which incidentally is Packwood’s problem too.

Aloha and keep the faith—rts
To make sure their students learn on state-of-the-art equipment, companies like the Corporate Training Center lease their computer equipment through Bancorp Leasing.

From Corporate Training Center’s point of view, the arrangement is definitely user friendly—Bancorp Leasing offers competitive rates, flexible terms and professional service.

If your business needs any type of computer equipment, from PC’s to a multi-million dollar mainframe, consider leasing. Give Bancorp Leasing a call at 537-8810. On the Neighbor Islands, 1-800-451-6022.

Bancorp Leasing of Hawaii
In 1975, physicians realized that the best way to protect themselves from professional liability was to start their own insurance company. MIEC was the West's first doctor-owned insurance company.

Twenty-one years later, MIEC is still owned by doctors and governed by doctors. We still put the needs of our policyholders first. Want an insurer you can depend on? Call MIEC. We'll give you the service you need. And deserve.

MIEC

Sponsored by the Hawaii Medical Association

Medical Insurance Exchange of California
6250 Claremont Avenue, Oakland, California 94618
Telephone: 800-227-4527  Fax: 510-654-4634

HAWAII CLAIMS OFFICE:
1360 South Beretania, Suite 405, Honolulu, Hawaii 96814
Telephone: 808-545-7231