"NEW JERSEY DEATH WITH DIGNITY ACT"
(A 3328)

A 3328[1] is an Oregon-style doctor-prescribed suicide bill.

The proposed law comes at a time when

- *More people in New Jersey die annually from suicide than from motor vehicle accidents.[2]*
- *Each year, suicides in New Jersey vastly outnumber homicides.[3]*

ANALYSIS

- **A 3328 would give government bureaucrats and profit-driven health insurance programs the opportunity to cut costs by denying payment for more expensive treatments while approving payment for less costly assisted-suicide deaths.**

  This has already been documented in Oregon – the state on which the New Jersey proposal is based. The Oregon Health Plan (OHP) has notified some patients that medications prescribed to extend their lives or improve their comfort level would not be covered, but that the OHP would pay for a lethal drug prescription.[4]

  Referring to payment for assisted suicide, the Oregon Department of Human Services explains, "Individual insurers determine whether the procedure is covered under their policies, just as they do any other medical procedure."[5]

  If A 3328 is approved, will health insurance programs and government health programs do the right thing – or the cheap thing?

- **A 3328 would allow family members or health care providers and others to advise, suggest, encourage or exert subtle and not so subtle pressure on patients to request doctor-prescribed suicide, setting the stage for elder abuse and pressure on vulnerable patients.**

  A 3328 would penalize anyone who "coerces or exerts undue influence"[6] on a patient to request the lethal prescription. However, those words have a very narrow legal meaning. The proposal does not prohibit someone from suggesting, advising, pressuring or encouraging a patient to request doctor-prescribed suicide.

  Since victims of domestic abuse, including elder abuse, are extremely vulnerable to persuasion from their abusers, it takes little imagination to understand how A 3328 could put abused patients at risk of being persuaded to request doctor-prescribed suicide.

- **A 3328 could lead a patient to request assisted-suicide based on fear of being a burden to others.**

  Under A 3328, the doctor is required to "recommend that the patient notify the patient's next of kin of the patient's decision" to request assisted suicide.[7] But such family notification by the patient is not required. If a patient fears becoming a burden and if loved ones are unaware of that concern, they are unable to reassure the patient of their care and love.

  In the last official Oregon report, the fear of becoming a burden on others was given as a reason for requesting lethal drugs by more than 57 % of those who died using that state's assisted-suicide law.[8]

- **Nothing in A 3328 requires that any of the patient's requests for an assisted-suicide prescription be made in person.**

  Just as with Oregon's assisted-suicide law, A 3328 requires that a patient make two oral requests and a written request to the attending physician before receiving the prescription for doctor-prescribed suicide.[9]

  Since nothing in the proposal requires that any of those requests be made in person, the oral requests could be made by telephone and the written request could be mailed to the physician.

- **Under A 3328, someone who would benefit financially from the patient's death could serve as a witness and claim that the patient is mentally fit and eligible to request assisted suicide.**

  A 3328 requires that there be two witnesses to the patient's written request for doctor-prescribed suicide. Only one of those witnesses shall not be a relative or someone entitled to any portion of the person's estate upon death.[10]

  However, this provides little protection since it permits one witness to be a relative or someone who *is* entitled to the patient's estate. The second witness could be the best friend of the first witness and no one would know.

  Victims of elder abuse and domestic abuse are unlikely to share their fears with outsiders or to reveal that they are being pressured by family members to "choose" assisted suicide.

- **A 3328 has no protections for the patient once the assisted-suicide prescription is filled.**

  Like the Oregon law, A 3328 only addresses activities taking place up until the doctor writes the lethal prescription. There are no provisions to insure that the patient is competent at the time the overdose is taken or that the patient knowingly and willingly takes the drugs.

Due to this lack of protection at the time of their deaths, A 3328 would put patients at enormous risk. For example, someone who would benefit from the patient's death could trick or even force the patient into taking the fatal drugs, and no one would know that the patient's death was not voluntary.

- **A 3328 gives the illusion of choice. Yet, it will actually constrict patient choice.**

  Under A 3328, before writing a prescription for death, a doctor must "inform" the patient of "the feasible alternatives to taking the medication, including, but not limited to, palliative care, hospice care, and pain control."[11] However, being "informed" of all options does not mean that patients will have access to all options. It only means they must be told about them.

  If doctor-prescribed suicide becomes just another treatment option, and a cheap option at that, the standard of care and provision of health care changes. There will be less and less focus on extending life and eliminating pain, and more and more focus on the "efficient" treatment option of death.

  Patients may find that their insurance does not cover the "feasible alternatives" their doctors informed them about but, instead, will pay for doctor-prescribed suicide. This has already happened in Oregon.[12]

- **A 3328 would permit assisted-suicide prescriptions for mentally ill or depressed patients.**

  Before receiving a prescription for death, patients do not need to have any psychological or psychiatric evaluation unless a doctor thinks that the patient is "suffering from a psychiatric or psychological disorder or depression that is *causing impaired judgment*."[13] If a counseling referral is made, it may consist of only one consultation.[14]

  Even if the counselor determines that the patient has a mental disorder or disease, the prescription for suicide could still be written as long as the counselor determines that the patient's judgment is not impaired.

  This provision is the same as that contained in Oregon's law where, in 2011, only one of the reported 141 patients who received lethal prescriptions was referred for counseling.[15] A study about Oregon's law found that it "may not adequately protect all mentally ill patients."[16]

- **A 3328 would allow doctors to prescribe death for patients who could live for many years.**

  Under A 3328, doctors would be permitted to prescribe assisted suicide to patients who have a "terminal disease," which is defined as "an incurable and irreversible disease that has been

medically confirmed and will, within reasonable medical judgment, result in a patient's death within six months."[17]

However, that definition does not require that the patient is expected to die within six months, *even with medical treatment*, nor does it require that the condition be *uncontrollable.* Therefore, it is possible that a patient could be considered "terminal" for the purpose of qualifying for assisted suicide even if, with medical treatment, the patient could live much longer.

For example, diabetes can be both incurable and irreversible but it is controllable. An insulin-dependent diabetic patient who stops taking insulin will, within reasonable medical judgment, die within six months. Thus, under A 3328, diabetics could be eligible for doctor-prescribed suicide even though they could live virtually normal lives with insulin.

There is documentation that this has occurred under Oregon's assisted-suicide law. In the latest official report from Oregon, diabetes is noted as the underlying terminal condition that made the patient eligible for a lethal prescription.[18]

- **A 3328 would permit a third party to request assisted suicide for a patient without any oversight to determine the accuracy of the request.**

  Under A 3328, patients are considered capable of requesting assisted suicide not only by communicating the decision on their own but also by "communication through persons familiar with the patient's manner of communicating if those persons are available."[19]

  This could include not only translating various languages but also facilitated communication[20] and could lead to a patient's wishes being misunderstood, misinterpreted, or disregarded. There is no requirement that such communication assistance be verified.

  Who will know if the person communicating on behalf of the patient is doing so accurately? What, if any, professional expertise will be required of those communicating on behalf of the patient?

- **A 3328 would allow drugs for suicide to be delivered to the patient by a third party.**

  Nothing in A 3328 requires the patient to obtain the drugs in person. A pharmacist can dispense the lethal drugs to an "expressly identified agent of the patient."[21] That agent could be the abusive spouse or heir who persuaded the patient to request the prescription and who witnessed the patient's written request.

- **A 3328 could permit a representative of an assisted-suicide advocacy organization to witness a vulnerable patient's written request.**

  If a patient is in a long term care facility, "one of the witnesses shall be an individual designated by the facility."[22] In Oregon, members of the assisted-suicide advocacy group

that spearheaded that state's law on which the New Jersey proposal is patterned, have acknowledged that they play a key role in the vast majority of deaths under the state's assisted-suicide law.[23]

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[1] The text of A 3328 is available at: http://cbsnewyork.files.wordpress.com/2013/02/bill.pdf (last accessed 3/20/13).
[2] CDC's most recent National Vital Statistics Report (NVSR, Vol. 61, No. 4, Table 19). Available at: http://www.cdc.gov/nchs/data/dvs/deaths_2010_release.pdf (last accessed 3/20/13).
[3] CDC's most recent National Vital Statistics Report (NVSR, Vol. 61, No. 4, Table 19). Available at: http://www.cdc.gov/nchs/data/dvs/deaths_2010_release.pdf (last accessed 3/20/13).
[4] KATU Television, "Letter noting assisted suicide raises questions," (interview about one such case and the response of the Oregon Health Plan). Available at: http://www.katu.com/news/26119539.html (last accessed 3/20/13).
[5] Oregon Dept. of Human Services, "FAQs about the Death with Dignity Act." Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/faqs.aspx (last accessed 3/20/13).
[6] Section 18 b.
[7] Section 6 a (6).
[8] Official report for 2012 deaths under Oregon's Death with Dignity Act, pg. 5. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf (last accessed 3/20/13).
[9] Section 11 a.
[10] Section 5 b.
[11] Section 6 a (3).
[12] KATU Television, "Letter noting assisted suicide raises questions," (interview about one such case and the response of the Oregon Health Plan). Available at: http://www.katu.com/news/26119539.html (last accessed 3/20/13).
[13] Section 8.
[14] Section 3, definition of "counseling."
[15] Official report for 2011 deaths under Oregon's Death with Dignity Act, pp. 3 and 5. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf (last accessed 3/20/13).
[16] Linda Ganzini, Elizabeth R. Goy, Steven K. Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey," *British Medical Journal*, Oct. 25, 2008, pp. 973-978.
[17] Section 3, definition of "terminal disease."
[18] Official report for 2012 deaths under Oregon's Death with Dignity Act, pg. 6, fn. 6. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf (last accessed 3/20/13).
[19] Section 3, definition of "capable."
[20] Facilitated communication in which a person, called a "facilitator," supports the hand or arm of a person who is impaired, using a device such as a keyboard to help the individual communicate.
[21] Section 6 b (2) (b).
[22] Section 5 d.
[23] Officers of Compassion in Dying/Compassion & Choices of Oregon were the chief proponents of Oregon's assisted-suicide law. They have proclaimed themselves stewards of the law. According to one spokesperson for the organization, in 2009, it was involved in 97% of deaths under the law. For documentation see: "The Proportion of Oregon Assisted Suicides by Compassion & Choices Organization." Available at: http://www.patientsrightscouncil.org/site/oregon-assisted-suicide-deaths (last accessed 3/20/13).

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