MSNJ
MEDICAL SOCIETY OF NEW JERSEY

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Opposition to A3328 "New Jersey Death with Dignity Act"

Dear Chairman Conaway and members of the Assembly Health and Senior Services Committee:

The Medical Society of New Jersey (MSNJ) respectfully opposes A3328 (Burzichelli/Eustace), which would permit a qualified patient to self-administer medication to end life. Simply, physicians should not be asked to cause or facilitate death.

MSNJ stands with the American Medical Association, which has repeated its policy on a few occasions:

> Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide)...Physician-assisted suicide is **fundamentally incompatible with the physician's role as healer**, would be difficult or impossible to control, and would pose serious societal risks...Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.[i]
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> It is the policy of the AMA that: [sic] Physician assisted suicide is fundamentally inconsistent with the physician's professional role.[ii]
>
> Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer.[iii]

The bill defines a terminal illness as one that a physician determines will cause death within 6 months (Section 3). This is an arbitrary and dangerous baseline for assisted suicide, as there is often possibility of improvement; patients do outlive their prognoses. The bill also requires physicians to "determine" and "verify" that a patient's decision to end life is "voluntary" and capably made (Sections 5 and 6). But, determinations of physical and mental health are related. Physicians should be expected to **treat** a patient's physical and mental health conditions, rather than **judge** them separately.

The bill tries to make clear that the patient, not the physician, is ending the life. But duties in such cases are not and cannot be so clear cut, putting physicians in precarious positions. For example, the bill permits patients to self-administer euthanizing medication outside of a healthcare setting. A patient may obtain prescriptions for euthanizing drugs, along with prescriptions for ancillary medication "intended to facilitate the desired effect to minimize the patient's discomfort." (Section 6). But, there is no requirement for a witness to the death. How can we ensure that the patient is in a safe environment and that the medications are taken and work properly?

If the patient does succeed, how will authorities be notified of the death? Section 14 requires the physician to send information about the death to the Division of Consumer Affairs. But, how will the physician get this information? Section 13 requires that "Any medication dispensed pursuant to this act that is not self-administered by a qualified patient shall be disposed of by lawful means." Who is the responsible party and what is the penalty for failure? Without strong protections, euthanizing drugs may be left for others to access.

On the other hand, if the patient is not alone, how do we know he is not coerced to take the medication, or even given the medication without consent? A terminally ill patient should not be exposed to such a risk.

The bill also allows self-administration of euthanizing medication in a health facility, which is clearly the safest setting. But this leads to the core issue in the bill, beyond issues with determining health conditions and writing prescriptions. If the self-administration of the drug does not work, will the physician have to administer medication needed to end a life quickly enough to cause the least amount of pain? **Putting a physician in this situation conflicts with the physician's obligation to protect the patient's life.**

In 1995, Dr. Pieter Admiraal, who has practiced euthanasia in the Netherlands for years, warned of the risk of failure associated with assisted suicide. After explaining the preparations that must be made for an assisted suicide death, he wrote: "In spite of these measures, every doctor who decides to assist in suicide must be aware that something can go wrong, with the result being a failure of the suicide. For this reason, one should always be prepared to proceed to active euthanasia.[iv] In addition, Derek Humphry - the founder of the Hemlock Society himself - wrote in 1994: "The new Oregon way to die will only work if in every instance a doctor is standing by to administer the coup de grace if necessary. The only two 100 percent ways of accelerated dying are the lethal injection of barbiturates and curare or donning a plastic bag."[v] Even the proponents of assisted suicide admit that it must in fact be **physician**-assisted suicide.

Though Section 17 prohibits any action taken pursuant to the bill to considered suicide or assisted suicide, this bill does in fact create a model for physician-assisted suicide. Unlike New Jersey's POLST and advanced directive laws, which have similar language, the physician, in this bill, is clearly needed to "to end the patient's life."

The ethical dilemma created by the bill only gets worse when the patient expires. Section 6 states: "The attending physician may sign the patient's death certificate, which shall list the underlying terminal disease as the cause of death." This provision **requires a physician to lie** on a death certificate, omitting that a fatal overdose was administered. This is this unethical. But it is also bad practice; a patient's record must be accurate for numerous reasons. It is inconsistent that Section 14 requires the physician to report dispensing information, while another prohibits the physician from reporting the drug as a cause of death.

Only Oregon and Washington allow physician-assisted suicide. **Forty-seven states prohibit it.** And States continue to reject it: in a referendum in Massachusetts just last year (November 2012), voters rejected a bill with the same title. Looking to a neighboring State, The New York Task Force on Life concluded long ago that "legalizing the practices would be profoundly dangerous for many patients who are ill and vulnerable...The risks would be most extraordinary for individuals whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group."[vi]

Thank you for your consideration of our position.

Sincerely,

Mishael Azam
Senior Manager, Legislative Affairs

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[i] Policy E-2.211. Issued June 1994 based on the reports "Decisions Near the End of Life," adopted June 1991, and "Physician-Assisted Suicide," adopted December 1993 (JAMA. 1992; 267: 2229-33); Updated June 1996.
[ii] Policy H-140.952.(CEJA Rep. 8, I-93; Reaffirmed by BOT Rep. 59, A-96; Reaffirm: Res. 237, A-99; Reaffirmed: CEJA Rep. 8, 2009)
[iii] Policy H-270.965.(Sub. Res, 5, I-98; Reaffirmed: CEJA Rep. 11, 2008)
[iv] Admiraal, P.V., "Toepassing van euthanatica," Ned Tijdschr Geneeskd, 2/11/95, p. 267
[v] http://www.nytimes.com/1994/12/03/opinion/l-oregon-s-assisted-suicide-law-gives-no-sure-comfort-to-dying-002798.html.
[vi] When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context," 1994