

2018 NJ "AID IN DYING FOR THE TERMINALLY ILL ACT" (A1504)

A1504¹ is an Oregon-style doctor-prescribed suicide proposal.

ANALYSIS

- **A1504 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. In Oregon, 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.²

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."³

If A1504 is approved, will health insurance programs and government health programs do the right thing – or the cheap thing?

- **A1504 would allow family members or health care providers and others to advise, suggest, encourage or exert subtle and not so subtle pressure on vulnerable patients to request doctor-prescribed suicide, setting the stage for elder abuse and pressure on vulnerable patients.**

A1504 would penalize anyone who "coerces or uses undue influence"⁴ 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 A1504 could put abused patients at risk of being persuaded to request lethal doses of drugs.

- **Nothing in A1504 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, A1504 requires that a patient make 2 oral requests and a written request to the attending physician before receiving the prescription for doctor-prescribed suicide.⁵

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 or sent by electronic means to the physician.

- **Under A1504, 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.**

A1504 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.⁶

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.

- **A1504 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."⁷ In Oregon, members of the assisted-suicide advocacy group that spearheaded that state's law have acknowledged that they play a key role in the vast majority of deaths under the state's assisted suicide law.⁸

- **A1504 has no protections for the patient once the assisted-suicide prescription is filled.**

Like the Oregon law on which it is patterned, A1504 only addresses purported patient-protection activities taking place up until the prescription is filled. 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, A1504 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.

- **A1504 gives the illusion of choice. Yet, it will actually constrict patient choice.**

Under A1504, 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."⁹ 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 one at that, the standard of care and the provision of health care change. 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" about which their doctors informed them but, instead, will pay for a prescription for doctor-prescribed death. This has happened in Oregon, the state on which New Jersey's bill is patterned.¹⁰

- **A1504 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 *causes impaired judgment*.¹¹ If a counseling referral is made, it may consist of only one consultation.¹²

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 2017, only five of the reported 143 patients who received lethal prescriptions were referred for counseling.¹³ A study about Oregon's law found that it "may not adequately protect all mentally ill patients."¹⁴

- **A1504 would allow drugs for suicide to be delivered to the patient by a third party.**

Nothing in A1504 requires the patient to obtain the drugs in person. A pharmacist can dispense the lethal drugs to an "identified agent of the patient."¹⁵ 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.

- **A1504 would allow doctors to prescribe the deadly overdose of drugs for patients who could live for many years.**

Under A1504, doctors would be permitted to prescribe assisted suicide-drugs to patients who are "terminally ill" which is defined as being in the "terminal state of an irreversibly fatal illness, disease or condition with a prognosis, based upon reasonable medical certainty, of a life expectancy of six months or less."¹⁶

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 is controllable. An insulin-dependent diabetic patient who stops taking insulin will die within six months. Thus, under A1504, 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, the law on which the New Jersey proposal is based. In official reports from Oregon, diabetes is noted as the underlying terminal condition that made a patient eligible for the lethal prescription.¹⁷

Dr. Charles Blanke, an oncologist and professor of medicine at Oregon Health and Science University, described the case of a young woman with Hodgkin lymphoma who had a 90 percent chance of living for decades with recommended treatment. The woman, however, refused the treatment. "That was a very challenging situation," he said. "You have to ask yourself, 'Why doesn't that patient want to take relatively non-toxic treatment and live for another seven decades?'" Blanke ended up prescribing the deadly overdose for the woman anyway.¹⁸

- **A1504 would set the stage for a patient's doctor-prescribed-suicide death based on fear of being a burden to others.**

Under A1504, 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.¹⁹ But such notification 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 official reports from Oregon, the fear of becoming a burden on others was given as one of the top five reasons for requesting doctor-prescribed suicide – far more than doing so because of pain or fear of pain.²⁰

- **A1504 would permit a third party to request assisted suicide for a patient without any oversight to determine the accuracy of the request.**

Under A1504, patients are considered capable of requesting assisted suicide not only by communicating the decision on their own but also by "communicating through persons familiar with the patient's manner of communicating if those persons are available."²¹

This could include not only translating various languages but also facilitated communication²² 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?

- **A1504 would require health care professionals to facilitate doctor-prescribed suicide.**

Although A1504 states that actions taken by a health care professional or facility are voluntary,²³ if the health care professional is unable or unwilling to participate in a request for doctor-prescribed suicide, "the professional *will be required to refer*" the patient to another health care provider.²⁴

¹ The text of A1504 is available at: http://www.njleg.state.nj.us/2018/Bills/A2000/1504_I1.HTM.

² Susan Donaldson James, "Death Drugs Cause Uproar in Oregon." *ABC News*, August 6, 2008. Available at: <http://abcnews.go.com/Health/story?id=5517492&page=1> (last accessed 3/8/18).

³ 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 3/8/18).

⁴ Section 18 b.

⁵ Section 10 a.

⁶ Section 5 b.

⁷ Section 5 d.

⁸ Officers of Compassion in Dying/Compassion & Choices of Oregon were the chief proponents of Oregon's assisted suicide law. They have self-proclaimed that they are the 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 3/8/18).

⁹ Section 6 a (3).

¹⁰ Susan Donaldson James, "Death Drugs Cause Uproar in Oregon." *ABC News*, August 6, 2008. Available at: <http://abcnews.go.com/Health/story?id=5517492&page=1> (last accessed 3/8/18).

¹¹ Section 8.

¹² Section 3, definition of "counseling."

¹³ Official report for 2017 deaths under Oregon's Death with Dignity Act, pp. 7 and 10. Available at: <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf> (last accessed 3/8/18).

¹⁴ 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.

¹⁵ Section 6 b (2) (b).

¹⁶ Section 3, definition of "terminally ill."

¹⁷ 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 3/8/18).

¹⁸ Tara Bannow, "Rural Oregonians Still Face Death with Dignity Barriers," *Bend Bulletin*, August 14, 2017. Available at: <http://www.bendbulletin.com/health/5512373-151/oregonians-can-choose-how-their-roads-end> (last accessed 3/8/18).

¹⁹ Section 6 a (7).

²⁰ Official report for 2017 deaths under Oregon's Death with Dignity Act, pg. 10. Available at: <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf> (last accessed 3/8/18).

²¹ Section 3, definition of "capable."

²² 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.

²³ Section 3, definition of "participate in this act."

²⁴ For requirement, see the last paragraph of the official statement attached to A1504 (emphasis added).

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