

## GETTING TO THE GOOD PLACE: IMPLEMENTING NEW JERSEY'S MEDICAL AID IN DYING FOR THE TERMINALLY ILL ACT

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### I. INTRODUCTION

In 2019, New Jersey approved an aid in dying bill and joined several states that have expanded legal end of life choices to include forms of physician-assisted death. New Jersey's Medical Aid in Dying for the Terminally Ill Act (hereinafter "the Act") raises interesting questions about patient choice, but some patients have not been able to use this choice since the Act became effective on August 1, 2019. Robin Granat, a former singer and ice skater, diagnosed with an incurable brain tumor, made an appointment for August 19, 2019, to make her first request for the aid in dying medication.<sup>1</sup> Before the appointment, a Mercer County court had already placed a temporary restraining order on the Act.<sup>2</sup> A few days later, Robin lost her ability to speak and could not make her first oral request as required by the Act.<sup>3</sup> Other New Jersey patients have used or still hope to use the Act. Katie Kim, a former pharmacist, diagnosed with an incurable neuromuscular disorder eight years prior, wanted to move to a state with an aid in dying law, but her doctors were

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<sup>1</sup> Lindy Washburn & Stacey Barchenger, *She Hoped for Death on Her Own Terms. Then NJ's Aid-In-Dying Law Was Challenged*, NORTH JERSEY REC. (Aug. 30, 2019, 5:30 AM), <https://www.northjersey.com/story/news/new-jersey/2019/08/30/nj-aid-dying-law-challenge-prevents-woman-with-brain-cancer-from-ending-life-on-her-own-terms/2123105001/>.

<sup>2</sup> *Id.* The temporary injunction on the use of the Act had been removed, but the lawsuit continued. Stacey Barchenger, *New Jersey's 'Aid-in-Dying' Law Reinstated After a Pair of Court Rulings*, TRENTON BUREAU (Aug. 27, 2019, 10:53 AM), <https://www.northjersey.com/story/news/2019/08/27/nj-aid-dying-law-reinstated-appeals-court/2129382001>. The doctor suing argued that the Act as a whole was unconstitutional, and he objected to turning over patient records in compliance with the Act. *Id.* In 2020, the judge dismissed the case for "failure to state a claim upon which relief may be granted." *Glassman v. Grewal*, No. MER-C-53-19 (N.J. Super. Ct. Ch. Div. Apr. 1, 2020) (order granting dismissal of complaint).

<sup>3</sup> Washburn & Barchenger, *supra* note 1.

all in New Jersey.<sup>4</sup> When New Jersey allowed a similar choice, she hoped to use the law to help her die in peace.<sup>5</sup> Within the first several weeks of the Act, at least one New Jersey resident used the Act to request and self-administer medication to end her suffering.<sup>6</sup> Zebbie Geller, a retired teacher, was diagnosed with terminal lung cancer nine months prior and was told she had only months left to live.<sup>7</sup> From July 2019 to her death at the end of September 2019, Zebbie and her family contacted 40 doctors before they could find physicians willing to aid in Zebbie's death.<sup>8</sup> At eighty-years-old and while surrounded by family, Zebbie swallowed an anti-nausea pill and apple juice mixed with digoxin, "a cardiac drug that slows the heart," and died within 90 minutes.<sup>9</sup> Zebbie's story depicts how the Act was made to work. Zebbie met the standard requirements, physicians could personally object to aid in her dying, and Zebbie could request and self-administer her own medication.<sup>10</sup>

This Comment discusses considerations for implementation for New Jersey doctors and facilities on behalf of New Jersey patients who want to participate in successful aid in dying stories like Zebbie's. As readers consider this Comment, they should think about these patients and the myriad of other patients who might choose to request or use aid in dying medication. This Comment will not discuss whether New Jersey patients should have the right to make this choice. This Comment will examine other states and countries where patients have similar end of life options and make suggestions for New Jersey safeguards and best practices so the Act may best serve its purpose in providing patients with this end of life choice and protecting against unintended consequences and abuse.

While the Act does promise to give patients more choice while protecting them from coercion, abuse, or neglect, and is partially modeled after statutes in other states, this Comment argues that New Jersey can learn from other states and countries in its implementation

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<sup>4</sup> Susan K. Livio, *She Wants to End Her Life Because of Agonizing Pain. 'Every Day Katie Asks Me to Help Her Die.'*, N.J. ADVANCE MEDIA (Aug. 23, 2019), <https://www.nj.com/news/2019/08/she-wants-to-die-because-of-agonizing-pain-from-incurable-disease-but-law-that-gave-hope-is-stalled.html>.

<sup>5</sup> *Id.*

<sup>6</sup> Susan K. Livio, *N.J. Woman Used New Law to End Her Life. 'I'm Ready, Let's Do It.'*, N.J. ADVANCE MEDIA (Oct. 18, 2019), <https://www.nj.com/news/2019/10/nj-woman-used-new-law-to-end-her-life-im-ready-lets-do-it.html>.

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> *See id.*

<sup>10</sup> *See id.*

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and application while considering its unique population and statutory definitions. Part II introduces the Act and the statutory language describing the self-administration, residency, and time between requests requirements and discusses initial concerns with the definitions and language. Part III analyzes and compares other states' and countries' definitions of the three requirements discussed in this Comment, with an emphasis on the self-administration requirement. Part IV compares usage and implementation based on a statistical analysis of census data and state aid in dying reports. Part V converts these comparisons into considerations for New Jersey's implementation and best practices.

## II. DEFINITIONS IN NEW JERSEY'S MEDICAL AID IN DYING FOR THE TERMINALLY ILL ACT

This Part introduces New Jersey's Medical Aid in Dying for the Terminally Ill Act and explains three definitions from the Act: self-administer, resident, and time between requests.

### A. *Introduction to the Act*

In April 2019, after seven years of proposed legislation,<sup>11</sup> Governor Murphy signed New Jersey's Medical Aid in Dying for the Terminally Ill Act.<sup>12</sup> While Governor Murphy grappled with the ethical questions raised by this legislation, he ultimately wanted New Jersey residents to have the freedom to make their own end of life choices.<sup>13</sup> The Act itself states its purpose to continue the state's "long-standing commitment to individual dignity, informed consent, and the fundamental right of competent adults to make health care decisions."<sup>14</sup>

Under the Act, only specific adults will be eligible to make aid in dying their end of life choice.<sup>15</sup> The Act defines a qualified terminally ill patient as follows:

[A] capable adult who is a resident of New Jersey and has satisfied the requirements to obtain a prescription for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.). A

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<sup>11</sup> To read more about the years of legislation, see *New Jersey, COMPASSION & CHOICES*, <https://compassionandchoices.org/in-your-state/new-jersey/#extended-state-content> (last visited Oct. 29, 2019).

<sup>12</sup> Philip D. Murphy, *Governor's Statement Upon Signing Assembly Bill No. 1504* (Apr. 12, 2019), <http://d31hzhk6di2h5.cloudfront.net/20190412/4b/cd/8b/1f/02854e1f1393a35250679633/A1504.pdf>.

<sup>13</sup> *Id.*

<sup>14</sup> N.J. STAT. ANN. § 26:16-2 (2019), [https://www.njleg.state.nj.us/2018/Bills/PL19/59\\_PDF](https://www.njleg.state.nj.us/2018/Bills/PL19/59_PDF).

<sup>15</sup> § 26:16-1 to 20.

person shall not be considered to be a qualified terminally ill patient solely because of the person's age or disability or a diagnosis of any specific illness, disease, or condition.<sup>16</sup>

Furthermore, "[t]erminally ill' means that the patient is in the terminal stage 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."<sup>17</sup> A qualified patient must make three requests before an attending physician can prescribe aid in dying medication.<sup>18</sup> The Act provides a sample written request form for patients to use as one of the three requests.<sup>19</sup> The attending physician must also refer the qualified patient to a consulting physician who may confirm the physical diagnosis and the patient's capability to make an informed and voluntary decision.<sup>20</sup> If either physician has questions or concerns about a patient's mental capability, that physician must refer the patient to a mental health care professional.<sup>21</sup> The Act clarifies twice that any health care professional or patient who takes action under the Act does not participate in euthanasia, suicide, assisted suicide, or homicide.<sup>22</sup> Therefore, this Comment respectfully refers to the actions taken under the Act as furthering aid in dying but uses other states' and countries' respective terms, such as euthanasia, when discussing those jurisdictions' laws.

#### B. *Defining and Applying Self-Administration*

In New Jersey's statute, "[s]elf-administer' means a qualified terminally ill patient's act of physically administering, to the patient's own self, medication that has been prescribed pursuant to" the Act.<sup>23</sup> This language impliedly excludes any patient who may otherwise qualify for the Act but lacks enough physical strength or coordination to administer their own medication. This may include patients who had an existing physical disability limiting strength or coordination before acquiring a terminal illness and becoming otherwise eligible for the Act. The Act could also exclude a patient who, through the time it takes to complete the Act's requirements, loses her strength and ability to self-administer medication. Remember that Zebbie Geller needed enough

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<sup>16</sup> § 26:16-3.

<sup>17</sup> *Id.*

<sup>18</sup> § 26:16-10.

<sup>19</sup> § 26:16.

<sup>20</sup> § 26:16-6.

<sup>21</sup> § 26:16-8.

<sup>22</sup> § 26:16-15, -17.

<sup>23</sup> § 26:16-3.

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control of her limbs and head to take a pill and drink a medication.<sup>24</sup> The Act, however, does not explicitly state that a patient must ingest (rather than inject) medication, but the requirements discussed herein imply an expectation that a patient would have the physical ability to ingest the medication.

Further analysis of the Act demonstrates how the term “self-administer” imposes certain physical eligibility requirements for patients beginning with the first request. A patient must complete a valid written request for the aid in dying medication.<sup>25</sup> A valid written request must be initialed, signed, and dated by the patient.<sup>26</sup> The Act requires a patient to have enough physical strength and coordination to initial, sign, and date a document. The same hypothetical patient discussed above, who had a physical disability before terminal illness or who acquired a physical disability since diagnosis of a terminal illness, could be excluded even before consideration of whether that patient can physically self-administer if that patient physically cannot complete the required written request.

### *C. Defining and Applying Residency*

Under the Act, the attending physician who would ultimately prescribe the aid in dying medication must require the patient to demonstrate New Jersey residency.<sup>27</sup> The patient must provide the physician with a copy of:

- a. a driver’s license or non-driver identification card issued by the New Jersey Motor Vehicle Commission;
- b. proof that the person is registered to vote in New Jersey;
- c. a New Jersey resident gross income tax return filed for the most recent tax year; or
- d. any other government record that the attending physician reasonably believes to demonstrate the individual’s current residency in this State.<sup>28</sup>

This language allows for a person who previously lived in New Jersey but currently resides across the accessible borders of New York or Pennsylvania to continue to utilize a New Jersey driver’s license to easily access the Act. In becoming a terminally ill patient, a person could utilize a license with her hometown address to access the Act while residing in New York City. Patients with terminal illnesses may not have

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<sup>24</sup> See Livio, *supra* note 6.

<sup>25</sup> § 26:16-5.

<sup>26</sup> § 26:16-20.

<sup>27</sup> § 26:16-6.

<sup>28</sup> § 26:16-11.

the strength or ability to change states.<sup>29</sup> But an inability to travel because of a need for particular doctors or lack of strength may be made easier by the physical proximity of New Jersey's neighboring states. Part (d) of the residency definition leaves room for physician discretion in determining residency.<sup>30</sup> As applied by an attending physician, this discretionary portion could work either in favor of or against patient access to aid in dying medication. A physician could reasonably find residency in (d) even when a patient may not be a New Jersey resident. A patient who is a resident of New Jersey may only have (d) documentation but be denied legitimate access to the Act because of the physician's discretionary determination of residency. While physicians are always allowed to refuse to participate in aid in dying,<sup>31</sup> patients without an ID, voter registration, or a most recent tax return might feel a sense of injustice if their request is denied for lack of such documentation. Residency seems like it should be a simple checkmark in the Act's requirements, but entire court cases can dispute a person's residency in one or multiple locations.<sup>32</sup>

#### D. *Defining and Applying Time Between Requests*

Under the Act, patients and physicians must follow a minimum timeline for making requests and writing prescriptions.<sup>33</sup> The timeline requires that:

- (1) at least 15 days shall elapse between the initial oral request and the second oral request; . . .
- (3) the patient may submit the written request to the attending physician when the patient makes the initial oral request or at any time thereafter; . . .
- (5) at least 15 days shall elapse between the patient's initial oral request and the writing of a prescription pursuant to P.L.2019, c.59 (C.26:16-1 et al.); and
- (6) at least 48 hours shall elapse between the attending physician's receipt of the patient's written request and the writing of a prescription . . .<sup>34</sup>

In applying the quickest scenario possible, a patient could submit an oral and written request on Day One, wait fifteen days, submit a second oral request on Day Sixteen, and receive a prescription to self-administer the

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<sup>29</sup> See, e.g., Livio, *supra* note 4.

<sup>30</sup> § 26:16-11.

<sup>31</sup> See § 26:16-3.

<sup>32</sup> See generally Sheehan v. Gustafson, 967 F.2d 1214 (8th Cir. 1992).

<sup>33</sup> § 26:16-10.

<sup>34</sup> *Id.*

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same day.<sup>35</sup> But if a patient waits until his second oral request on Day Sixteen to provide a written request, then the attending physician must wait until at least Day Eighteen to write the prescription.<sup>36</sup> A clear reading of the Act does not impose a maximum time limit between patient requests. A qualified terminally ill patient could make an initial request in January 2021, survive past a six-month prognosis, and make the second oral request with a written request in January 2022. Under the Act, the patient has not re-started the aid in dying process. Additionally, the Act does not set a maximum amount of time between an attending physician receiving oral and written requests and writing a prescription for medication.<sup>37</sup>

The lack of maximum time between requests will become an issue when trying to evaluate the efficiency of implementation under the Act. While attending physicians are required to document all requests,<sup>38</sup> an attending physician is only required to report the dispensing medication record and the death record to the Department of Health for statistical purposes.<sup>39</sup> Therefore, the public data of the Act will only show two points in the aid in dying process; thus, limiting New Jersey's understanding of average time spent considering and completing this end of life option. If a purpose of the Act is to increase patient choice in treatment, then New Jersey should understand the length of time a patient takes to make and implement treatment choices.

### III. IMPLEMENTATION AND COMPARISON OF OTHER STATES' AND COUNTRIES' AID IN DYING LAWS

In the United States, individual states can enact statutes to create an ability for physicians and patients to participate in aid in dying, but states may also explicitly ban any physician-assisted death without violating the Constitution.<sup>40</sup> Even as applied to competent, terminally ill adult patients,<sup>41</sup> the federal Constitution does not protect a patient's access to aid in dying medication.<sup>42</sup> In *Washington v. Glucksberg*, the

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<sup>35</sup> *See id.*

<sup>36</sup> *See id.*

<sup>37</sup> *See id.*

<sup>38</sup> § 26:16-10(d).

<sup>39</sup> N.J. STAT. ANN. § 26:16-13.

<sup>40</sup> *See Washington v. Glucksberg*, 521 U.S. 702, 728, 735 (1997).

<sup>41</sup> This is one of four scenarios where a person may wish to accelerate death. The other three are suicide of a non-terminally ill person or patient, withdrawal of life support of a terminally ill patient, and physician active euthanasia of a terminally ill patient. *See* NOAH R. FELDMAN & KATHLEEN M. SULLIVAN, CONSTITUTIONAL LAW 595 (20th ed. 2019).

<sup>42</sup> *See Glucksberg*, 521 U.S. at 735.

Supreme Court concluded that past precedent allowing patients to deny unwanted, life-sustaining treatment does not transform into a right to assisted suicide.<sup>43</sup> Furthermore, it held that the right to personal autonomy under the Due Process Clause of the federal Constitution does not extend to every possible personal decision.<sup>44</sup> This Part will compare the self-administration, residency, and time between request requirements in New Jersey to those requirements in other states and countries.

A. *Definitional Comparisons of United States Statutes*

In Oregon, patients have access to medication to hasten death through the state's Death with Dignity Act.<sup>45</sup> In 1994, citizens voted in the act by a small margin, but then an injunction stalled the process until 1997 when a second vote to keep the legislation resulted in the law's enactment.<sup>46</sup> Oregon Health Authority has been collecting data since that year.<sup>47</sup> Oregon's act does not provide specific language for a self-administration requirement.<sup>48</sup> It does, however, require a written request signed and dated by a qualified patient,<sup>49</sup> which suggests a need for the patient to have a level of physical strength and control, similarly required for physical self-administration in New Jersey.<sup>50</sup> The Oregon Health Authority does clarify that a patient must self-administer and that a physician may not administer.<sup>51</sup> Oregon's residency requirement provides a list of acceptable documentation, such as a driver's license, voter registration, and tax return,<sup>52</sup> but leaves discretion, like in New Jersey's act, by allowing other documentation. Additionally, the ability for a person to show he leases property as documentation<sup>53</sup> may allow for a non-resident to meet this requirement. Oregon required fifteen days between the first request and a prescription and 48 hours between

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<sup>43</sup> See *id.* at 725–26. The Court references its discussion of removing treatment in *Cruzan v. Director, Missouri. Dept. of Health*, and of ending life in *Vacco v. Quill*. *Id.*

<sup>44</sup> See *id.* at 727–28. The Court references its discussion of right to abortion in *Planned Parenthood of Southeastern Pennsylvania v. Casey*. *Id.*

<sup>45</sup> *Frequently Asked Questions: Oregon's Death with Dignity Act*, OR. HEALTH AUTHORITY, <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/faqs.aspx> (last visited Nov. 1, 2020).

<sup>46</sup> *Id.*

<sup>47</sup> See *id.*

<sup>48</sup> OR. REV. STAT. §§ 127.800–127.897 (1994).

<sup>49</sup> § 127.810-2.02.

<sup>50</sup> See *supra* text accompanying note 23.

<sup>51</sup> *Frequently Asked Questions: Oregon's Death with Dignity Act*, *supra* note 45.

<sup>52</sup> OR. REV. STAT. § 127.860-3.10.

<sup>53</sup> *Id.*



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a written request and prescription<sup>54</sup> and, like New Jersey, did not set a maximum time period between requests. But a change to Oregon law in 2019 allowed Oregon patients to bypass the fifteen-day waiting period if they are expected to die within the fifteen days.<sup>55</sup>

In California, qualified terminally ill patients can request aid in dying medication through the End of Life Option Act.<sup>56</sup> California's history in allowing aid in dying as an end of life option began, in part, with a patient named Brittany Maynard.<sup>57</sup> At twenty-nine-years-old, Brittany was diagnosed with a brain tumor but with an otherwise healthy body and expected a lengthy, painful death.<sup>58</sup> After doing some research about her treatment options, she chose to use aid in dying medication, but that option was unavailable in California.<sup>59</sup> Brittany moved to Oregon, found new doctors, and established residency to qualify for Oregon's act.<sup>60</sup> She received the aid in dying medication in Oregon but kept fighting for a change in California's law and end of life options.<sup>61</sup>

Under the California act, an aid in dying drug is *specifically* defined as a drug an individual can self-administer,<sup>62</sup> and "[s]elf-administer" means a qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about his or her own death."<sup>63</sup> California also explicitly requires that an individual must have the physical ability to self-administer,<sup>64</sup> and reinforces these physical requirements by mandating (a) a request form signed and dated by the patient;<sup>65</sup> and (b) a final attestation form signed, initialed, and dated by the patient 48 hours before the patient self-administers.<sup>66</sup> Notably, California's act explicitly prohibits a person who is present at

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<sup>54</sup> § 127.850-3.08.

<sup>55</sup> The Oregonian/OregonLive Politics Team, *New Law Shortens 'Death with Dignity' Waiting Period for Some Patients*, OREGONIAN (July 24, 2019), <https://www.oregonlive.com/politics/2019/07/new-law-shortens-death-with-dignity-waiting-period-for-some-patients.html>.

<sup>56</sup> *End of Life Option Act*, CAL. DEP'T PUB. HEALTH, <https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx> (last visited Nov. 1, 2020).

<sup>57</sup> *See Brittany Maynard*, COMPASSION & CHOICES, <https://compassionandchoices.org/stories/brittany-maynard> (last visited Nov. 1, 2020).

<sup>58</sup> *Id.*

<sup>59</sup> *See id.*

<sup>60</sup> *Id.*

<sup>61</sup> *See id.*

<sup>62</sup> CAL. HEALTH & SAFETY CODE § 443.1 (West 2015).

<sup>63</sup> *Id.*

<sup>64</sup> § 443.2.

<sup>65</sup> *Id.*

<sup>66</sup> § 443.5, .11.

the time of death from helping a patient *ingest* the medication.<sup>67</sup> Overall, California's language and requirements surrounding self-administration are more explicit than those in New Jersey's act. New Jersey lacks any language describing how a patient must *ingest* a medication and does not specifically reinforce the physical strength needed near the time of self-administration through a final attestation form, as California's act does.

Unlike New Jersey, California does not allow for any unlisted forms of identification to show residency.<sup>68</sup> California's requirement does, however, allow for a patient to demonstrate residency through a leased property,<sup>69</sup> similar to Oregon's residency requirement.<sup>70</sup> California's requirement of a minimum of fifteen days between requests, but no maximum number of days,<sup>71</sup> parallels New Jersey's requirement.<sup>72</sup> California does, however, add a maximum time of 48 hours for a patient to complete a final attestation form and self-administer the aid in dying drug.<sup>73</sup> New Jersey's law contains no similar temporal limitation.

In Washington state, patients can access aid in dying medication through the Death with Dignity Act.<sup>74</sup> The law was approved by voters in 2008 after a ballot initiative campaign launched in 2005 with the support of Oregon funds and advisers; then, it became effective in March 2009.<sup>75</sup> Washington's act clarifies that self-administration must be through an act of ingesting medication.<sup>76</sup> In Washington, a qualified patient must sign and date a written request;<sup>77</sup> this suggests the same level of physical strength and ability to self-administer under the New Jersey act, which does not *explicitly* say that a patient must ingest aid in dying medication. Washington's residency requirement allows for unlisted documentation outside the options and allows for a patient to show leased property as evidence of residency.<sup>78</sup> These broad options allow for more residency options than the acts in New Jersey, Oregon,

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<sup>67</sup> CAL. HEALTH & SAFETY CODE § 443.14.

<sup>68</sup> § 443.2.

<sup>69</sup> *Id.*

<sup>70</sup> OR. REV. STAT. § 127.860-3.10.

<sup>71</sup> CAL. HEALTH & SAFETY CODE § 443.3.

<sup>72</sup> N.J. STAT. ANN. § 26:16-10.

<sup>73</sup> CAL. HEALTH & SAFETY CODE § 443.5.

<sup>74</sup> *Death with Dignity Act*, WASH. ST. DEP'T HEALTH, <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct> (last visited Oct. 31, 2019).

<sup>75</sup> *Washington*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/washington> (last visited Sept. 18, 2019).

<sup>76</sup> WASH. REV. CODE § 70.245.010 (2008).

<sup>77</sup> § 70.245.090.

<sup>78</sup> § 70.245.130. Options to show residency include a state driver's license, voter registration, and owning or leasing property in the state. *Id.*

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and California. The fifteen days required between oral requests and 48 hours required from a physician receiving a written request and writing a prescription<sup>79</sup> match New Jersey's time between requests requirements.<sup>80</sup>

In Colorado, terminally ill patients can access aid in dying medication pursuant to Colorado's End-of-Life Options Act,<sup>81</sup> which voters approved in 2016.<sup>82</sup> Colorado requires a qualified patient to make an informed decision to self-administer.<sup>83</sup> "Self-administer" means a qualified individual's affirmative, conscious, and physical act of administering the medical aid in dying medication to himself or herself to bring about his or her own death."<sup>84</sup> This language is similar to the California law but, like New Jersey's statute, it fails to explicitly require that a patient ingest the medication. Colorado also requires a patient to sign and date a written request,<sup>85</sup> which, like New Jersey's requirement, reinforces the requirement of the patient's physical ability to self-administer. Unlike New Jersey, Colorado only allows for the listed documentation options to prove residency, but one of these options includes showing a leased property in the state.<sup>86</sup> Colorado requires fifteen days between oral requests<sup>87</sup> but, unlike New Jersey, does not add an additional forty-eight-hour waiting period between the patient making the written request and the physician writing the prescription.

Patients in Maine recently gained access to aid in dying with Maine's Death with Dignity Act.<sup>88</sup> The state legislature voted in the act in Spring 2019, and Governor Janet Mills signed it into law in June 2019.<sup>89</sup> In Maine, a qualified patient may self-administer by "voluntarily ingest[ing] medication to end the qualified patient's life in a humane and dignified manner."<sup>90</sup> This language differs from New Jersey's approach by specifically requiring a patient to ingest the medication. Like New Jersey and other states, the Maine act requires the patient to have the

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<sup>79</sup> § 70.245.090, .110.

<sup>80</sup> N.J. STAT. ANN. § 26:16-10.

<sup>81</sup> *Medical Aid in Dying*, COLO. DEP'T OF PUB. HEALTH & ENV'T, <https://www.colorado.gov/pacific/cdphe/medical-aid-dying> (last visited Oct. 31, 2019).

<sup>82</sup> *Id.*

<sup>83</sup> COLO. REV. STAT. § 25-48-102 (2016).

<sup>84</sup> *Id.*

<sup>85</sup> § 25-48-104; *see also* § 25-48-112.

<sup>86</sup> § 25-48-102.

<sup>87</sup> § 25-48-104.

<sup>88</sup> Paula Span, *Aid in Dying Soon Will Be Available to More Americans. Few Will Choose It*, N.Y. TIMES (July 8, 2019), <https://www.nytimes.com/2019/07/08/health/aid-in-dying-states.html>.

<sup>89</sup> *Id.*

<sup>90</sup> ME. REV. STAT. ANN. tit. 418, § 2140(2)(L) (2019).

physical capacity to sign and date a written form.<sup>91</sup> Maine's residency requirement offers the longest list of options for documentation of residency and gives the most detail in what the documentation can and cannot show.<sup>92</sup>

The residence of a person is that place where the person has *established a fixed and principal home to which the person, whenever temporarily absent, intends to return*. The following factors may be offered in determining a person's residence under this Act and *need not all be present* in order to determine a person's residence: A. Possession of a valid driver's license issued by the Department of the Secretary of State, Bureau of Motor Vehicles; B. Registration to vote in this State; C. Evidence that the person owns or leases property in this State; D. The location of any dwelling currently occupied by the person; E. The place where any motor vehicle owned by the person is registered; F. The residence address, not a post office box, shown on a current income tax return; G. The residence address, not a post office box, at which the person's mail is received; H. *The residence address, not a post office box, shown on any current resident hunting or fishing licenses held by the person*; I. The residence address, not a post office box, shown on any driver's license held by the person; J. *The receipt of any public benefit conditioned upon residency, defined substantially as provided in this subsection*; or K. *Any other objective facts tending to indicate a person's place of residence*.<sup>93</sup>

Unlike other states, Maine's other evidence option relies more on objective facts of residency than other forms of identification. Additionally, the "need not all be present" phrase can prompt physicians to consider multiple forms of identification, which other states, including New Jersey, have failed to recommend.<sup>94</sup> While Maine's residency requirements are unique, its waiting period requirements for a minimum of fifteen days between oral requests<sup>95</sup> and 48 hours from a patient writing a request and the physician writing a prescription<sup>96</sup> parallel the requirements in New Jersey and the majority of the states discussed *infra*.

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<sup>91</sup> § 2140(5).

<sup>92</sup> § 2140(15).

<sup>93</sup> *Id.* (emphasis added).

<sup>94</sup> N.J. STAT. ANN. § 26:16-11.

<sup>95</sup> ME. REV. STAT. ANN. tit. § 2140(11) (2019).

<sup>96</sup> § 2140(13).

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B. *Aid in Dying Around the World: A Comparison of New Jersey and United States Requirements with International Requirements*

In Belgium, competent adults and emancipated minors gained access to hasten their death pursuant to The Belgian Act on Euthanasia on May 28, 2002.<sup>97</sup> These persons must be patients “in a medically futile condition of constant and unbearable physical or mental suffering that can not [sic] be alleviated, resulting from a serious and incurable disorder caused by illness or accident.”<sup>98</sup> In 2014, Belgium removed its previous age limit; thus, the country radically extended its law to allow children of any age to request the lethal injection as long as the parents give consent.<sup>99</sup> Since then, physicians have euthanized seventeen-, eleven-, and nine-year-old patients.<sup>100</sup> Rather than requiring patients to self-administer, Belgium allows euthanasia, which it defines as a physician—not the patient—terminating the patient’s life.<sup>101</sup>

The *default* requirements under Belgian law do assume some level of patient physical strength and ability. Similar to New Jersey and other United States acts, Belgium’s act requires a patient to write and sign a request.<sup>102</sup> Unlike in New Jersey and the United States, however, Belgium provides an exception where a patient may designate a person to write and sign the request if the person lists why the patient is incapable of independently writing a request.<sup>103</sup> Therefore, Belgium does not necessarily restrict patients who are physically disabled from their illness or a previous condition from access to euthanasia, whereas New Jersey and other states restrict these patients from access to aid in dying options.

Additionally, Belgium’s act does not contain residency requirements.<sup>104</sup> Further, Belgium’s equivalent of the time between requests requirements offers more discretion than New Jersey or other

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<sup>97</sup> *Belgium*, PATIENTS RTS. COUNCIL, <http://www.patientsrightscouncil.org/site/belgium> (last visited Sept. 19, 2019).

<sup>98</sup> § 1 [The Belgian Act on Euthanasia] of May 28, 2002, 10 EUR. J. HEALTH L. 329 (2003).

<sup>99</sup> *Belgium*, PATIENTS RTS. COUNCIL, <http://www.patientsrightscouncil.org/site/belgium> (last visited Nov. 13, 2020). Note that while technically the child makes the decision, it is easy to imagine the technical lines blurring between a child making a decision and a parent making a decision but a child expressing it as her own.

<sup>100</sup> Dale Hurd, *The ‘Default Way to Die’: Are Dutch and Belgian Doctors Euthanizing People Who Don’t Want to Die?*, CHRISTIAN BROADCASTING NETWORK (Aug. 28, 2019), <https://www1.cbn.com/cbnnews/world/2019/april/euthanasia-becoming-default-way-to-die-in-belgium>.

<sup>101</sup> § 1 [The Belgian Act on Euthanasia] of May 28, 2002.

<sup>102</sup> § 3(4) (Belg.).

<sup>103</sup> *Id.*

<sup>104</sup> *See* [The Belgian Act on Euthanasia] of May 28, 2002.

United States laws. The act requires physicians to engage in “several” conversations with the patient about the patient’s request and physical and mental suffering over a “reasonable period of time.”<sup>105</sup> Belgium’s act is clear, however, in requiring at least one month between the written request and euthanasia if the “physician believes patient is clearly not expected to die in the near future.”<sup>106</sup> One month between a written request and death is longer than New Jersey’s 48 hours,<sup>107</sup> but the above language leaves the physician some discretion and an ability to euthanize even before 48 hours have elapsed.

Even though Belgium does not require a maximum time between requests and death, Belgium does cap advance directives for euthanasia; still, people who may not be mentally competent at the time of administration may access Belgium’s act.<sup>108</sup> If the patient’s euthanasia request comes as an advance directive, the directive will only be valid if it was drafted in the last “five years prior to the person’s loss of the ability to express his/her wishes.”<sup>109</sup>

In 2019, developments to Canada’s aid in dying law offered some compelling justifications for why a state or country should allow advance directives for medically assisted dying.<sup>110</sup> Members of Canada’s legislative body recognize that Alzheimer’s patients are in a unique position: when they are first diagnosed, they may be able to consent to medical assistance in dying, but they are not at the required “end of life.”<sup>111</sup> But, when an Alzheimer’s patient is near the end of life, they have lost their ability to make a decision about medical assistance in dying.<sup>112</sup> This legislative debate follows the *Lamb* case, where the court expanded what it means for a patient’s death to be “reasonably

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<sup>105</sup> § 3(2) (Belg.).

<sup>106</sup> § 3(3) (Belg.).

<sup>107</sup> N.J. STAT. ANN. § 26:16-10.

<sup>108</sup> § 4(1) (Belg.). “[A]n *advance directive*, a legal document that goes into effect only if you are incapacitated and unable to speak for yourself. This could be the result of disease or severe injury—no matter how old you are. It helps others know what type of medical care you want.” NAT’L INST. ON AGING, *Advance Care Planning: Healthcare Directives*, U.S. DEP’T HEALTH & HUM. SERVS., <https://www.nia.nih.gov/health/advance-care-planning-healthcare-directives#after> (last visited Jan. 9, 2020).

<sup>109</sup> § 4(1) (Belg.).

<sup>110</sup> See *Quebec to Expand Law on Medically Assisted Dying, Look at Advance Consent*, CBC NEWS (Nov. 29, 2019 9:34 AM), <https://www.cbc.ca/news/canada/montreal/medical-assistance-in-death-report-1.5377890>.

<sup>111</sup> See *id.*

<sup>112</sup> See *id.* See *infra* pp. 870–72, for an explanation of why New Jersey should not use advance directives for aid in dying.

foreseeable.”<sup>113</sup> The Supreme Court ruled against the current legislative members’ understandings of “reasonably foreseeable” and in favor of a *patient-centered* definition where “patients can meet the ‘reasonably foreseeable’ criterion if they have demonstrated a clear intent to take steps to make their natural death happen soon or to cause their death to be predictable.”<sup>114</sup> The case could expand the current understanding of the legislation to allow for advance directives, which may not require informed consent at the time of request and the time of either euthanasia or self-administration.<sup>115</sup> An advance directive could mean the patient has lost his capacity to make informed consent by the time he is requesting or receiving aid in dying treatment. Canada already allowed patients with dementia, who still understand the requests they are making, to be capable of the required informed consent.<sup>116</sup>

Since 2002, doctors in the Netherlands have been legally allowed to perform euthanasia on patients or assist in their suicides, even if the patients do not have a terminal illness.<sup>117</sup> By 2015, 4.5% of deaths in the Netherlands were caused by acts of euthanasia, with non-terminally ill patients being a small portion of that percentage.<sup>118</sup> In 2018, committees reviewed cases of euthanasia to compile resources and guidance for physicians in the Euthanasia Code 2018.<sup>119</sup> In addition to the lack of minimum or maximum time required between requests and death,<sup>120</sup> the Netherlands act is not concerned with a specific prognosis. It only requires that a patient’s suffering be “lasting and unbearable.”<sup>121</sup>

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<sup>113</sup> Jocelyn Downie, *A Watershed Month for Medical Assistance in Dying*, POL’Y OPTIONS POLITIQUES (Sept. 20, 2019), <https://policyoptions.irpp.org/magazines/september-2019/a-watershed-month-for-medical-assistance-in-dying>.

<sup>114</sup> *See id.*

<sup>115</sup> *See Medical Assistance in Dying*, GOV’T OF CAN., <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html> (last visited Feb. 14, 2020).

<sup>116</sup> *See, e.g.,* The Sunday Edition, *B.C. Man Is One of the First Canadians With Dementia to Die with Medical Assistance*, CBC RADIO (Oct. 27, 2019), <https://www.cbc.ca/radio/thesundayedition/the-sunday-edition-for-october-27-2019-1.5335017/b-c-man-is-one-of-the-first-canadians-with-dementia-to-die-with-medical-assistance-1.5335025>.

<sup>117</sup> The Associated Press, *Euthanasia Deaths Becoming Common in Netherlands*, CBS NEWS (Aug. 3, 2017), <https://www.cbsnews.com/news/euthanasia-assisted-suicide-deaths-netherlands>.

<sup>118</sup> *Id.*

<sup>119</sup> *Euthanasia Code 2018*, REGIONAL EUTHANASIA REV. COMM. (Jan. 10, 2019), <https://english.euthanasiacommissie.nl/the-committees/documents/publications/euthanasia-code/euthanasia-code-2018/euthanasia-code-2018/euthanasia-code-2018>.

<sup>120</sup> Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001, 137. Art. 2(1)e (Neth.), <https://www.worldtrtd.net/dutch-law-termination-life-request-and-assisted-suicide-complete-text>.

<sup>121</sup> *See id.* at Art. 2(1)b (Neth.).

Netherlands' act does not contain language requiring a patient to administer his own medication. Rather, in the Netherlands, doctors can give a lethal injection to a person with unbearable suffering and no reasonable alternative.<sup>122</sup> In its first criminal investigation of euthanasia, the Netherlands court cleared a doctor of any criminal charges for administering a sedative and lethal injection to a dementia patient who exhibited mixed signals about wanting to die.<sup>123</sup> The patient in this case, and like many other reported cases in the Netherlands, had an advanced directive for euthanasia, and the doctor had to perform that directive with due care.<sup>124</sup>

At first glance, this case seems like the result of the “slippery slope” people might be wary of and that United States laws want to protect against by allowing only patients to self-administer their prescribed aid in dying medications. But the doctor or the patient administering is not the only distinction in this case. Even if states allowed for physician administration, patients and health care professionals would not face the issues seen in the Netherlands case. In that case, the patient had an advance directive for euthanasia, like the law in Belgium allows and possible changes to the law in Canada would allow;<sup>125</sup> no United States statute, however, allows advance directives for aid in dying medication. The Netherlands patient was not able to change her mind at the time of administration, and the doctor ignored her mixed signals because of her dementia.<sup>126</sup> A New Jersey case would never reach this point—even if physicians could administer or prepare injections—because New Jersey further requires the qualified patient to be capable and “hav[e] the capacity to make health care decisions and to communicate them to a health care provider, including communication through persons familiar with the patient’s manner of communicating if those persons are available.”<sup>127</sup> Given the symptoms of dementia,<sup>128</sup> it does not seem

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<sup>122</sup> Palko Karasz, *Dutch Court Clears Doctor in Euthanasia of Dementia Patient*, N.Y. TIMES (Sept. 11, 2019), <https://www.nytimes.com/2019/09/11/world/europe/netherlands-euthanasia-doctor.html>. For more recent examples of Dutch courts allowing physicians to euthanize patients with dementia, see *Another Netherlands Court Approves Euthanasia by Advance Directive*, MED. FUTILITY BLOG (Sept. 14, 2020), <http://www.bioethics.net/2020/09/another-netherlands-court-approves-euthanasia-by-advance-directive>.

<sup>123</sup> See Karasz, *supra* note 122.

<sup>124</sup> See *id.*

<sup>125</sup> See *supra* pp. 857–59.

<sup>126</sup> See Karasz, *supra* note 122.

<sup>127</sup> N.J. STAT. ANN. § 26:16-3.

<sup>128</sup> “Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—and behavioral abilities to such an extent that it interferes with a person’s daily life and activities. These functions include memory, language skills, visual



like many qualified terminally ill patients with dementia would be deemed capable to make this health care decision.<sup>129</sup> Even if a physician found an otherwise qualified terminally ill patient with early-stage dementia capable under the New Jersey act, the patient would not have the ability to make an advance directive for when the dementia progresses and would always have the ability to rescind a request regardless of his patient's previous wishes.<sup>130</sup> New Jersey's lack of a maximum time between requests would allow the patient to complete the request process very early in the stages of dementia, then, wait to take the medication.

In Western Australia, patients gained access to aid in dying with the Voluntary Assisted Dying Bill.<sup>131</sup> As the Victorian Voluntary Assisted Dying Act 2017 became effective in June 2019, another Australian state, Western Australia, was developing legislation in its parliament for its own Voluntary Assisted Dying Act.<sup>132</sup> As Western Australia continued developing legislation, an Australian woman became the first to use Victoria's new law.<sup>133</sup> After a twenty-six-day approvals process, terminal cancer patient Kerry Robertson died at a nursing home.<sup>134</sup>

Of all these international sources, Western Australia's requirements and safeguards for administration of medication, residency, and timing of requests most closely parallel those used across the United States, so New Jersey could implement some of Western Australia's safeguards. Furthermore, Western Australia's act allows United States health departments to draw more exact international comparisons about aid in dying and consider cross-cultural explanations for differences in trends. It is more challenging to compare numbers across countries' sets of data when the countries allow

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perception, problem solving, self-management, and the ability to focus and pay attention." Nat'l Inst. of Aging, *What Is Dementia? Symptoms, Types, and Diagnosis*, U.S. DEP'T HEALTH & HUM. SERVS., <https://www.nia.nih.gov/health/what-dementia-symptoms-types-and-diagnosis> (last visited Jan. 9, 2020).

<sup>129</sup> *But see* The Sunday Edition, *supra* note 116.

<sup>130</sup> N.J. STAT. ANN. § 26:16-6(8).

<sup>131</sup> *See Voluntary Assisted Dying Bill 2019 (WA)* (Austl.), [https://www.parliament.wa.gov.au/Parliament/Bills.nsf/502E87F2E1B94E27482584A3003A757C/\\$File/Bill139-2.pdf](https://www.parliament.wa.gov.au/Parliament/Bills.nsf/502E87F2E1B94E27482584A3003A757C/$File/Bill139-2.pdf); *see also Voluntary Assisted Dying Bill 2019*, PARLIAMENT W. AUSTRALIA, <https://www.parliament.wa.gov.au/parliament/bills.nsf/BillProgressPopup?openForm&ParentUNID=502E87F2E1B94E27482584A3003A757C> (last visited Jan. 10, 2020).

<sup>132</sup> Bregje Onwuteaka-Philipsen, Lindy Willmot & Ben P. White, *Regulating Voluntary Assisted Dying in Australia: Some Insights from the Netherlands*, MED. J. AUSTRALIA (Sept. 9, 2019), <https://www.mja.com.au/journal/2019/211/10/regulating-voluntary-assisted-dying-australia-some-insights-netherlands#4>.

<sup>133</sup> *Assisted Dying: Australian Cancer Patient First to Use New Law*, BBC NEWS (Aug. 5, 2019), <https://www.bbc.com/news/world-australia-49230903>.

<sup>134</sup> *Id.*

patients of different ages and categories, such as minors or non-terminally ill patients, to access aid in dying options.<sup>135</sup>

Even though the Western Australian bill was modeled after the Victorian act, it differs in its definition of acceptable administration methods.<sup>136</sup> In Western Australia, self-administration is the default option for a patient receiving medication.<sup>137</sup> A patient with a six-month prognosis<sup>138</sup> can make the decision to have her physician administer the substance if the physician has certain qualifications to be an administering practitioner, including specific training.<sup>139</sup> A patient may choose to self-administer or to have the practitioner administer the medication.<sup>140</sup> Patients have an equal ability to choose between practitioner administration or self-administration, but the provision requires that practitioner administration should only be used when it would be impossible or inappropriate for a patient to self-administer.<sup>141</sup> This language strikes a balance between (a) an emphasis on patients taking their own voluntary assisted death actions and (b) a conscious inclusion of patients who may lack physical ability but who are identical to other patients in every other requirement. The signed, written declaration requirement<sup>142</sup> suggests that patients using the law must have the physical ability to self-administer, as New Jersey's act requires. But, as Belgium's act requires,<sup>143</sup> an Australian patient who is unable to sign the declaration can have another person sign the declaration on her

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<sup>135</sup> In other words, current cross-cultural comparisons are limited because of the certain requirements in other countries. For example, if data trends showed patients in Belgium spending five years between request and administration and New Jersey patients show an average of six months between request and administration, it would be hard to infer that this has something to do with the culture of healthcare in either country because Belgium, unlike New Jersey, does not require a six-month prognosis but does allow advance directives. A data analyst trying to infer cultural differences between any/all U.S. states and Western Australia could be more confident in that comparison because the similarities between the laws means eliminating differing requirements that would otherwise be intervening variables.

<sup>136</sup> Frances Bell, *Voluntary Euthanasia Bill to Be Introduced into West Australian Parliament*, ABC NEWS (Aug. 6, 2019), <https://www.abc.net.au/news/2019-08-06/voluntary-assisted-dying-bill-introduced-to-wa-parliament/11386512>.

<sup>137</sup> *Voluntary Assisted Dying Bill 2019* (WA) pt 4 div 2 s 56 (Austl.), [https://www.parliament.wa.gov.au/Parliament/Bills.nsf/502E87F2E1B94E27482584A3003A757C/\\$File/Bill139-2.pdf](https://www.parliament.wa.gov.au/Parliament/Bills.nsf/502E87F2E1B94E27482584A3003A757C/$File/Bill139-2.pdf).

<sup>138</sup> *Id.* pt 2 s 16. But a twelve-month prognosis is required for neurodegenerative illness. *Id.*

<sup>139</sup> *Id.* pt 4 div 1 ss 54–55.

<sup>140</sup> *Id.* s 56.

<sup>141</sup> *See id.*

<sup>142</sup> *Voluntary Assisted Dying Bill 2019* (WA) pt 3 div 5 s 42.

<sup>143</sup> § 3(4) [The Belgian Act on Euthanasia] of May 28, 2002.

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behalf.<sup>144</sup> The default option encourages a patient's physical ability to self-administer, but the exception allows a patient with a physical disability from a previous condition or the terminal illness to still access voluntary assisted dying. Physically disabled patients in New Jersey and across the United States, however, are not granted these exceptions for providing written documentation or for self-administration.

Western Australia's residency requirement is based on objective facts about residency in the prior year, rather than specific documentation.<sup>145</sup> The most notable part of this requirement is the specific ability of a patient to appeal to the Western Australian residency decision from either the coordinating or consulting physician to a tribunal.<sup>146</sup> New Jersey does not specifically allow for this type of external, non-medical professional appeals process. Western Australia only requires nine days between the first and final request for voluntary assisted dying<sup>147</sup> and allows for an exception to the minimum nine days if, among other requirements, the coordinating physician believes "the patient is likely to die, or to lose decision-making capacity in relation to voluntary assisted dying, before the end of the designated period."<sup>148</sup> While New Jersey does not currently allow for physicians and patients to hasten this process, future amendments should mirror the exceptions in the Western Australian act and the amended Oregon act.<sup>149</sup>

#### IV. STATISTICAL COMPARISON OF NEW JERSEY AND OTHER STATES AND COUNTRIES

This Part reviews aid in dying data from other states and countries discussed in this Comment, compares it with United States census data, and makes predictions about how providers and patients could use New Jersey's act. This Part also considers data-reporting concerns similar to those in other states and concerns unique to New Jersey.

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<sup>144</sup> *Id.*

<sup>145</sup> *See id.* pt 2 s 16.

<sup>146</sup> *Id.* pt. 5 sec. 84.

<sup>147</sup> *Id.* pt. 3 div. 6 sec. 47.

<sup>148</sup> *Id.* pt. 3 div. 6 sec. 47.

<sup>149</sup> *See OregonLive Politics Team, supra* note 55.

*A. Reported and Expected Deaths from Aid in Dying Medications*<sup>150</sup>

In Oregon's data from 2017 through 2018, physicians wrote 467 prescriptions for aid in dying medication, and within the two years, 311 people died from ingesting the prescribed medication.<sup>151</sup> United States census data for July 2017 through July 2018 revealed that 36,052 people died in Oregon that year,<sup>152</sup> suggesting that 0.86% of deaths in Oregon could have resulted from aid in dying medication.

California's 2017–2018 data showed that physicians wrote 1,029 prescriptions for aid in dying medication, and within that period, 711 people died from the medication.<sup>153</sup> Census data for July 2017 to July 2018 revealed that 280,674 people died in the state that year,<sup>154</sup> suggesting that 0.25% of deaths in California could have resulted from aid in dying medication.

Washington's 2017–2018 data shows that physicians wrote 479 prescriptions for aid in dying medication, and within the two years, 367 people died from the medication.<sup>155</sup> Census data for July 2017 to July

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<sup>150</sup> See *infra* App'x. at 874. Note the lack of data for two other continental states that allow physician-assisted dying. Montana's Supreme Court ruled that Montana's laws allow for physicians to provide medication to hasten patient death; thus, the state has not created an aid in dying statute with a reporting requirement and has not made data readily available. See *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009); see also *Montana*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/montana> (last visited Jan. 5, 2020). Vermont's statute requires physicians to report writing prescriptions and death by aid in dying medication, but the state is only required to report every other year. See *Report Concerning Patient Choice at End of Life*, VT. DEP'T HEALTH (Jan. 15, 2018), <https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life>. The initial and most recent report included years 2013–2017, so Vermont's available data is not comparable to the other states' 2017–2018 data. See *id.*

<sup>151</sup> *Death with Dignity Act Annual Reports*, OR. HEALTH AUTHORITY, <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx> (Year 2018) (last visited Sept. 20, 2019).

<sup>152</sup> *2018 National State and Population Estimates: Table 5. Estimates of the Components of Resident Population Change for the United States, Regions, States, and Puerto Rico: July 1, 2017 to July 1, 2018*, U.S. CENSUS BUREAU, <https://www.census.gov/newsroom/press-kits/2018/pop-estimates-national-state.html> (last visited Sept. 20, 2019) [hereinafter *2018 National State and Population Estimates*]. Note that available census data to track vital life events are measured from July 2017 through July 2018, while the states produce annual aid in dying reports on the calendar year. *Id.* This means, for example, a death in Colorado in June 2017 would be reflected in Colorado's data, but not in the census for July 2017–July 2018.

<sup>153</sup> *End of Life Option Act 2018 Data Report*, CAL. DEP'T PUB. HEALTH, at 3, <https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act.aspx> (last visited Sept. 20, 2019). Note that the two most common prescriptions were for sedatives and "a combination of a cardiotoxic, opioid, and sedative." *Id.* at 3.

<sup>154</sup> See *2018 National State and Population Estimates*, *supra* note 152.

<sup>155</sup> *2018 Death with Dignity Act Report*, WASH. ST. DEP'T HEALTH, at 1, <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct>

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2018 revealed that 57,568 people died in the state that year,<sup>156</sup> suggesting that 0.25% of deaths in Washington could have resulted from aid in dying medication.

In its first two years of implementing its act, Colorado collected data showing that physicians wrote 197 prescriptions for aid in dying medication and that between 2017 and 2018, 174 people died from ingestion.<sup>157</sup> Census data for July 2017 to July 2018 revealed that 38,367 people died in the state that year,<sup>158</sup> suggesting that 0.45% of deaths in Colorado could have resulted from aid in dying medication.

### B. Data-Reporting Concerns and Predictions

The lack of a maximum time between requests contributes to a data-reporting issue. Current reports do not measure the time a patient spends in the initial stages of the aid in dying process.<sup>159</sup> A future evaluation of the efficacy of the Act would benefit from understanding how long patients take to complete a decision. The prescription-to-administration-and-death timeline is only measured by the calendar year in current reports.<sup>160</sup> The states' data referenced above measures when a patient received a prescription in one year but ingested the medication in another year,<sup>161</sup> but the reports cannot show whether these dates happen quickly between December and January of two calendar years or if patients tend to hold medication for many months or even a full year before self-administering. New Jersey's future data, if it only follows its current reporting requirements,<sup>162</sup> will also fail to measure these points and track these issues.

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2018.pdf (last visited Sept. 20, 2019); *2017 Death with Dignity Act Report*, WASH. ST. DEP'T HEALTH, at 1, <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf> (last visited Sept. 20, 2019).

<sup>156</sup> See *2018 National State and Population Estimates*, *supra* note 152.

<sup>157</sup> *Colorado End-of-Life Options Act, Year Two 2018 Data Summary, with Updates to 2017 Data*, COLO. DEP'T PUB. HEALTH & ENV'T, at 2, <https://drive.google.com/file/d/1FmoyCcL2gHopDO9rCJ2lGFEMUye8FQei/view> (last visited Sept. 20, 2019). Some individual state data, such as Colorado's data, indicates the patient's terminal illness. See *id.* Looking at this available data and discussing the physical symptoms of different illnesses might provide insight on the different capabilities of patients to self-administer.

<sup>158</sup> See *2018 National State and Population Estimates*, *supra* note 152.

<sup>159</sup> See sources cited *supra* notes 151–157.

<sup>160</sup> See sources cited *supra* notes 151–157.

<sup>161</sup> See sources cited *supra* notes 151–157.

<sup>162</sup> The New Jersey statute includes the following reporting requirements:  
(1) No later than 30 days after the dispensing of medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.), the physician or pharmacist who dispensed the medication shall file a copy of the dispensing record with the department, and shall otherwise facilitate the collection of

Despite these omissions of potentially useful data, this Comment purports to make predictive calculations for New Jersey's use of aid in dying. These predictions are simply rough calculations to raise potential concerns, address typical questions around aid in dying, and encourage facilities and physicians to further prepare for the Act in New Jersey. The average of the above states' percentages of death from ingesting prescribed medication is approximately 0.55% of state deaths. The average lies closest to Colorado's 0.45%, which reflects a percentage of deaths in a state that has only had an aid in dying option for a few years. By taking the 0.55% average and multiplying by the number of Maine deaths from July 2017 to July 2018 (14,079 deaths),<sup>163</sup> we can predict 77 deaths in Maine from ingesting prescribed medication. By multiplying the same 0.55% average by New Jersey's total deaths from July 2017 to July 2018 (76,370),<sup>164</sup> we can estimate about 420 deaths within two years.<sup>165</sup>

The average number of prescriptions within the past two years in Oregon, California, Washington, and Colorado is 543 prescriptions. The average of the confirmed deaths from ingesting prescribed medication is 390.75 deaths. Comparing the 543 prescriptions to the 390.75 deaths, there is an average proportion of 1.4 aid in dying prescriptions per death from ingesting the medication. Applying this proportion to Maine suggests 107.8 prescriptions within two years. Applying it to New Jersey suggests 588 prescriptions within two years. These predictions would be even higher than the values for the past two years in Oregon,<sup>166</sup> a state that has had its act in place for decades.

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such information as the director may require regarding compliance with P.L.2019, c.59 (C.26:16-1 et al.).

(2) No later than 30 days after the date of the qualified terminally ill patient's death, the attending physician shall transmit to the department such documentation of the patient's death as the director shall require.

N.J. STAT. ANN. § 26:16-13.

<sup>163</sup> See *2018 National State and Population Estimates*, *supra* note 152.

<sup>164</sup> See *id.*

<sup>165</sup> On July 31, 2020, approximately a year after enactment, New Jersey's Department of Health released its first annual report. *Annual Report Chronicles Impact of New Jersey's Death with Dignity Law*, N.J. DEP'T OF HEALTH (July 31, 2020) [hereinafter *Annual Report*], <https://www.nj.gov/health/news/2020/approved/20200731b.shtml>. While only twelve reported deaths, the state only released from between August 1, 2019 and December 31, 2019. *Id.* The release offers no explanation for the lack of reports between January 1, 2020 and July 30, 2020. *Id.*

<sup>166</sup> See *supra* note 151 and accompanying text.

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These numbers do not, however, support any slippery slope argument about people choosing to end their lives in New Jersey more than in other states.<sup>167</sup> Furthermore, these elementary predictions are simply meant to alert physicians and facilities that, insofar as New Jersey is similar to other states and has a similar statute, patients may use the Act similarly. At an estimated 588 prescriptions per approximately two years, participating physicians across the state could be writing approximately one prescription every other day. This potential level of use supports the concerns in the discussion below about considerations for changing residency and implementation to avoid errors in physician discretion and use of the Act. These statutes are as much about patient choice as they are about compliance and the ability to report compliance with the definitions discussed above.

### C. *New Jersey Residency*

While not explicitly stated in New Jersey's act, it is important to consider how New Jersey patients, physicians, and caretakers might lose protection under the Act if a patient self-administers in another state.<sup>168</sup> This is an especially important consideration for people who qualify as New Jersey residents because other states—New York and Pennsylvania, namely—are in such close proximity but do not offer any protections for medical aid in dying. Depending upon physical ability and the type of illness, any transportation at the ultimate stage of an illness may become impossible, but the self-administration and writing requirements<sup>169</sup> in New Jersey do require some level of physical strength that might make traveling with a terminal illness more probable. While not the focus of this Comment, it is important to mention that a patient's ability to move and take a drug elsewhere would create inaccuracies in how many people died in any given year in a state from self-administering medication and could distort results in reporting data as required by many of these statutes.

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<sup>167</sup> New Jersey just has more people, and more people could lead to a higher number—but there is no need for concern. As a potential counter to any slippery slope concerns about New Jersey's trends: if New Jersey followed the Netherlands trend of 4.5% of deaths from euthanasia, it would be estimating about 3,437 deaths, a number more than eight times greater than the 420 deaths predicted based off of United States trends. In fact, in the first six months, New Jersey only recorded twelve deaths. See *Annual Report*, *supra* note 165.

<sup>168</sup> "If you take a dose prescribed under a death with dignity law outside the state where you obtained it, you may lose the legal protections afforded by the law in question. For example, your death may be ruled a suicide under another state's law, with resulting effects on your insurance policies." *Frequently Asked Questions*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/faqs> (last visited Sept. 18, 2019).

<sup>169</sup> See discussion *supra* Section II.B.

## V. RECOMMENDATIONS FOR NEW JERSEY

This Part will recommend best practices for New Jersey facilities, including private practices or hospitals, under the current Act. Then, it will offer some recommendations for amendments to the Act.

A. *Implementation and Best Practices Under the Current Act*

New Jersey facilities have to be careful not to unfairly limit a patient's ability to access the Act, but they can implement the internal safeguards below without changing the procedures outlined in the Act. Facilities have an interest in protecting their physicians and treating their patients with respect, whether or not their physicians are willing and able to aid in a patient's death under the Act.

## 1. Provide Training for Self-administration

Similar to how Western Australia requires all physicians to learn how to administer,<sup>170</sup> New Jersey facilities or medical and hospital associations could provide training that teaches physicians how to teach patients to self-administer properly. By enabling physicians to show patients and families how to properly self-administer, New Jersey might increase access to the Act for patients with certain physical disabilities who may think they are incapable of using the Act. This training could also show physicians how to teach caretakers to prepare drugs for a patient's self-administration. If New Jersey wants to follow other states in requiring that the drugs be ingested rather than self-injected, the training would have to differentiate between those two forms of administration. This would help enforce that patients should be ingesting medication, without explicitly changing the language of the Act. Below, this Comment discusses the possibility of clarifying the Act to include both forms of administration explicitly, therefore, expanding the training possibilities. Lastly, providing physician training could become a method for facilities and patients to determine which physicians may be willing and able to participate in the aid in dying process.

## 2. Documentation of Residency

Facilities should consider providing an internal system that allows physicians to confirm a patient's residency with a central residency point-person. Similar to the tribunal appeal system required in Western Australia, under the proposed system, a patient could ask for reconsideration of a residency decision. Before the initial decision or at

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<sup>170</sup> See *supra* note 139 and accompanying text.



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the time of reconsideration, a physician and patient could refer to a point-person in a facility's legal department or a resource at a state-wide medical or hospital association. While New Jersey's act explicitly states that the physician has discretion to accept another government document as confirmation of residency,<sup>171</sup> there is nothing in the Act to prevent a physician from consulting with other professionals about whether the patient meets the residency requirement. The point-person could have a list of other documents, such as a lease in the state, or an understanding of a patient's permanency or intent to return (similar to Maine's residency requirements)<sup>172</sup> to help a physician consider a patient's residency. The point-person could thoroughly consider what, if any, properties, licenses, or leases a patient has in other states that may determine whether a patient intends to stay in New Jersey or return to another state or country.

A system for confirming residency would address some current implementation issues that result from requiring medical professionals to make determinations of residency. Such a system would protect physicians from falsely identifying a patient as a resident through any of the documentation. The system would also protect patients by making sure that they are not prohibited from using the Act simply because one physician did not determine residency under New Jersey's requirement. While there may be instances where a physician determines that a person, such as an undocumented person, has enough "other documentation" to show residency, but the point-person disagrees, there could also be the inverse scenario where a physician does not find enough documentation, but the point-person does and increases access to the Act.

Facilities should additionally consider including residency documentation within their data collection. Without including the patient's actual residency information, a facility could keep a record of which type of documentation was provided to determine residency and whether the facility found the patient to be a resident. If a facility, through internal documents or state reports, finds that the unlisted options available are being used frequently, this may be a warning that non-New Jersey residents are crossing local state borders to access the Act.

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<sup>171</sup> N.J. STAT. ANN. § 26:16-11.

<sup>172</sup> ME. REV. STAT. ANN. tit. 418, § 2140(15) (2019).

### 3. Limiting Time Between Requests

New Jersey only requires a minimum waiting period between requests. Patients can wait more than fifteen days to make a second request and can wait after two oral requests to make a written request;<sup>173</sup> the law does not, however, prevent a physician from continually clarifying that a patient is voluntarily requesting the medication. Unlike other statutes, New Jersey physicians do not need to prepare final request forms under the Act. Facilities could require professionals participating in the Act to use similar forms to indicate the physician's own opinion at the time of prescription, even if an initial determination of eligibility was made months or years earlier. This Comment does not suggest that facilities require patients to make more than the required number of requests, but rather that facilities supply a tool for physicians to review the patient's eligibility if the requests are spread over time. New Jersey's Department of Health website currently provides a follow-up form, but it is only to confirm that the physician followed the Act's requirements.<sup>174</sup> A facility or physician's practice should have its own form, similar to the final attestation form in California,<sup>175</sup> that notes a patient's mental health and physical capacity at the time the final request is made and confirms that the physician informed the patient of the facility's ingestion recommendation and procedures.

### 4. Implementing Reporting Requirements

In teaching New Jersey health care professionals about the Act and how to implement it effectively, it is important to recognize that, like many other statutes, New Jersey's act has reporting requirements.<sup>176</sup> Even though reporting is already required, implementation efforts for the above definitions should continually emphasize the importance of accurate reporting. Accurate reporting in patient medical records could prevent medical errors that could be irreversible in an aid in dying case.<sup>177</sup> Physicians do not want to expose themselves to criminal liability for following the Act but failing to report, just as they want to

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<sup>173</sup> N.J. STAT. ANN. § 26:16-10.

<sup>174</sup> *Medical Aid in Dying*, N.J. DEP'T HEALTH, <https://www.state.nj.us/health/advance-directive/maid/#3> (last visited Jan. 10, 2020).

<sup>175</sup> See *supra* note 73 and accompanying text.

<sup>176</sup> Span, *supra* note 88.

<sup>177</sup> See generally Christina Farr, *This Patient's Medical Record Said She'd Given Birth Twice - In Fact, She'd Never Been Pregnant*, CNBC (last updated Dec. 9, 2018 8:25 PM), <https://www.cnbc.com/2018/12/09/medical-record-errors-common-hard-to-fix.html> (discussing the national issue with minor medical reporting errors, including mistaken patient identity, leading to major problems).

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avoid any medical reporting error that could put a lethal prescription in the wrong hands.<sup>178</sup>

## B. *Changes to the Act*

### 1. Medication Administration

New Jersey should consider explicitly allowing self-injection as a form of administration to increase access to the Act for people with existing or developed physical disabilities who cannot self-administer through ingesting a prepared regimen of aid in dying medication. To complement this expansion of the Act to people with physical disabilities, New Jersey also needs an exception to the rule that the written request be executed solely by the patient. To further implement these expansions, New Jersey might have to allow for a non-verbal form of communication typical of the patient, so the patient could convey his aid in dying wish without saying, "I would like aid in dying medication." This might be a loved one conveying the patient's interest and the patient showing or making a sound typical of that patient's agreement to confirm the desire to make the request.<sup>179</sup> This change, however, would need close monitoring. While other states' data has shown few instances of coercion and abuse,<sup>180</sup> states have not allowed non-verbal requests; thus, New Jersey would need to report how the request was made to determine if non-verbal requests are correlated with higher instances of coercion and abuse.

Even if New Jersey allows an injected form of self-administration, it would still have safeguards and restrictions, such as age, residency, and terminal illness requirements, which prevent access by certain patients. Even if New Jersey extended past any other state to allow physician administration, New Jersey would not follow international trends. New Jersey does not allow for advance directives for aid in dying, so the patient would be able to stop the treatment up until the moment of administration.

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<sup>178</sup> For more examples of implementation techniques, see *The N.J. Aid in Dying for the Terminally Ill Implementation Toolkit*, N.J. Hosp. Ass'n, <http://www.njha.com/resources/toolkits/the-nj-aid-in-dying-for-the-terminally-ill-implementation-toolkit> (last visited Feb. 14, 2020).

<sup>179</sup> I recognize the slippery slope concerns about coercion and elder abuse, but data from other states have not supported these arguments. If New Jersey follows similar trends for patients who use the Act, the state can avoid these arguments and make changes to its Act.

<sup>180</sup> See sources cited *supra* notes 151–157.

New Jersey could decrease potential use by further changing the law by adjusting the “age” requirement to consider more than just an individual’s stated age. New Jersey could require more than just an arbitrary eighteen-year-old age requirement and look into the actual brain development of the individual to determine that individual’s mental capacity for making such a major, and permanent, health care decision. This suggestion comes from recent developments in neuroscience, showing that most people do not have fully developed frontal lobes—the area of the brain used for decision-making—until their mid-twenties.<sup>181</sup> This practical change to the law would include a requirement, similar to the requirement for checking general mental health capacity,<sup>182</sup> that a physician sends patients aged 18 to 25 to mental health professionals. The mental health professional would consider symptoms and brain scans of the patient’s frontal lobe, then determine if the patient is capable of adult-like decision-making.

## 2. Minimum Time Between Requests

Like Oregon,<sup>183</sup> New Jersey could amend its law to include an exception to the fifteen-day and forty-eight-hour waiting periods between requests and prescriptions. While the current waiting period is important for encouraging patients to consider their decisions and consult family and mental health resources, it may be too arbitrary. New Jersey should leave timing questions to the doctors who know whether a patient may die painfully between requests or lose the ability to complete the requests.

## VI. CONCLUSION

This Comment compared definitions and use across the United States and the world to raise some potential concerns for New Jersey facilities and physicians as they continue to choose whether to participate in New Jersey’s Medical Aid in Dying for the Terminally Ill Act. This Comment identified trends that New Jersey might follow and

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<sup>181</sup> See NELL BERNSTEIN, *BURNING DOWN THE HOUSE* 207–09 (2014) (explaining recent studies and their subsequent influence on understanding the risks of incarcerating juvenile offenders in adult prisons); see also *Neurolaw and Order*, BBC NEWS (Dec. 6, 2017), <https://www.bbc.co.uk/programmes/w3cswcll>. for a recent argument in favor of halting the execution of a man who committed murder at age nineteen but was tried and sentenced to death before current developments in neuroimaging and studies of adolescent brains, see Dr. Jason Chein, *Insight: Adolescent Brain Immaturity Makes Pending Execution Inappropriate*, TEMPLE UNIV. (Sept. 17, 2020 4:00 AM), <https://news.bloomberglaw.com/coronavirus/insight-adolescent-brain-immaturity-makes-pending-execution-inappropriate>.

<sup>182</sup> N.J. STAT. ANN. § 26:16-8.

<sup>183</sup> See OregonLive Politics Team, *supra* note 55.

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potential concerns of those trends. This Comment recommended self-administration training, utilization of residency experts, additional public reporting, and use of final report forms where no time limit between requests exists. Additionally, this Comment suggested New Jersey amend its law to include both ingestion and injection administration, a less arbitrary age requirement, and exceptions to waiting periods. This Comment encourages New Jersey facilities to use such recommendations and to be on alert to how future states and countries create aid in dying laws and address these issues. New Jersey should consider its data over the next several years to re-evaluate the Act and consider whether making the above amendments would be appropriate given those results.

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State	Prescriptions Written in 2017 & 2018	Death by Aid in Dying Medication in 2017 & 2018	Total Census Deaths July 2017–July 2018	% Total Deaths by Aid in Dying Medication
OR	467	311	36,052	0.86%
CA	1029	711	280,674	0.25%
WA	479	367	57,568	0.25%
CO	197	174	38,367	0.45%
ME			14,079	
NJ			76,730	

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<sup>184</sup> This Table displays the numbers discussed in the text accompanying notes 150–165.