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To be, or not to be: New Jersey's Proposed Death With Dignity Act

By Rocco Seminerio

Whether or not, as Shakespeare wrote, it is nobler in the mind to suffer the slings and arrows of outrageous fortune, or to take arms against a sea of troubles--should be ultimately decided by the individual patient faced with a terminal illness. On one hand there are genuine scenarios where patients with serious debilitating terminal illnesses should be legally permitted, despite advances in palliative care, to request death-hastening drugs. On the other hand, although the proposed New Jersey Death with Dignity bill would allow for that legal possibility, the safeguards built into the draft of the bill introduced in 2013 are inadequate to address concerns about undue influence, oversight, and competency. As a result, this paper proposes additional mechanisms and fundamental changes in the safeguards in the oversight process before New Jersey should endorse this well-intentioned but flawed bill. The paper proceeds as follows: a general background on Death with Dignity Acts (DWDAs), followed by a discussion of the constitutional status of the right to die, a discussion of the arguments for and against the bill and proposed amendments, and then suggestions for minor changes. The paper concludes that, if amended to include greater safeguards, the New Jersey legislature should enact the Death with Dignity Act.

I. Background

By the year 2020, 2.5 million people aged 65 or older will die annually.¹ Thanks to advances in medicine and health care, in the past century the average life span has increased by

¹Vicki Lachman, *Assisted Suicide: Compassionate Liberation or Murder?* 19(2) MEDSBURG NURSING 123 (March/April 2010).

thirty years in the United States.² The increase in the elderly population exacerbates a set of pressing challenges for end of life health care not only to physicians, but affected family members and society as well. Statistically there is a trend of increased cancer risk as people age, and it is no surprise that older adults and the elderly have the highest rates of cancer.³ Therefore, larger numbers of elderly persons and their families are facing a myriad of end-of-life healthcare decisions. One of the more controversial possibilities at the end of life is that of physician-assisted death or suicide. In the majority of states, including New Jersey,⁴ there are statutes which make it a second degree criminal offense to assist others in suicide.⁵

Across the nation legislatures and citizens have been considering the question of physician assisted death. There have been bills before the legislatures of Connecticut, New Hampshire Pennsylvania, Hawaii, Kansas, and Massachusetts.⁶ So far however, the only states to pass legislation allowing for physician-assisted death have been Oregon, Washington, and Vermont.⁷ Legalization of physician-assisted death began when the citizens of Oregon exercised their democratic powers by voting in favor of the Oregon Death with Dignity Act (DWDA).⁸ After the Oregon DWDA was enacted in 1997, Vermont and Washington followed suit. DWDAs allow someone who has been diagnosed with a terminal disease to request medication that will hasten death.⁹ The state of Montana, although it has not formally enacted a DWDA, allows doctors to offer an affirmative defense of consent in court should they be charged with assisted suicide,

²James E. Dallner, *Death with Dignity in Montana*, 65 MONT. L. REV. 309, 310 (2004) citing *U.S. Department of Health & Human Services, Ten Great Public Health Achievements - United States, 1900-1999*, 48 Morbidity & Mortality Weekly Rep. 241 (1999).

³See *Cancer Incidence By Age*, Cancer Research UK (July 26, 2012), <http://www.cancerresearchuk.org/cancer-info/cancerstats/incidence/age/>

⁴N.J.S.A. 2C:11-6

⁵See *Compassion in Dying v. Washington*, 79 F.3d 790, 847 (9th Cir. 1996) (Beezer, J., dissenting) ("In total, forty-four states, the District of Columbia and two territories prohibit or condemn assisted suicide").

⁶*Death with Dignity Acts*, Death with Dignity National Center (2012), <http://www.deathwithdignity.org/acts>

⁷*Id.*

⁸OR. REV. STAT. § 127.805 § 2.01(1) (2005 & Supp. 2005).

⁹*Id.*

thanks to court precedent.¹⁰ On September 27, 2012, New Jersey Assemblyman Burzichelli introduced a bill that would be the equivalent of the DWDAs in other jurisdictions.¹¹ New Jersey is therefore faced with an important decision.

Physician-assisted death has generated tremendous controversy nationwide. A 2007 poll found that 71% of people thought that doctors should be allowed to legally assist a person hasten death in the case of an incurable disease.¹² This is slightly higher than a two-thirds majority in favor of physician-assisted suicide found by a poll in 1991.¹³ In the context of a group consisting of mostly health-care providers, a 2013 poll of *New England Journal of Medicine* readers revealed that 67% opposed physician-assisted suicide.¹⁴ In yet another poll from 2012, 55% of Americans supported physician assisted suicide and 45% opposed it.¹⁵

These polls reveal a country deeply divided on the question of physician-assisted death. The main argument advanced in favor of physician-assisted death is the desire to give terminally ill patients the control to end their lives on their own terms.¹⁶ The main argument against physician-assisted death is fear of a slippery slope of abuse and the death of ill patients or members of vulnerable populations who do not wish to end their lives.¹⁷ Moral and religious judgments also factor into support or opposition to physician-assisted death. The various ancillary and counter arguments for and against physician-assisted death are considered later.

¹⁰Baxter v. Montana, 224 P.3d 1211, P49 (Mont. 2009).

¹¹N.J. Assemb., No. 3328 (2012), http://www.njleg.state.nj.us/2012/Bills/A3500/3328_11.HTM.

¹²Joseph Carroll, *Public Divided over Moral Acceptability of Doctor-Assisted Suicide*, GALLUP (May 31, 2007), <http://www.gallup.com/poll/27727/Public-Divided-Over-Moral-Acceptability-DoctorAssisted-Suicide.aspx>.

¹³Cathy Collison, *News for Young Readers*, DET. FREE PRESS, NEWS, at 2A (Nov. 14, 1991).

¹⁴Bahar Gholipour, *Physician-Assisted Suicide: Poll Shows Divide Among Experts*, Live Science (September 11, 2013), <http://www.livescience.com/39571-physician-assisted-suicide-poll.html>.

¹⁵Scott Hensley, *Americans Support Physician-Assisted Suicide for Terminally Ill Patients* (Dec. 28, 2012), <http://www.npr.org/blogs/health/2012/12/27/168150886/americans-support-physician-assisted-suicide-for-terminally-ill>.

¹⁶CANDLE M., WESTER-MITTAN, PHYSICIAN-ASSISTED DEATH: FOUR VIEWS ON THE ISSUE OF LEGALIZING PAD: A LEGAL RESEARCH GUIDE, XVIII (2009).

¹⁷*Id.*

III. Is There A Right To Die? Constitutional and Policy Concerns

A. *Washington v. Glucksberg*

In the Supreme Court case of *Washington v. Glucksberg*, three terminally-ill patients challenged the constitutionality of Washington statutes against assisting suicide.¹⁸ Five physicians willing to aid patients in dying and an organization known as Compassion in Dying joined the original plaintiffs.¹⁹ The District Court had held that there was a right to die for terminally ill patients inherent in the Due Process Clause because of personal autonomy and dignity.²⁰ The Court of Appeals, sitting en banc, affirmed the District Court decision.²¹

Justice Rehnquist, writing for the majority to reverse the lower courts, began his analysis by noting that the nation's history and legal traditions have criminalized assisting a suicide.²² Furthermore, he characterizes the prohibition on aiding suicide as a commitment to the protection and preservation of all human life.²³ Justice Rehnquist mentions that opposition and condemnation of suicide as well as assisted suicide have been longstanding themes of our nation's philosophical, legal and cultural heritage.²⁴ After discussing common law and history of the attitudes towards suicide, Justice Rehnquist makes a very important point. He writes that, "...the prohibitions against assisting suicide *never contained exceptions for those who were near death.*"²⁵ Death with dignity acts do exactly what has traditionally been excluded – they create exemptions under assisted suicide laws for physicians in compliance with the DWDA. Emphasizing the essential value of life, Rehnquist quotes *Blackburn v. State*: "the life of those to

¹⁸Wash. v. Glucksberg, 521 U.S. 702, 707-708 (U.S. 1997).

¹⁹*Id.*

²⁰*Id.*

²¹*Id.*

²²*Id.* at 706-707.

²³*Id.* at 710 *citing* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (U.S. 1990).

²⁴*Id.*

²⁵*Id.* at 714.

whom life had become a burden—of those who were hopelessly diseased or fatally wounded—nay, even the lives of criminals condemned to death, were under the protection of law, equally as the lives of those who were in the full tide of life’s enjoyment, and anxious to continue to live.”²⁶

Justice Rehnquist then finally turns to the main issue that confronted the Court in *Washington v. Glucksberg*, namely whether there is a liberty interest protected by the Due Process Clause that covers a right to commit suicide and the right to assistance in doing so.²⁷ Given the history and legal traditions against suicide, the distinction between a refusal of unwanted medical treatment and induced hastening of death, and a refusal to come to the “sweeping conclusion that any and all important, intimate, and personal decisions are...protected”, Justice Rehnquist determined that there was no fundamental right at issue in the case.²⁸

The last important take-away from the majority opinion in *Washington v. Glucksberg* is Justice Rehnquist’s enumeration of state interests in banning physician-assisted suicide. Justice Rehnquist’s list of state interests and Justice Souter’s enunciation of the state’s arguments in his concurrence comprehensively encapsulate the anti-physician assisted suicide position. Justice Rehnquist writes that a state has an interest in 1) preserving human life; 2) preventing suicide; 3) protecting the integrity of the medical profession; 4) protecting vulnerable populations such as the elderly and poor from undue influence or mistakes; and 5) preventing the popularization of euthanasia as an outgrowth of allowing physician assisted suicide.²⁹

In Justice Souter’s concurrence, he notes at least three additional state concerns and

²⁶*Id.* at 715 citing *Blackburn v. State*, 23 Ohio St. 146, 163 (1872).

²⁷*Id.*

²⁸*Id.* at 727.

²⁹*Id.* See also Jennifer Bradford, *Vacco v. Quill and Washington v. Glucksberg: Thou Shalt Not Kill, Unless Your State Permits Physician-Assisted Suicide*, 26 PEPP. L. REV. 121, 137 (1998).

arguments. The state argued that 6) It is not always possible to say with certainty how long a person may live; 7) the right to die could not be confined to the terminally ill, i.e. there is “*no principled basis* on which the right can be limited to the prescription of medication for terminally ill patients to administer to themselves when the right's justifying principle is as broad as merciful termination of suffering”; 8) a person's competence cannot always be assessed with certainty.³⁰

B. *Vacco v. Quill*

Decided together with *Washington v. Glucksberg*, the facts before the Court in *Vacco v. Quill* were very similar to those in *Glucksberg*. Three mentally competent and terminally ill patients dying from AIDS and cancer joined three physician plaintiffs who were willing to help their patients end their lives but feared criminal prosecution.³¹ The plaintiffs claimed that they had a fundamental right to physician-assisted suicide and that the New York statutes criminalizing such were unconstitutional.³² Judge Rehnquist again writing for the majority used the same reasons he used in the *Glucksberg* case. He cited the nation's legal history and traditions and stated that New York had a rational basis to make the distinction between a refusal of unwanted medical treatment and the induced hastening of death, or natural versus artificial death.³³ The Supreme Court thereby overruled the Second Circuit below, which reasoned from the *In re Quinlan* case that the state's interest in preserving life weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims.³⁴

Justice Stevens in a concurring opinion makes several interesting remarks. Justice Stevens completely agrees with the Court that there is no categorical and fundamental right to commit

³⁰*Id.* at 754-755.

³¹*Vacco v. Quill*, 521 U.S. 793, 797 (U.S. 1997).

³²*Id.*

³³*Id.* at 803

³⁴*Quill v. Vacco*, 80 F.3d 716, 729 (2nd Cir. 1996) *citing* *In re Quinlan*, 355 A.2d 647 (1976).

suicide under the liberty interest protected by the Due Process Clause.³⁵ Justice Stevens reasons from Washington’s authorization of the death penalty that it has concluded that the sanctity of life does not require that life always must be preserved.³⁶ Furthermore, Stevens acknowledges that there are situations in which an interest in hastening death is legitimate.³⁷ He not only suggests that such an interest is legitimate, but says that he is “convinced” that there are times when it is entitled to constitutional protection.³⁸

But Justice Stevens goes yet even further. Stevens wrote that the Cruzan case demonstrated that some state intrusions on the right to decide how death will be encountered are intolerable.³⁹ He invokes the Casey case’s discussion of the “outer limits of the substantive sphere of liberty”, which “definitely includes” protection for matters “central to personal dignity and autonomy.”⁴⁰ As is often pointed out by disability-advocate groups, Justice Stevens notes that many terminally ill people find their lives meaningful even despite pain or lack of independence.⁴¹ However, this is not the case in every scenario. Stevens wrote that in general the State’s interest in a person’s contribution to society and in preserving life triumphs, but this interest does not have equal force when applied to terminally ill patients who are “faced not with the choice of whether to live, only how to die.”⁴² Stevens characterizes this as a “critical threshold” of death.⁴³

In part three of his concurring opinion, Justice Stevens writes that allowing the individual instead of the State to make judgments “about the ‘quality’ of life that a particular individual may enjoy” does not imply that therefore the lives of the terminally-ill or disabled people have less

³⁵Vacco, 521 U.S. at 809.

³⁶*Id.*

³⁷*Id.*

³⁸*Id.*

³⁹*Id.*

⁴⁰*Id.* citing *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 851 (U.S. 1992).

⁴¹*Id.*

⁴²*Id.*

⁴³*Id.*

value than lives of those who are in good health.⁴⁴ To the contrary, Stevens writes that it gives recognition to the individual’s interest in choosing how to end life, as opposed to an end which “demeans her values and poisons memories of her.”⁴⁵

C. Glucksberg & Quill: The Bottom Line, Democracy & New Jersey’s Choice

The Supreme Court in both the *Glucksberg* and *Quill* cases confirmed that there is no “fundamental” right to die inherent in the liberty protected by the Due Process clause. We see the concerns of the state in finding a right to die enumerated by Justice Rehnquist and Justice Souter. But we also see from Justice Steven’s concurrence in *Quill* that there is a possibility that on a particularized set of facts, statutes prohibiting physician assisted suicide may be constitutionally impermissible because of the individual’s intimate liberty interest in how she will meet death.

Despite the fact that the Supreme Court did not find a fundamental right to die, the States were given a green light on enacting their own physician-assisted death legislation. The closing remarks of Justice Rehnquist in *Glucksberg* promote the continued debate over the “morality, legality, and practicality of physician-assisted suicide.”⁴⁶ Justice Rehnquist states that the Court’s holding permits the aforementioned debate to continue, “as it should in a democratic society.”⁴⁷

In a similar vein, the Montana Supreme Court determined in 2010 that physician-assisted suicide did not violate Montana’s public policy.⁴⁸ Although a rigorous dissenter in that case and opposed to the holding, Justice Rice concluded that the court “should allow the public debate to continue, and allow the citizens of this State to control their own destiny on the issue.”⁴⁹

⁴⁴*Id.* citing *Cruzan*, 497 U.S. at 282.

⁴⁵*Id.*

⁴⁶*Glucksberg*, 521 U.S. at 735.

⁴⁷*Id.*

⁴⁸*Baxter*, 224 P.3d at P50.

⁴⁹*Id.* at P117.

New Jersey's "destiny on the issue" is now at hand. A recent 2012 poll reports that among a sample of New Jersey voters, 46% support the proposed DWDA while 38% oppose it.⁵⁰ The following section advances why New Jersey should pass the bill conditioned on several proposed amendments.

IV. Affording the Legal Right to Die: Reasons in Favor

A. Self-determination, Autonomy, & Treatment with Dignity

Autonomy comprises "...the interest in independence in making certain kinds of important decisions."⁵¹ As Justice Stevens observed in his *Quill* concurrence, autonomy is part of an individual's right to liberty protected by the constitution. Because matters at the end of life involve "the intimate and personal choices" a person can make in their lifetime, which therefore implicate personal autonomy and dignity, these choices are "central to the liberty protected by the Fourteenth Amendment."⁵² Justice Stevens left open the door for the possibility of an assisted suicide ban being unconstitutional as applied to particular facts. Even though a blanket fundamental right to die does not apply to all situations, New Jersey should as a matter of policy favor the legality of physician-assisted death in order to respect individual autonomy. If you ask the terminally ill themselves, at least one study of 988 participants indicates that 60% support the legal option of physician-assisted death and 10% were seriously pursuing that option.⁵³

In a concurring opinion in *Baxter v. Montana*, Justice Nelson quoted a previous court case which held that "respect for the dignity of each individual ... demands that people have for themselves the moral right and moral responsibility to confront the most fundamental questions

⁵⁰Matt Friedman, *Poll: N.J. Voters Support Controversial Bill Allowing Doctor-Assisted Suicide*, The Star Ledger (Dec. 4, 2012), http://www.nj.com/politics/index.ssf/2012/12/poll_nj_voters_support_controv.html.

⁵¹*Whalen v. Roe*, 429 U.S. 589, 599-600 (U.S. 1977).

⁵²*Compassion in Dying v. Washington*, 79 F.3d 790, 848 (9th Cir. 1996) *citing* *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2807 (U.S. 1992).

⁵³Emanuel EJ, Fairclough DL, Emanuel LL: *Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers*, 284 JAMA 2460-8 (2000).

about the meaning and value of their own lives and the intrinsic value of life in general...⁵⁴ If we refuse to respect such a right, we are in danger of implementing “treatment which is paternalistic—treating adults like children incapable of making autonomous choices for themselves, or by trivializing what choices they do make about how to live their lives.”⁵⁵

Inherent in democratic ideals is respect for the autonomy of the individual person to decide for herself what is best. Justice Nelson in *Baxter* goes on to cite a law review article wherein its authors explain that, “The only reasonable political compromise we can reach in modern times...when we must accept as fact that different segments of society will have deeply conflicting...views about how one ought to live one’s life, is to agree to treat each other...with mutual respect and tolerance.”⁵⁶ Furthermore, it is noted that this compromise of mutual respect and tolerance make a modern constitutional democracy possible by respecting autonomous liberty.⁵⁷ The authors conclude that we must “focus on honoring the worth of autonomous individuals. To remain consistent...the right to treatment with dignity must not be defined according to some parochial, sectarian religious or some controversial, philosophical notion of human dignity—those richer conceptions of dignity about which we have agreed to disagree.”⁵⁸

DWDAs have so far only allowed competent⁵⁹ adults to exercise the option of physician-assisted death.⁶⁰ It is therefore understandable that one might argue that DWDAs are discriminatory, because while they allow competent terminally ill patients to end their lives, they

⁵⁴*Baxter*, 224 P.3d at P65 citing *Armstrong v. State*, 989 P.2d 364, P30 (Mont. 1999).

⁵⁵*Id.* citing Matthew O. Clifford & Thomas P. Huff, *Some Thoughts on the Meaning and Scope of the Montana Constitution’s “Dignity” Clause with Possible Applications*, 61 MONT. L. REV. 301, 307-08 (2000).

⁵⁶*Id.* citing Clifford and Huff, 61 MONT. L. REV. at 326-27.

⁵⁷*Id.*

⁵⁸*Id.* citing Clifford and Huff, 61 MONT. L. REV. at 326-27.

⁵⁹“Capable” is used in lieu of competency in the bill. Capable means “means having the capacity to make health care decisions and to communicate them to a health care professional, including communication through persons familiar with the patient’s manner of communicating if those persons are available.” Sect. 3 of N.J. Assemb., No. 3328 (2012).

⁶⁰See section 4 of N.J. Assemb., No. 3328 (2012).

prohibit advance planning for assisted suicide given incompetency or surrogate decision-making more generally. The difficulty with this objection however is that one of the fundamental grounds for allowing physician-assisted death – self-determinative autonomy – is undermined if a patient is not competent. In a famous New Jersey case, Judge Handler concurring and dissenting in part, notes that incompetent persons have been “deprived by nature” of the right to personal choice.⁶¹ Judge Handler suggests that it “would be amiss” to stress notions of individual privacy or autonomy and that such cannot enhance the ability to make life or death decisions in the context of an incompetent patient’s best interests.⁶² If we were to afford the right of surrogates or guardians to administer death-hastening drugs to their wards, we would be undermining the fundamental ground of self-determination and autonomy justification for physician-assisted death in the first place. Although guardians are said to be acting on “behalf” of their ward, the ward is certainly not personally acting out of self-determination. Instead, as Judge Handler points out, surrogates are acting for the best interests of the ward. Autonomy and self-determination are therefore no longer relevant. None of this should suggest, however, that the determination of whether or not someone is competent or ‘capable’ is an insignificant concern. To the contrary, it certainly is and will be addressed below. Respect for competent patient autonomy and choice is the strongest reason for passing the proposed New Jersey DWDA.

B. Illegal Practice & Violent Suicide

Underground practice of physician assisted suicide and suicide by other means are problems particularly in jurisdictions where there is no legal procedure to hasten death. Before the passage of the Washington DWDA, a study was conducted of physicians in Washington State. When asked whether they had been requested to assist a suicide on terminally ill patients, 218 out

⁶¹In re Conroy, 98 N.J. 321, 392 (N.J. 1985) *citing* In re Grady, 85 N.J. 235, 274 (N.J. 1981) (Handler, J. concurring).

⁶²*Id.*

of 828 doctors who responded answered in the affirmative.⁶³ Furthermore, forty-three of those doctors actually complied.⁶⁴ We are therefore faced with some pressing questions. First, will legalization of physician-assisted death help regulate the practice? At least two authors think that legalization will fail to successfully regulate physician assisted death. The authors reason that if doctors are ignoring the existing prohibitions against physician-assisted death in anti-suicide or assisted suicide statutes, then why would they obey new regulations on the practice?⁶⁵ We are dealing with several groups of doctors—those who would perform PAD regardless of its legality, those who would not even if it became legal, and those who would only perform PAD if it was legal. For the latter group, we may assume for our present purposes that they would be likely to comply with new regulation. In the aforementioned study of Washington physicians, out of the 218 doctors who received a request, 26 cited that they refused for fear of the legal consequences.⁶⁶ We are not concerned with the group of doctors who would never perform physician-assisted death for moral or personal reasons.

But what about physicians who have been operating “underground” despite illegality and have provided the means for a patient to die—won’t they ignore the law as they have in the past? I think the answer is largely no. As noted previously, a majority of physicians are against physician-assisted suicide. But those who support it often do so for moral reasons. Physicians who risk being prosecuted by assisting someone with dying probably feel a moral obligation that they believe justifies the risk of breaking the law. Instead of having a broad prohibition on physician-assisted death, DWDAs would allow those previously underground practitioners to

⁶³Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919 (1996).

⁶⁴*Id.*

⁶⁵Daniel Callahan, Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICH L. REV. 1, 10 (1996).

⁶⁶Back, *supra*.missing info

comply legally and still, in most cases, do what they believe is right in assenting to a patient's request.

Studies suggest that suicide risk is about double for cancer patients than it is for the general population.⁶⁷ There have been numerous and sad individual reports of suicide.⁶⁸⁶⁹ There are also reports of individuals attempting suicide, but failing.⁷⁰ Not much needs to be said here save that some sort of legal framework wherein a terminally ill patient could request death-hastening drugs would be preferable to patients finding ways on their own out of desperation. We should legalize and regulate physician-assisted death to provide a proper channel for those who have a desire to end their lives when they have a terminal illness.

V. The Good, the Bad, & the Ugly: Arguments Against the NJ Death With Dignity Act

A. The Slippery Slope, Vulnerable Populations, & Undue Influence

One of the most common objections to DWDAs is a fear that if physician assisted death is legalized, it might lead to “the acceptance of the physician assisted suicide for the chronically ill, the disabled, and the psychologically distressed, as well as to the acceptance of active euthanasia...”⁷¹Of specific concern is the fear that particularly vulnerable persons of society will be unwilling or unduly influenced victims of the slippery slope. Economic worries and high

⁶⁷William Breitbart, *Suicide Risk and Pain in Cancer and AIDS Patients*, <http://www.painresearch.utah.edu/cancerpain/ch04.html> citing Fox BH, Stanek EJ, Boyd SC, Flannery JT., *Suicide Rates Among Cancer Patients in Connecticut*, 35 J CHRONIC DIS 85-100 (1982) & Louhivuori KA, Hakama J., *Risk of Suicide Among Cancer Patients*, 109 AM. J. EPIDEMIOL 59-65 (1979).

⁶⁸Plymouth Herald, *Terminally Ill Man Bought Drug and Suicide Manual Online Before Killing Himself*, (Sept. 13, 2013), <http://www.plymouthherald.co.uk/Terminally-ill-man-bought-drug-suicide-manual/story-16892007-detail/story.html>.

⁶⁹Delores Lewis, *New Jersey: Pass the Death with Dignity Act for Terminally Ill Patients*, <http://www.change.org/petitions/new-jersey-pass-the-death-with-dignity-act-for-terminally-ill-patients>.

⁷⁰Cathleen F. Crowley, *Life Interrupts An Attempt to Die at Home*, (Sept. 26, 2011), <http://www.timesunion.com/local/article/Life-interrupts-an-attempt-to-die-at-home-2188158.php>

⁷¹Monika Ardelt, *Physician-Assisted Death*, C.D. Bryant et al. (eds.): *Handbook of Death and Dying*, Thousand Oaks, CA: Sage 424, 426 (2003) citing Mike Brogden, *Geronticide: Killing the Elderly*, Philadelphia: Jessica Kingsley (2001).

medical costs contribute to the pressure to end life.⁷² It is perceived that “support for euthanasia derives from an attitude of excessive preoccupation with efficiency...which sees the growing number of elderly and disabled people as intolerable and too burdensome.”⁷³ The New York State Task Force on Life and the Law in its 1994 report writes,

“The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group. The risk of legalizing assisted suicide...in a health care system and society that cannot effectively protect against the impact of inadequate resources...and social disadvantages, would be extraordinary.”⁷⁴

Extraordinary claims require extraordinary evidence. Yet there is little evidence from which these fears could infer valid justification. In a 2007 study of Oregon and the Netherlands, it was concluded that there is no evidence of *disproportionate* impact on vulnerable groups.⁷⁵

Analyzing the data from the Oregon Reports and three independent studies, the data yielded no disproportionate impact among the “elderly, women, the uninsured, people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities...” relative to the background populations.⁷⁶ The only group that was disproportionately represented was those with AIDS.⁷⁷

Even more so, evidence from Washington and Oregon show that not many people choose to request death-hastening drugs, let alone ingest them. In Washington between March 2009 and

⁷²Andrew R. Page, *What's the Cost of Living in Oregon These Days? - A Fresh Look at the Need for Judicial Protections in the Death with Dignity Act*, 22 REGENT U.L. REV. 233, 237 (2010).

⁷³John F. Coverdale, *The Legacy of John Paul II to Lawyers*, 36 SETON HALL L. REV. 1, 29 (2005) citing John Paul II, *Evangelium Vitae*, p. 64 (1995).

⁷⁴Callahan & White, *supra* at 43 citing The New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 120 (1994).

⁷⁵Margaret P. Battlin, *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in “Vulnerable” Groups*, 33(10) J. MED. ETHICS 591-597 (2007).

⁷⁶*Id.*

⁷⁷*Id.*

December 2011 a total of 114 patients inquired into the DWD program.⁷⁸ Of those 114, only 40 participants chose to pursue the program after counseling and upon request.⁷⁹ Of those 40 who received the death-hastening drugs, only 24 chose to ingest.⁸⁰ Recipients typically were white, male, and well educated.⁸¹ Similarly, in Oregon for 2012 only 115 patients requested and received the drugs, and 77 chose to ingest.⁸²

Trice Loggers, the lead researcher of the Washington study reports that, “Each year, there are over 50,000 deaths in Washington state...The number who chose to participate in the DWD program is miniscule. This study shows that people are not making these decisions lightly.”⁸³ Furthermore, the Oregon Report reveals that the reasons for choosing physician-assisted death are “loss of autonomy” (93% of participants), “decreasing ability to participate in activities that made life enjoyable” (92.2%), and “loss of dignity” (77.9%).⁸⁴ In another study the authors concluded that patients engaged in “PAS after a deliberative and thoughtful process.”⁸⁵ Only 38% overall of patients who died from ingesting death-hastening drugs reported that burden on family, friends or caregivers were among their concerns.⁸⁶ A paltry 2.7% of patients who died from ingesting drugs reported that financial implications of treatment were among their concerns.⁸⁷ These statistics do not completely alleviate concerns of undue influence. Human motivation is complex after all, and

⁷⁸Elizabeth Trice Loggers, *Implementing a Death with Dignity Program at a Comprehensive Cancer Center*, 368 N ENGL J MED 1417-1424 (2013).

⁷⁹*Id.*

⁸⁰*Id.*

⁸¹*Id.*

⁸²Oregon Public Health Division, *Oregon’s Death with Dignity Act—2012*, (2013), <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf>.

⁸³Serena Gordon, *Physician-Assisted Suicide Program Rarely Used, Study Finds*, (2013), <http://health.usnews.com/health-news/news/articles/2013/04/10/physician-assisted-suicide-program-rarely-used-study-finds>

⁸⁴*Oregon’s Death With Dignity Act—2012, supra*.

⁸⁵Robert A Pearlman, *Motivations for Physician-assisted Suicide: Patient and Family Voices*, 20(3) J GEN INTERN MED. 234-239 (2005).

⁸⁶*Oregon’s Death With Dignity Act—2012, supra*.

⁸⁷*Id.*

it is possible for family members and close friends to subtly influence a patient. The bill does provide that there are criminal penalties for willfully altering or forging “a request for medication ... or conceals or destroys a rescission...with the intent or effect of causing the patient's death...”⁸⁸ Nonetheless, chances of detection in the normal course of things are probably slim given the current supervision system. One author suggests that we have the courts handle these drug requests because of their experience in handling issues involving undue influence as is the case with contracts and wills.⁸⁹ Ultimately this is a risk that we will have to take if we wish to legalize physician-assisted death. Respect for autonomy does potentially mean that some people will choose to die for other reasons than wanting to have control over his or her death.

Looking at the data, there does not seem to be explosive use of the DWDAs. The slippery slope argument in the context of vulnerable groups does not seem terribly strong given the statistics. Nonetheless, the distribution of drugs intended to induce death or drugs that can induce such a death-hastening effect need to be monitored. One of the many things that need to be addressed before endorsement of this bill by New Jersey citizens is the laying out of how the Division of Consumer Affairs will monitor the prescription of death-hastening drugs more carefully than is provided in the bill.⁹⁰

B. Uncertainty in Prognosis of a Terminal Illness

One of the state's concerns mentioned by Justice Souter in his *Washington v. Glucksberg* concurrence is that it's not possible to say with certainty how long a person may live.⁹¹ Under

⁸⁸N.J. Assemb., No. 3328 (2012).

⁸⁹Andrew R. Page, *supra*.

⁹⁰The Director of the Division of Consumer Affairs (DCA) is required to collect reports from providers within 30 days of the dispensing of the medication and within after 30 days of the patients death, documentation of that death. However, once dispensed the lethal medication is not monitored. There needs to be an amendment that requires the return of the drugs after the patient's death, whether used in part or not. There should also be investigations conducted if all the drugs are not returned if the patient was not reported as ingesting.

⁹¹Glucksberg, *supra* at 754.

section 3 of the New Jersey Bill, a terminal illness or disease is defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in a patient’s death within six months.”⁹² Among the arguments against physician-assisted death, uncertainty in prognosis is one of the stronger ones. In a 1999 study of Oregon Physicians, it was found that 27% of physicians who received requests from patients for physician-assisted death were not confident that they could predict that the patient had a life expectancy of less than six months.⁹³ Studies suggest that physician predictions of life expectancy are “generally inaccurate.”⁹⁴ The Oregon Report from 2004 shows that some people who were diagnosed with a terminal illness lived far beyond six months.⁹⁶

Outside of DWDAs, the six month prognosis model is already being used as a qualification requirement for hospice care pursuant to Medicare regulations.⁹⁷ The implementation of the six month standard in hospice care has been heavily criticized; some have gone as far as to call the standard “meaningless.”⁹⁸ The six month standard for hospice care is identical to the standard in DWDAs, thus generating the same difficulties. One study showed that approximately ten percent of patients who satisfied the six month standard and were admitted to hospices were eventually discharged because of remission or misdiagnosis.⁹⁹ Another study involving patients in Chicago hospice programs concluded that doctors got the

⁹²N.J. Assemb., No. 3328 (2012).

⁹³Monika Ardel, *supra* citing Linda Gazini, *Oregon Physicians’ Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death With Dignity Act*, 285(18) JAMA 2363-69 (2001).

⁹⁴Callahan & White, *supra* citing Robert A. Pearlman, *Inaccurate Predictions of Life Expectancy*, 148 ARCHIVES OF INTERNAL MEDICINE 2537 (1988).

⁹⁵Nicholas A Christakis, *Extent and Determinants of Error in Doctors’ Prognoses in Terminally Ill Patients: Prospective Cohort Study*, 320 BMJ 469 (2000).

⁹⁶*Sixth Annual Report on Oregon’s Death with Dignity Act*, Department of Human Services (2004).

⁹⁷Patrick M. Curran, Jr., *Regulating Death: Oregon’s Death with Dignity Act and the Legalization of Physician-Assisted Suicide*, 86 GEO. L.J. 725, 732 (1998).

⁹⁸*Id.*

⁹⁹*Id.* citing D. Allan Shewmon, *Active Voluntary Euthanasia: A Needless Pandora’s Box*, 3 ISSUES L. & MED. 219, 223 (1987).

prognosis right only about twenty percent of the time, and sixty-three percent of the time overestimated their patients' survival.¹⁰⁰ The lack of a certain or near-precise scientific basis for determining when a patient is going to die is a source of great difficulty for prognosis standards of terminal illness.

It is therefore conceivable that a patient might ingest death-hastening drugs long before he or she would die from their illness or condition. Occurrences like these pose serious concerns. Given the inability of a physician to determine exactly when a patient will die, language in the bill requires that a physician must confirm the prognosis "within reasonable medical judgment."¹⁰¹ According to one right to die newsletter, the six month standard "...not only calls on doctors to make an unreliable prediction, but prescribes a pointless time limit."¹⁰² Given the six month prognosis standard, there seems to be no remedy for these calculative difficulties. Diagnosis is one thing, prognosis altogether another. One suggestion is to require that physicians "extensively document a patient's disease" and prognosis to serve as tangible evidence requirements.¹⁰³ Documentation of the attending physician's diagnosis and prognosis are already required to be on the patient's medical record pursuant to 11(c)(2) of the proposed bill.¹⁰⁴ While requiring additional documentation would provide grounds for a lawsuit against a doctor if said documentation was inadequate, it is nonetheless impractical for doctors and does nothing to remedy the difficulties inherent in predicting the course of a disease.

¹⁰⁰Nicholas A Christakis, Elizabeth B Lamont, *Extent and Determinants of Error in Doctors' Prognoses in Terminally Ill Patients*, 320(7233) BMJ 469-473 (2000).

¹⁰¹N.J. Assemb., No. 3328 (2012).

¹⁰²Eric Gargett, *Changing the Law in South Australia*, World Right-to-Die Newsletter, p. 3 (May 2001).

¹⁰³Andrew R. Page, *supra* citing Raphael Cohen-Almagor & Monica G. Hartman, *The Oregon Death with Dignity Act: Review and Proposals for Improvement*, 27 J. LEGIS. 269, 283 (2001).

¹⁰⁴N.J. Assemb., No. 3328 (2012).

A sounder alternative would be to change the prognosis standard to one that would better serve patients. The purpose of the terminal illness safeguard is to ensure that the patient is already dying before considering any life-ending decisions.¹⁰⁵ To achieve the aims of this safeguard, the terminal illness standard for the proposed DWDA should be amended to: 1) whether the diagnosed disease or condition has no known cure and there is no way to stop progression of the disease, 2) whether the overall nature of symptoms is becoming progressively worse, and 3) the nature of the disease is such that it will lead to death. These considerations eliminate the need for physicians to hopelessly attempt to predict the schedule of death. Such a multi-pronged standard also allows people with progressive diseases like Alzheimer's or ALS to request death-hastening drugs. Nonetheless, the requirement of capacity still stands and will in effect bar those who suffer from advanced stages of certain diseases which affect the brain and thus capacity from acquiring death-hastening drugs.

C. Determination of Capability

In Justice Souter's *Glucksberg* concurrence he notes that the state argued that there are difficulties with assessing the competence or capability of a patient. Grave concerns loom here because they strike at the very heart of the justification for physician assisted death – autonomy and self-determination. Physicians often are not confident in their ability to assess the competence or capability of patients.¹⁰⁶ Nonetheless, guidelines do exist for determining competency in the context of health-care decisions. In fact, our courts are generally the best judges (literally) as to competency in questionable cases simply because they have experience

¹⁰⁵James Park, *Certification of Terminal Illness or Incurable Condition*, Right-to-Die Portal (2013), <http://www.tc.umn.edu/~parkx032/SG-TERMI.html>.

¹⁰⁶Raphael Cohen-Almagor & Monica G. Hartman, *The Oregon Death with Dignity Act: Review and Proposals for Improvement*, 27 J. LEGIS. 269, 283 (2001).

in competency determinations in a number of different settings.¹⁰⁷ In scenarios where there is ambiguous evidence or where competency is questionable, physicians should resort to New Jersey General Equity & Chancery courts for guidance. The NJ DWDA should be amended to require court determination of competency in cases where there are objections by family members as to the patient's competency. Court determinations should be permissible, but not mandatory under the bill, when the two physicians seek more assurance in a situation of which they are unsure.

For most capacity determinations however, going to court should be unnecessary. The proposed NJ bill delegates capacity determinations to physicians. Pursuant to the bill, a capacity determination must be within the physician's "reasonable medical judgment."¹⁰⁸ The requirement of capacity is motivated by a balance between respect for patient autonomy and protecting a patient from the consequences of a poor decision.¹⁰⁹ When making an assessment of competency, a physician "should attempt to strike the same balance that would result if a court in the jurisdiction decided the case."¹¹⁰ When assessing capacity there is generally a presumption that the person is capable and evidence of inability to form reasoned decisions is required before a physician can determine that a patient is incompetent.¹¹¹

Typically, physicians do not have the knowledge or training required for adequate patient competency determination. Physicians often are simply unaware that the patient lacks capacity.¹¹² Physicians often fail to consider all relevant factors when they do attempt to make

¹⁰⁷Andrew R. Page, *supra*.

¹⁰⁸N.J. Assemb., No. 3328 (2012).

¹⁰⁹Paul S. Appelbaum, M.D., *Assessment of Patients' Competence to Consent to Treatment*, 357 N. ENGL. J. MED. 1834-40 (2007).

¹¹⁰*Id.*

¹¹¹James L. Werth Jr., Andrew H. Benjamin, Tony Farrenkopf, *Assessing Patient Decisional Competency Under Law: Requests for Physician-Assisted Death: Guidelines for Assessing Mental Capacity and Impaired Judgment*, 6 PSYCH. PUB. POL. & L. 348, 354 (2000).

¹¹²*Id.*

a capacity determination.¹¹³ Some of these factors include the ability to communicate a choice, understand the relevant information, appreciate the consequences of actions, and reason about treatment options.¹¹⁴ Therefore, if the vital safeguard of competency is to function properly, physicians counseling patients about the possibility of ending their lives must know what to look for in the context of competency. Therefore to achieve this goal the NJ proposed DWD bill should require that a physician receive training in assessing competency in order to prescribe death-hastening drugs. In scenarios where even with training the physicians are unsure, they should be permitted, but not required to go to a court of General Equity for guidance.

E. Depression, Psychological Disorders, and Capacity

Deteriorating mental ability is not the only concern with respect to competency. Depression or other psychological disorders like bipolar disorder further complicate the issue as such conditions can invalidate decision-making by impairing a patient's rational judgment. Clinical depression or commitment to a mental institution is not dispositive in determining incapacity.¹¹⁵ Neither the "principle of autonomy nor its legal manifestation, the doctrine of informed consent, are automatically abrogated or trumped...solely because s[he] has been categorized by health care professionals with the diagnostic label of clinical depression."¹¹⁶

Clinical depression is often linked to suicide.¹¹⁷ However, general studies on "traditional" suicide and mental disorders may not be fully applicable in the context of

¹¹³*Id.*

¹¹⁴*Id. citing* T. Grisso, Paul S. Appelbaum, *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals*, New York: Oxford University Press (1998).

¹¹⁵James L. Werth Jr., Andrew H. Benjamin, Tony Farrenkopf, *supra*.

¹¹⁶Marshall B. Kapp, *Geriatric Depression: Do Older Persons Have a Right to Be Unhappy?* ELDER LAW REVIEW Vol. 1, 28 (2002).

¹¹⁷JAMES L. WERTH, JR., *RATIONAL SUICIDE? IMPLICATIONS FOR MENTAL HEALTH PROFESSIONALS*, TAYLOR & FRANCIS, 27-30 (1996).

DWD.¹¹⁸ In fact, one study found that a mere 12% out of a sample of 92 clinically depressed participants scored in the “impaired” range using competency factors.¹¹⁹ It would be a grave mistake, therefore, to attribute impaired judgment simply by virtue of a mental illness or clinical depression. Instead, the focus should be on the factors that relate to capacity and whether the patient is capable of understanding their situation and is able to reason about consequences. The physician who is making a competency determination in the context of a patient with a mental disorder or clinical depression must not let the request the patient is making influence the conclusion of the evaluation; instead, the physician should focus on the process involved in making the decision to request death-hastening drugs.¹²⁰ Evaluators of competency must be careful not to let their own values cloud their judgment in determining whether or not a patient is actually competent or not.¹²¹ The decision to request death-hastening drugs coupled with a mental disorder or depression may suggest that an evaluation should be performed, but the choice by itself cannot provide a basis to conclude that the patient is not competent.¹²² This aside, even patients themselves often have “second thoughts” about physician-assisted death.¹²³ Many, as is evident from the Oregon Reports, do not ingest the death hastening drugs even after acquiring them. Physician training in assessing competency as required by an amended version of the bill should increase the chance of recognizing the signs of impaired decision making. Mental disorders or clinical depression serve as red flags and physicians should be especially careful about writing prescriptions in these scenarios. Requiring anti-depressant medications or additional psychological

¹¹⁸ *Id.*

¹¹⁹ Jessica Wilen Berg, Paul S. Appelbaum, Thomas Grisso, *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345, 372 (1996).

¹²⁰ James L. Werth Jr., Andrew H. Benjamin, Tony Farrenkopf, *supra*.

¹²¹ *Id.*

¹²² *Id.*

¹²³ See generally anti-assisted suicide disability rights group, “Second Thoughts”, at www.second-thoughts.org.

examination should not be mandatory under the bill. If a physician is uncertain, he or she may suggest psychiatric expert evaluation or anti-depressant medication contingent on a patient's willing cooperation. A physician does not need to grant a patient's request and is not compelled to participate in the DWD program. As mentioned earlier, a physician may also seek court guidance. The focus of a physician in assessing competency in the case of depression or mental disorder should be evaluating how the patient performs on factors integral to competency. If those factors are satisfied, the physician should comply with the patient's wishes.

E. Hospice & Palliative Care

Palliative care is an “interdisciplinary sub-specialty that focuses on relieving suffering and improving the quality of life for patients with serious illnesses.”¹²⁴ Generally, palliative care is the much preferred alternative to physician-assisted death. Hospice care is “generally available for people with a life expectancy of 6 months or less who have decided to forgo curative treatment in favor of comfort care.”¹²⁵ Many argue that better pain control should be offered to every patient regardless of that patient's medical condition.¹²⁶ Nonetheless, hospice and palliative care have their limits. In fact, an average 83% of patients who decided to ingest death-hastening drugs in Oregon received hospice care.¹²⁷

In the *Baxter v. Montana* case Justice Nelson notes a response to the state's argument that palliative care is a reasonable alternative to physician-assisted death. The response articulated two stories of individual patients one of which will very briefly be indicated here. One of the individuals, “despite the conscientious efforts of his personal doctor, hospice

¹²⁴Laura P. Gelfman, Diane E. Meier, *Making the Case for Palliative Care: An Opportunity for Health Care Reform*, 8 J. HEALTH & BIOMED. L. 57, 57 (2012).

¹²⁵Monika Ardelt, *supra* citing Christine K. Cassel, Beth Demel, *Remembering Death: Public Policy in the USA*, 94 JOURNAL OF THE ROYAL SOCIETY OF MEDICINE 433-36 (2001).

¹²⁶*Id.*

¹²⁷*Oregon Death With Dignity Act—2012, supra.*

nurses, and caregivers to provide comfort...endured both physical and emotional pain of stunning magnitude. His mind was haunted by an acute awareness that his body was stiffening...becoming immobile. He described a sense of “being ‘stuck’, ‘trapped’, ...’tieddown,’ ‘in prison.’”¹²⁸ The individual in question also suffered from severe muscle spasms, shortness of breath, fear of suffocation, anxiety, panic attacks and claustrophobia.¹²⁹ It is noted that before his death he had been exploring physician-assisted death options but found no doctor willing to help him.¹³⁰ Mr. Baxter, a plaintiff in the case, powerfully stated, “These stories demonstrate that the State’s ‘palliative care is the answer’ argument has real limitations and grossly dehumanizing failures.”¹³¹

Palliative care is the ideal. We should be focusing on reducing suffering and giving support to patients. Even with this noble goal in sight, we must nonetheless keep in mind that we are not at the stage where everyone is receiving optimal care. Even if we were, we must be cautious of imposing our moral or practical judgments on others if they seek to end their lives. In extreme cases, where sedation may be necessary to keep suffering at bay, patients should have the option of physician-assisted death. We need not—and should not—actively encourage the exercise of physician-assisted death, but we ought to make it available as an alternative if the patient so chooses.

F. Disability Discrimination, Autonomy, & the Threshold of Death

The most forceful argument against DWDAs is that they are discriminatory. As it stands, DWDAs require self-administration of death-hastening drugs. The purpose behind this requirement is to ensure that death is voluntary. However, it is simply unfair to allow patients

¹²⁸Baxter, *supra* at P89 n.9.

¹²⁹*Id.*

¹³⁰*Id.*

¹³¹*Id.*

whose condition prevents them from swallowing pills or from physically self-administering the drugs to be precluded from access to physician-assisted death, even though they have a terminal illness and are capable of making health care decisions.¹³² Two necessary justifications for allowing physician-death are the previously discussed self-determinative autonomy and Justice Steven's 'threshold of death'. Like love and marriage -- you can't have one without the other. Self-determinative autonomy but without the condition of being on the threshold of death would permit the administering of death-hastening drugs to practically anyone, regardless of their health. The threshold of death – or an individual's liberty interest in controlling the last moments of their life and how they are going to face death, therefore acts as a limiting principle on self-determinative autonomy. Conversely, a patient on the threshold of death but who lacks self-determinative autonomy has no interest in choosing how they are to face death, because as noted from the *In re Conroy* case, they cannot make a choice. Accordingly, both are prerequisites to allowing a request for physician-assisted death.

However, a terminally ill person who is incapable of self-administering drugs by virtue of physical limitations, but who still is able to communicate and make health care decisions, fully satisfies the requirements of self-determination and being on the threshold of death. By requiring self-administration of the drugs the bill is therefore discriminatory on its face towards individuals with certain disabilities or the "wrong diseases."¹³³ For example, ALS (amyotrophic lateral sclerosis) also known as Lou Gehrig's disease, slowly causes muscle weakening and eventual muscle failure.¹³⁴ A person with such a disease might be unable to use his or her arms or swallow. Two authors in particular suggest that for those patients who are unable to ingest oral medication,

¹³²Monika Ardelt, *supra* at 427.

¹³³*Id.*

¹³⁴*Amyotrophic lateral sclerosis*, A.D.A.M. MEDICAL ENCYCLOPEDIA (2012), <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001708/>.

that “a mechanism can be introduced by which all that patients are required to do is to activate a lethal injection administered by a qualified physician.”¹³⁵ This solves one of our discriminatory scenarios. But what about a patient who can talk, but not physically self-administer? Perhaps a mechanism whereby the patient bites to activate a mechanism would be adequate. The New Jersey bill must change to reflect these kinds of scenarios to avoid being discriminatory against certain persons with disabilities. Therefore, an amendment to the self-administer clause must be expanded to allow self-activated intravenous injection, so long as the ultimate act which begins the flow the death-hastening drugs is caused by the patient him or herself.

There is still yet one more problematic scenario. What about a patient who appears to be suffering, but has lost the ability to communicate via oral or written means?¹³⁶ This is a difficult question without a very good answer. This is in essence a person who is “locked inside” his non-functional body but whose mind is still capable of rational thought and decision making. Sadly, such a person would not possess the means to effectuate her self-determinative autonomy. In a crude sense, as Judge Handler previously suggested, “nature has deprived her of choice.” It may be suggested that an advanced directive could effectuate the patient’s wishes. But an advanced directive defeats the requirement that the patient must in some way directly effectuate the death-hastening drugs. The choice must be in the moment – not years ago. In such an unfortunate scenario, a guardianship would have to be imposed.

VI. Minor Changes: Family Notification & Death Certificates

The proposed NJ DWDA does not require mandatory notification of family members when requesting death-hastening drugs. Not requiring notification of next-of-kin family members could potentially be disastrous and invite after-the-fact lawsuits. Furthermore, notifying family members

¹³⁵Raphael Cohen-Almagor & Monica G. Hartman, *supra* at 287.

¹³⁶Monika Ardel, *supra* at 427.

allows concerned relatives to show their support for the patient. Mandatory notification does not in any way impinge on the patient's ability to request or receive death-hastening drugs. In fact, having family present at death seems to be one of the benefits of DWDAs. According to one study, those receiving death-hastening drug prescriptions felt better prepared for death because they were able to say their goodbyes to loved ones.¹³⁷

Another minor change to the proposed DWDA does not concern the patients themselves. Typically, DWDAs do not require that physician-assisted death or death-hastening drugs be listed as the cause of death on a patient's death certificate. For example, in Washington the State Registrar will reject any death certificate that lists anything other than the terminal illness as the cause of death in the case of physician-assisted dying.¹³⁸ Terms such as mercy killing, death with dignity, physician assisted suicide, suicide, or euthanasia if listed on a certificate will not be accepted.¹³⁹ This is simply poor policy. The actual cause of death is indeed the death-hastening drugs. Listing the underlying terminal illness as the cause of death and not mentioning drugs taken is disingenuous. A woman diagnosed with terminal cancer who falls to her death has died from impact, not from the cancer. I propose that the NJ DWD bill be amended to demand that death certificates list both the underlying terminal illness and the choice to self-administer death-hastening drugs. The actual killing is done by the drugs. Nonetheless, the underlying illness should be also listed because of its intimate connection with the choice to self-administer death-hastening drugs.

VI. Summary of Suggestions & Conclusion

¹³⁷Kathryn A. Smith, Elizabeth R. Goy, Theresa A. Harvath, and Linda Ganzini, *Quality of Death and Dying in Patients who Request Physician-Assisted Death*, 14(4) JOURNAL OF PALLIATIVE MEDICINE 445-50 (April 2011).

¹³⁸Washington State Department of Health, *Instructions for Physicians and Other Medical Certifiers for Death Certificates: Compliance with the Death with Dignity Act*, (April 2009), <http://www.doh.wa.gov/portals/1/documents/5300/DWDAMedCertifier.pdf>.

¹³⁹*Id.*

As we have seen, the New Jersey Death with Dignity bill requires extensive changes. Among those already mentioned are 1) more careful oversight mechanisms for the distribution and tracking of death-hastening drugs, 2) physician training in assessing competency for participating physicians, and 3) alteration of the “self-administer” clause of the bill and allowing for intravenous self-activated injections. More minor changes proposed are 4) requiring that self-ingested drugs be listed on the patient’s death certificate in conjunction with the underlying terminal illness, and 5) requiring notification to families of a pending drug request.

There are genuine situations where a patient should be permitted to request and ingest death-hastening drugs to facilitate control of the circumstances of her death. Nonetheless, though a noble goal, its implementation faces hurdles. In discussing end of life care and physician-assisted death it is best to approach the issues with an open and cautious mind.. New Jersey faces a serious choice that should not be taken lightly. Given adoption of the aforementioned changes—and approval by the people of New Jersey—I believe that the New Jersey Death with Dignity Act could have a positive impact on New Jersey citizens, patients, and families.

To Be or Not to Be: New Jersey’s Proposed Death With Dignity Act
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