**Summary of Testimony to the Health and Senior Services Committee of the NJ State Assembly, June 5, 2014, by Anne L. H. Studholme, commenting on and opposing A-2270, the “New Jersey Death with Dignity Act.”**

**Every major disability group that has taken a position on assisted suicide opposes legalization, including:**

**ADAPT (American Disabled for Attendant Programs Today)**

**Association of Programs for Rural Independent Living**

**Autistic Self Advocacy Network**

**Disability Rights Education and Defense Fund**

**Justice For All**

**National Council on Disability**

**National Council on Independent Living**

**National Spinal Cord Injury Association**

**Not Dead Yet**

**TASH**

**The World Association of Persons with Disabilities**

**The World Institute on Disability**

**Reasons we oppose the bill:**

**1. The proposed “New Jersey Death with Dignity Act” immunizes physicians and other health-care personnel, including pharmacists and nursing home operators, for assisting the suicides of persons diagnosed as “terminal.”**

\* This bill carves out an exception to New Jersey’s criminalization of participation in the “suicide” of another person. The Act would permit doctors, nursing home operators, family members, and heirs to affirmatively facilitate suicide, an act that would be a crime but for the suicidal person’s diagnosis and disability.

\* Indeed, the Act guarantees these suicide attempts will succeed, unlike those of the majority of other persons with suicidal ideation.

\* A practice that the State otherwise criminalizes, and expends public health resources to prevent, is instead actively facilitated as long as the person has a “terminal” prognosis, however uncertain and unreliable such prognoses are widely acknowledged to be.

**2. The bill’s proponents acknowledge pain is not the motivation, but fear of disability is.**

\* Most laymen still labor under the misconception that modern medicine cannot, or refuses to, alleviate the pain associated with fatal diseases.

\* As everyone on both sides of this issue acknowledges, that is a misconception. Pain can be alleviated, including end-of-life pain. For example, the American Medical Association now fully supports and endorses pain palliation, including palliative sedation if pain-relieving medication alone is insufficient.

**3. Nor should physician-assisted suicide be confused with the issue of whether doctors can force unwanted medical procedures.** The right to refuse unwanted medical treatment was affirmed by the U.S. Supreme Court in 1990, over twenty years ago.

**4. Instead, the proponents claim that experiencing disability is “undignified,” and argue that people who fear acquiring disability should be helped to take their lives.** None of us should feel that we have to die to have dignity, that we have to die to be relieved of pain, or that we should die to stop burdening our families or society.

**5. As written, the bill tries to steer a middle course between the proponents’ desire for completely free access to lethal-dose prescription, and the need to appear to protect vulnerable people. Those desires directly conflict, and bill provisions promoting access also unavoidably promote danger. For example:**

\* There is no requirement that either of the witnesses to the voluntariness of the request know the patient. In fact, the patient is required to provide ID, so the witnesses can verify the patient’s identity.

\* One of the two witnesses is permitted to be an heir of the patient.

\* There is no requirement for psychological counseling.

\* There is no requirement for palliative care consult.

\* A third party is allowed to communicate with a doctor on behalf of a person in requesting a lethal dose, so long as the third party is “familiar with the patient’s manner of communicating.”

\* A third party is allowed to pick up the drugs from the pharmacy and deliver them to the place where the patient resides.

\* There is no requirement that family members be notified.

\* There is no language requiring the patient’s consent at the time of administration.

\* The Act does not state that “only” the patient may administer the lethal dose. The Act instead provides that the patient “self- administer” the dose, but the term “self-administer” does not mean that administration will necessarily be by the patient. “Self-administer” is instead defined as the “act of ingesting.”

\* There is no requirement that the death be witnessed. Nothing prevents an heir or other interested person from being the only person present with the patient.

\* The bill would permit a representative of an assisted-suicide advocacy organization to witness a vulnerable patient's written request.   In Oregon, members of the assisted-suicide advocacy group that spearheaded that state's law on which the New Jersey proposal is patterned have acknowledged that they play a key role in the vast majority of deaths under the state's assisted-suicide law.

\* The death certificate is required to list an underlying disease, not lethal drugs, as the cause of death.

**6. Therefore, under the Act:**

\* Someone other than the patient is allowed to administer the lethal dose.

\* The Act contains no requirement that the patient be competent or even aware when the lethal dose is administered.

\* The Act, however, states: “Any action taken in accordance with the provisions of this act shall not constitute suicide, assisted suicide, mercy killing, or homicide under any criminal law of this State.”

**7. Without witnesses, the opportunity is created for someone other than the patient to administer the lethal dose to the patient without his consent. Even if he struggled, who would know? The lethal dose request would provide the alibi.** This scenario would seem especially significant for patients with money.

**8. In the event anyone questions a patient’s death, a meaningful response from law enforcement is unlikely.** The death certificate is required to list an underlying disease as the official cause of death. It is prohibited from listing “suicide,” or from recording the request for the drugs. All of the pertinent medical records are subject to confidentiality protections under HIPAA.